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Strategies for Improving CAHPS Clinician & Group (CG-CAHPS) Survey Scores

Speakers

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Moderator

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Susan Edgman-Levitan

Edgman-Levitan (opening), Slide 1

Hello, everyone. My name is Susan Edgman-Levitan and I'm very happy to welcome you to the CAHPS Webinar today, which will focus on "Strategies for Improving CAHPS Clinician & Group Survey Scores." Today, we actually have a blockbuster crowd registered that is one of the largest participant groups that we've ever had on a CAHPS Webinar. I think that's because we've got two excellent presenters today who are going to be focusing on how they have improved their CG-CAHPS scores.

Edgman-Levitan (opening), Slide 2

This is part of the CAHPS Webcast series and these are funded by the Agency for Healthcare Research and Quality. The Consumer Assessment of Healthcare Providers and Systems Program has been active since 1995. We actually just celebrated our 20th anniversary in the fall. The Consortium developed standardized surveys and related products, including the CAHPS Database where people can deposit their data and then have access to national comparative data.

One of the hallmarks of the CAHPS surveys, is they assess patient experiences of care and they are developed for both the ambulatory and facility-based care.

Edgman-Levitan (opening), Slide 3

We have multiple surveys that we call the CAHPS family of surveys. On the facility side, we have H-CAHPS. We have the In-Center Hemodialysis or ICH-CAHPS. We also have the Nursing Home CAHPS Surveys.

On the ambulatory side, we have the Clinician & Group CAHPS Survey, which is designed to measure care at the level of a clinician or a practice. That's the survey that we'll be focusing on the results from today. We also have the Health Plan CAHPS Survey, a Surgical Care Survey, the ECHO CAHPS which measures people's experience with behavioral health services. We have a Dental CAHPS, an American Indian CAHPS, and a Home Health Care CAHPS Survey.

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Edgman-Levitan (opening), Slide 4

Today, we're going to be focusing on the updated CAHPS Ambulatory Care Improvement Guide. We're also going to be hearing about how two health systems have improved their CG-CAHPS scores. They will be talking about the specific improvement strategies they used, the kinds of barriers that they faced and how they overcame them, their results, and then the key lessons that they learned in the course of this work.

Edgman-Levitan (opening), Slide 5

A couple of things on the housekeeping side, if you need help and you don't have any sound from your computer speakers, you can join us by phone and the phone number is on the screen now. The conference ID is also available there. If you have trouble with your connection or your slides aren't moving, select F5 to refresh your screen, and you can also log out and log back in. If you have other problems, please use the Q&A box on the right of your screen to ask for help.

Edgman-Levitan (opening), Slide 6

If you want to ask a question, you can look down and there's a question box where you enter your question and hit "Submit." At the end of the presentations, we'll be answering as many questions or themes of questions that we can in the time we have allocated for that. Then you'll click on the Q&A icon and you'll get the window to appear. This is also down at the bottom of your screen.

Edgman-Levitan (opening), Slide 7

You can download the slides as people have already begun to ask questions about that. When you hit the icon for a PDF, that's also down at the bottom of your screen, that will enable you to download the slides from today's presentation.

Edgman-Levitan (opening), Slide 8

If you also want to access event materials and resources, you can click on the Resources icon.

Edgman-Levitan (opening), Slide 9

I want to just spend a couple of minutes talking about the CAHPS Improvement Guide. We first published this Guide in 2003, and over the years it has actually been one of the most popular features of the CAHPS Web site that is part of the AHRQ Web site. It was designed to be a comprehensive resource for health plans, medical groups and other providers seeking to improve their performance in the domains of quality measured by the ambulatory CAHPS surveys.

There are three goals for the Guide. One is to help organizations cultivate an environment that encourages and sustains improvements in patient-centered care. It also provides a lot of information about how to analyze your CAHPS survey results and, as well, other forms of patient feedback that can help you identify your strengths and weaknesses.

One quick comment about that; one of the things that we often find working on quality improvement around CAHPS is that when people get survey results that they're not pleased with, they often think that the next thing to do is another survey. When, in fact, it might be much more effective and cost efficient to actually use some of the more qualitative patient feedback that we highlight in the Improvement Guide to get a and deeper understanding of why people are responding to the survey the way they are. I think equally important is it also often gives you ideas about how to improve the scores.

The last big component of the Guide is strategies for improving performance that are based around the different domains of the CAHPS ambulatory surveys.

Edgman-Levitan (opening), Slide 10

The way that the Guide is structured is there's an "About the Improvement Guide." There's a section on why is it important to improve the patient's experience? It has a lot of the evidence about why this is an important component of quality.

It has a section called, "Are You Ready to Improve?" that helps people lay the foundation for things that we have learned are very, very important to have in place if your CAHPS improvement efforts are going to be successful.

The next segment of the Guide talks about ways to approach the quality improvement process. We then have a section on determining where to focus your efforts to improve the patient experience. Finally, we have a set of interventions in the last section under the "Strategies for Improving Patient Experience" that are designed to help you improve the different domains where you may be focusing your improvement efforts.

Edgman-Levitan (opening), Slide 11

This is a list of the strategies. I'm not going to go through all of these, but we have pretty robust improvement strategies here. We are in the process of finishing an update of the Guide that also has updated resources and Web sites and other materials and tools and resources that, hopefully, you will find helpful.

Edgman-Levitan (opening), Slide 12

Today's speakers, I've already introduced myself. I'm the Executive Director of the Stoeckle Center for Primary Care Innovation at Mass General. I've also been the co-PI on the Yale-Harvard CAHPS team since 1995.

We're very lucky today to have Rick Evans, who is the Senior Vice President and Chief Experience Officer at NewYork-Presbyterian Hospital, who's going to sharing some of the work that he did here at Mass General where he was until last fall also as the Chief Experience Officer.

Then we have Debra Rosen, who is the Director of Quality and Health Education at the Northeast Valley Health Corporation in San Fernando, California. They're going to be sharing their respective strategies for improvement.

With that, I'm going to turn this over to Rick.

Rick Evans

Evans, Slide 13

Good afternoon, everyone. It's a pleasure to be with you and to share some of the work that we've done, as Susan said both at Mass General in Boston, and a little bit here in New York City.

Evans, Slide 14

Just a word about NewYork-Presbyterian. We are a large academic medical center with multiple sites scattered throughout Manhattan and around the Greater New York area.

You can see our stats there. I won't do the commercial. We also have four regional hospitals that are associated in addition to our six core campuses. So making change in patient experience here is challenging and has to be done really at scale and so we have to be very creative.

Evans, Slide 15

I wanted to start with talking today about where do you begin improvement work when you're using CG-CAHPS? I thought I would share some ways that we prioritize and set targets. We've learned from experience.

First of all, you really can't work on the whole survey at once. It's better to pick pieces of it and to try to prioritize. Again, as Susan said, I'm referring now specifically to some of the work we did at Mass General.

We look at the scores for our CG-CAHPS Survey at the enterprise division and department level, all the way down to the practice, so we look at those cuts of data. We try to see how we're doing when compared to national benchmarks. We've been great with our vendors to be able to get some of those benchmarks, so we have some sense of how we compare nationally and even in some cases regionally.

Then, as we're setting targets we try to look at how we're doing both at the enterprise division level and then down to the department and practice. At Mass General, for instance, every year we would have some enterprise targets around particular indicators off the survey. I'm going to talk about that more shortly. Then, we would assign targets by division and down to practice relative to how those divisions and practices compare to MGH as a whole. We found that was very helpful. People could peg their performance for their area based on the entire hospital.

We also have a very robust organization at Mass General and at NewYork-Presbyterian of Patient and Family Advisory Councils who give us fantastic feedback on what we should focus on. Something may look compelling from a data standpoint, and then when you talk to patients and families sometimes your priorities shift.

We also learned from experience that in picking priorities and targets for improving we really wanted to take the whole team into account. I'll talk a little bit more about that as we get into the slides. My point is that providers needed to be involved and other staff needed to be involved. The whole thing works better if everyone is working on something and that the targets and priorities somehow relate to one another and also reinforces the team.

We also find that often in picking an improvement target means work for leaders at the practice level especially. They've got a lot of work on their plates, sometimes more than they feel they can handle. We've never wanted patient experience targets to be standalone. We try to pick targets that are going to support other key organizational initiatives.

In Boston at Mass General, very often that would be targets connected with our overall work to improve access; our overall work to do well at population health management. We would make sure that the targets we were picking and the work that came with them were going to help people hit multiple bogies, not just a patient experience target.

Of course, there's the magnitude of the target. If you pick an indicator off the survey, it might be the one, for instance, on the courtesy of staff. Where are we today and where do we want to be at the end of the year? We want to give people targets that are ambitious, but doable. We look at as much data as we can about how fast these items are changing and improving nationally, so that we're pegging a goal that is going to be ambitious, doable and hopefully keep us improving at a pace that exceeds that of the rest of the country. That's kind of a starting point.

Evans, Slide 16

In terms of how we made improvement happen, again, most of the examples I'm using today are from Mass General. We're implementing these at NewYork-Presbyterian as well. We would have leadership groups, and I've talked about these on a previous Webinar, at the facility and divisional levels. For instance, the Orthopedics division would have its own targets, but they would have we called a 'Service Cabinet' or a 'Patient Experience Cabinet' that would consist of the department chair, some other key physicians, nursing leadership, administrative leadership. My team, the Patient Experience Team, would staff those cabinets. The patient

experience improvement work would be done and led by people who actually run the division. We were there helping key things up and keeping it moving, but it was led by the people who actually run that division or that practice.

We required, and we've done this at Mass General and at NYP, specific action plans with targets. We really want people to think about at the beginning of an improvement cycle, which for us was usually a calendar year, what indicator or indicators they're working on; what pieces of the experience. What best practices or actions they were going to take throughout the year to change the experience, improve the experience, and then see that validated in the metric.

We learned over time that the best way to do this is to make it an open-book test. Most practice leaders, any kind of clinical leader, they didn't go to service school. This isn't their core competency. That's where my team and I come in. We make sure that we bring to the table almost a menu of evidence-based best practice, so that's really important. It can't be a hunch, or gee, we think this might make it better. We really try to bring practices that have literature to back them up. That's particularly important in an academic medical center. Then we get the team together and we work on the plan and we create it as a group. They can pick from the menu. They can learn about best practices and choose the ones that they think apply to them and to the team the best.

That seemed to work very, very well. It made it not just a check-off exercise where I submitted my plan. I'm not sure if it was good, but I checked off the box. The plans became meaningfully. Again, in our experience we tried to balance – this was the last slide when I was talking about team interactions – we wanted to avoid the finger-pointing physician saying, "Well, I'm doing a great job. It's the front desk staff." Or the front desk staff saying, "The providers make it so hard for us."

We tried to pick indicators that really reinforced the team, including the indicators on staff courtesy and helpfulness. They are certainly the indicators on provider communication. We found very often we were working on wait time and test result issues as well. Those are by definition team functions. Those are the ways we try to structure our improvement.

Evans, Slide 17
In terms of barriers, we thought we'd be a little transparent here what made this hard. Again, most of these barriers, all of them, I've encountered and I have the scars to prove it. In terms of provider buy-in, we found the best way to get providers to buy in was to show them their individual results. CG-CAHPS is great for that. You can very often narrow it down to the provider so they can see the specific feedback about the perceptions of their care of their patients.

Leader bandwidth is always tough, whether that be provider leadership or administrative leadership. As I mentioned earlier, we try to link things to other organizational priorities so that nothing is a one-off. Best practices implemented as part of a patience experience improvement plan will also help really improve quality, safety and access other key issues.

A huge issue I think and becoming more and more prominent is provider cynicism and burnout. There's a lot of misperception out there about what patient experience is all about. I won't even say patient satisfaction anymore, because I think we've gone well beyond that. A lot of providers they are rushed. They have a lot of pressure. It comes down to, you know, I'm trying to make patients happy whether or not it's clinically good for them.

That's when you start to see these articles out there about, you know, I'll get good scores. I'll just give everybody pain meds and that kind of thing. We don't believe in that at all. The goal of patient experience improvement in

our estimation is helping patients feel confident in the care that we provide. I refer to it as 'taking a deep breath' and being able to know you're in good hands. On the provider side, if you don't put forward best practices that also have the potential to make the provider's day go better, go easier, you're not going to make any progress. We always try to think of best practices that if implemented are really going to make everybody's day go better, including the patient and family.

I already mentioned that we try to pick indicators to reflect the work of the team, so you don't have the doctors blaming the staff and the staff blaming the doctors, or some other version of that. You really have to know your survey and your data. I'm sure anyone on the phone knows this, that if you are speaking to providers the first refuge that people will take is 'the survey is bad'. The 'data is bad' and this is just not true. This is a validated instrument. It's solid. The data with our vendors is solid. We have lots of things that we can act on.

Being able to go in and speak to providers and others about the survey, about the methodology and about the data itself is critical. I would argue that you've got to figure your first couple of meetings are going to be talking about this. You can't be upset with the questions. You have to let them come and answer them one by one so that people can see over those issues and start to talk about making things better.

Then there's the accountability piece. We learned again from experience you've got to report on your data regularly. It should be as transparent as possible. Our cabinets that I mentioned earlier, they are the ones looking over the data and holding people accountable, not the patient experience types like me.

Evans, Slide 18
In terms of improvement, so you might imagine that when I came to NewYork-Presbyterian I no longer have access to Mass General data, which is as it should be. I could tell you that over four years there we saw significant year-over-year improvement in a number of domains, particularly in our wait time scores. We were starting to make progress with our test result score. We have a couple of examples here where initially in our Ortho Department our provider scores were dramatically higher than our staff scores. By the time we did work there, that had actually reversed and now the providers were trying to catch up with the staff.

We had a situation where a chairperson of a department was upset that the scores were low and asked to the see the results for every provider. We had the enviable task of telling him that it was him. It was his scores. To his credit he embraced it and he went from the bottom 5% in our provider scores to the top 5% in a year and his whole division increased. There were lots and lots of stories of success, both at the practice level, the individual provider level, all the way up to the enterprise level. We were very pleased with our results year-over-year.

Evans, Slide 19
In terms of sustaining, again it's really hard. There's a lot of cynicism about patient experience. Everybody thinks they know what it's all about and, quite frankly, they don't sometimes. That allows people to get very cynical. We have found, again at NewYork-Presbyterian and at Mass General, that this has got to become part of the lifecycle of the organization. We have annual improvement cycles that begins at the beginning of the year. We look at our data from last year. We pick usually three indicators. We set targets and we work all year and keep ourselves updated.

We also focus a lot on management training and coaching. In fact, I was just on the phone today with one of our nurse leaders about getting her staff together to do some coaching with them around how to keep the effort fresh and roll it out and help management learn how to lead. Senior leader buy-in is critical and, of course, partnering with our physicians. Again, the way to do that is it's got to be a win/win for them.

Evans, Slide 20

Some free advice, again as I mentioned before, it's very, very important to know your survey and the data. If providers see doubt in your eyes, you've kind of lost the battle. It's really important. There are times where providers – my degree is in theology, not statistics and so I'll bring a vendor in with me to make sure we can answer the questions – pick the right evidence-based practices. We find friendly competition works very, very well. I've already mentioned about linking and collaborating so that people see what's in it for them.

I think it's particularly important with our providers to show that we understand what their day is like and that we are not here to make that worse, quite frankly, to make it better. We try very hard to become part of the teams where we're working on improvements.

Evans, Slide 21

That's kind of a high-level summary of what's worked for us, both at Mass General and here at NewYork-Presbyterian. I hope that was helpful.

Susan Edgman-Levitan

Thank you, Rick. Let's keep moving and, Debra, we'd love to hear from you now about your work in California.

Debra Rosen

Rosen, Slide 23

Sure, thank you. Since I'm in California, I'd like to say good morning to everyone. We are a very different organization. I'm presenting from a Federally Qualified Health Center.

Rosen, Slide 24

To give you a little background about our organization, as I said we're an FQHC. We're in Los Angeles County.

We're fairly large for an FQHC; 14 sites, about 66,000 users/unique patients, about 290,000 visits in 2014. Our numbers are ever increasing, though. Twenty-three percent state they're best served in a language other than English, and about 81% are below 100% of the Federal Poverty Level. The stats here on the uninsured have changed. Now in 2016, we actually are at about just 20% uninsured. Almost all of our children now have insurance and about 80% of our adults as well.

Rosen, Slide 25

We have been implementing the CAHPS survey with PCMH items since 2012. We are expecting our 2015 data just in a few weeks, so we're excited to see results. When we look at the data, we are looking at of course how to analyze the data and we look at overall or enterprise-wide. We also look specifically at sites and we review the data. Typical of all of our QI work, we look to our sites within our Health Center; those that are performing well, and we share best practices among each other.

We're also comparing to the benchmark and, in the 2014 data that I'll be presenting, we're looking at a benchmark of 2013, which is a mean of 833 adult practice sites that submitted data to CAHPS. Of course, we're comparing ourselves to that benchmark. Then, of course, we're looking at changes from one year to the next and we're analyzing them to determine if the change is statistically significant.

Northeast Valley also uses other surveys and data. It's very important that we need to supplement the CAHPS data. We do the CAHPS survey annually, so it's a long period of time from one dataset to another.

In between that, we have implemented another survey, which is a Point of Care survey called the Pulse One-Minute Survey. That is done at the end of the visit; just two short questions asking the patient an open-ended

question. "In thinking about your visit today, what went well and what could be improved?" Here the patient has an opportunity to really write what's important to them and their verbatim responses are quite powerful.

We also shadow our patients. With permission we ask our patients if we can shadow them through their visit. This gives an opportunity to really see the visit through the eyes of the patient, which is critically important. We also have Patient Advisory Councils and we're able to elicit their feedback, their questions and they help us with our quality improvement efforts.

Rosen, Slide 26

I am going to share data for our results from 2012 to 2014. As you can see, there are many different categories in adding the PCMH items. You can see that also there hasn't been tremendous change over the three-year period. It is very challenging to move the dial. I'll share with you more and more, but it does take very focused and intensive intervention to make changes. These are basically the top-box answers, either Always or Usually. The questions may A lot or Yes. In the provider rating, it is between 8 and 10. You can see that there is quite a range with some of these answers and then I'm going to go a little bit more on how we focused our efforts.

Rosen, Slide 27

Where do we start? We of course review the data. We look at the CAHPS results, the PCMH items and, as mentioned before, we look at a lot of supplemental data as well. We also make sure that we're compliant with regulatory agencies and they direct us in many ways as well. We are Joint Commission Accredited and we are PCMH Recognized. In there, we're looking at improving self-management goals. That's an area of focus to make sure that we're compliant with the Joint Commission.

We also report meaningful use clinical data and also to the Bureau of Primary Health Care our UDS data. They have some clinical measures that help us focus. In terms of the Affordable Care Act, I talked already about the number of patients who are now insured. Although I'm going to be talking in a minute more about communication, although our communication scores were fairly high, this was an area of concern prior to the Affordable Care Act.

The Blue Shield of California reported that in the safety net environment 60% of the patients would be interested in changing their healthcare facility if given the option. We were really concerned about that and we wanted to make sure that we developed strong relationships with our patients, that communication skills were strong, and that they would stay with Northeast Valley. We have found that to be true, but that was an area of focus even though our scores in communication were fairly high.

Also the Board of Directors, which for a Federally Qualified Health Center must be 51% consumers, so the Board of Directors also drives our quality improvement efforts.

Rosen, Slide 28

In looking at where we focused and some of the successes and challenges, I already talked a bit about communication training. As mentioned, we did start off fairly strong. In 2012, we did an organization-wide effort to provide communication training. We actually implemented a four-hour training for the entire organization, providers and all levels of staff. We continue that training every year. We have added training for managers on helping them coach their staff and we have provided some motivational interviewing training.

We haven't seen major improvement in this area. It still does remain strong, but we know that unfortunately education is not enough to change behavior and we're continuing to look at ways that we can improve our communication scores even more.

The second area that we are currently focusing on and as I mentioned we are accredited by Joint Commission and recognized as a PCMH organization, we are looking to improve our self-management support throughout the organization. It is a current effort, so we're hoping to see those scores improve. As I will talk about, we're also measuring that internally, which is critically important. Again, only looking at data once a year is not enough, so we need to look at data monthly and we share that widely across the organization.

The next measure we have focused on is in Adult Behavioral Health. This is actually above the benchmarks for this measure. In particular, there is one question that asks, "Did your provider office ask you about feeling sad, empty or depressed?" We're required, as many other organizations are, to assess annually for depression with 12 year olds and up. Since we have implemented this, we saw in many of our locations statistically significant improvement in this particular question.

Last but not least, we are focusing very, very closely on Access to Care. We have been successfully implementing interventions. Again, we are looking at data internally because a year is a long time. I'm going to share with you some specifics about that area.

Rosen, Slide 29
Access to Care has many questions, but the one that we focused on is, "Did you see your provider within 15 minutes of your appointment?" I want to make sure that's clear. It's not, "Were you called back by the nurse or medical assistant," or "Were you vitaled," but "Are you with your provider within 15 minutes of your appointment?" As you can see, the results for adults were at 45.5%. That is well below the benchmark and the benchmark was at 74.6%. This was a particularly challenging area that we knew as an organization that we needed to focus on. Wait time in general, and then we decided as I said to focus on, "Were you seeing the provider within 15 minutes?"

Rosen, Slide 30
We decided that we needed to focus on Access as a priority area. We identified this both through the CAHPS, but specifically also through that Point of Care data, through patients' comments and complaints. This was really a focus of our patients. In fact, we really feel that our patients would be extremely happy with our organization if we can improve in this area. It was also driven by our Board of Directors and our Executive Team.

We knew that it was important to measure it internally, so we actually think our patients were quite generous with giving us a 45.5% score, but we had to measure it ourselves. We had been measuring cycle time score, cycle time from the beginning of registration to the end of the visit, but in particular we had to develop a way to measure from registration to seeing the provider. We were able to do that and we know the importance of sharing the data widely across the organization. We compare ourselves one site to another and we review that information monthly and there is some friendly competition. No one wants to be at the bottom of any measure and particularly this Access measure.

As I said, we compare from site to site and although we use best practices for interventions, we're also looking to the site to really work with their staff to create interventions that may be effective at their site. I'm going to mention some of these and these are not rocket science. As you can see, the first one is that one site decided that they would bring their medical assistants in 30 minutes earlier. It makes perfect sense. That way when the provider arrives that patient is already in the room, vitaled and ready to be seen. That we know has been very, very effective and our other health centers are adopting that intervention.

We have asked patients to come in 15 minutes prior to the appointment, and as you can imagine some do and some do not. We are as an organization reinforcing that they need to come in early to make sure that we are seeing them on time. We're implementing robust calling. We have automated call systems to remind patients of their appointments. We do text messaging, but robust calling is a little bit different. Those are live calls where we're assessing whether that patient is coming in.

We still have a much higher broken appointment rate. It's a very challenging population and we want to see if those patients will be coming in. We also handle any insurance problems before they get there and that, again, improves cycle time. Some sites have implemented some team competitions within their own health center.

Rosen, Slide 31

What do we see in terms of internal data and our trending? We have implemented a method to measure this ourselves. When we measured this first in April of 2015, we saw that only 25%, only 1 out of 4 of our patients, were seen by their provider within 15 minutes of their appointment. We see some immediate improvement. It's amazing.

Once you share data, already people are paying attention to that. That leveled off a little bit, but now we are at 33% across the organization. We have this trending data for each and every site and by discipline and by provider as well. That providers' care team sites can really dig in to see how they are doing and some sites are improving quite well.

Rosen, Slide 32

The next is that we're also looking at our total cycle time in minutes. This is a measure that we were measuring prior, but we started at an average of 82 minutes in the first quarter of 2015. Again, enterprise-wide we are at 68 minutes, so we are really pleased with this improvement. We are very excited to see our next CAHPS scores and definitely hope to see improvement in this area.

Rosen, Slide 33

Just in summary, of course we analyze the variation between our sites. We compare ourselves to the benchmark, which helps us prioritize what we need to focus on. We identify areas we excel in, and there are many, and we identify opportunities for improvement. We utilize the data from CAHPS, but we supplement with other patient experience data. We determine and prioritize overall and site-specific interventions, keeping in mind compliance with our regulatory agencies.

It's really important to focus priorities. Small changes are not going to make a change in our CAHPS survey. They really need to be focused either at the particular site, or throughout the entire organization. To see significant change efforts, as I said, significant efforts must occur to see the CAHPS score improve.

Rosen, Slide 34

The last slide is just my contact information. If you have any questions in the future, I'd be happy to answer them. Thank you.

Susan Edgman-Levitan
Thank you, Debra. We've got some great questions and I am going to try to hopefully walk us through so that we can answer as many as possible. We do have some common themes. I guess one thing that I think both Debra and Rick mentioned was trying to foster friendly competition in the improvement work. Rick, can you say a little bit about how you have done that?

Rick Evans
Edgman-Levitan (closing), Slide 35

We do it across the enterprise sharing scores and results by division. Like at Mass General and even here at NYP, I'll present to our clinical chiefs and they'll see cardiology next to ortho next to neurology, etc. That tends to foster some competition. We will show providers their scores alongside one another. At its best, that also fosters competition. Showing practices their data alongside one another also allows for competition and also sharing of best practices. There are a number of ways we show data and, again, we try to keep it positive and focused on, "How did you guys do that?" kind of thing.

Susan Edgman-Levitan

That's great. One quick comment from Mike, I've had experience working with our ambulatory primary care practices across the Partners HealthCare System. When we had individual physician-level data, I think that that was also very helpful to share the data with everyone, all the providers in the practice. Because in addition to fostering competition, they also were able to learn from each other and they could see the high and low performers. They could shadow one another and get best practices from each other, which was often quite helpful because many of our practices have fairly distinct patient populations.

Debra, are there any thoughts from you about how you fostered competition in a positive way?

Debra Rosen

Yes, sir, I think the theme is there. We share data across the organization from one site to another. We recognize success. We provide certificates, sometimes small incentives, but it is really learning from those sites that are excelling. The good thing is that throughout all of our QI measures there's usually one site that is excelling in at least one area. Again, we learn from each others' best practices.

Rick Evans

I would add, too, that you made me think of. We actually had an awards program where we would recognize on an annual basis every practice that met its targets. We'd also recognize the highest rated and those who had improved the most and we give them trophies. Every time I think this really doesn't mean anything, it blows me away the power of that kind of recognition on people and on momentum.

Susan Edgman-Levitan

Yes, I think that's really important. We've got a question if you could both just answer very briefly what modes of administration you use? Debra, we've also got several questions if you could say a little bit more about the monthly, the Pulse One-Minute survey that you're using?

Debra Rosen

Yes. We send out the questionnaires and then we call them up to five times to get our results. That's the method of the CAHPS survey. The Pulse One-Minute Survey is a very short survey. Just two questions, the first one is open-ended and we ask patients to write down 15 words and they do write that in English and Spanish. We also are able to not only have the value of the qualitative data, those are quantified so we can see numbers associated and what areas they focus on. How many mentioned the provider? How many mentioned wait time, which was focused on a lot. Then there's the 0 to 10 scale. It's just two questions, that Point of Care Survey.

Susan Edgman-Levitan

Rick, what about you?

Rick Evans

At Mass General, our CG-CAHPS was administered by phone and email option. At NYP, it's paper and email option.

Susan Edgman-Levitan

Actually just one quick thing, when you say 'by phone' it was primarily done using Interactive Voice Recognition. Is that correct?

Rick Evans

That's correct, IVI.

Susan Edgman-Levitan

Yes, okay. All right, another question is several people have asked about both of your experiences with the patient shadowing, and also what kind of input you've gotten from your patient and family advisors that's been helpful. Rick, do you want to speak first to that and then Debra?

Rick Evans

Sure. Our Patient Advisory Councils focused us like a laser beam on wait times and on test result metrics. They were very, very strong about that. We tended to focus first on provider communication or on staff courtesy and those things are important and priorities. But, what they were telling us was that they needed to be informed both of where they were in the process and of their test results. That was a pretty strong refocusing of our effort.

The shadowing, we actually have a wonderful shadowing program at Mass General and we're building one here at NYP. We had a person on our staff who was an executive coach actually and an expert in communication coaching. She would shadow our providers for half a day and then give them feedback and best practices. We had 100% satisfaction with it. Even people who came sort of reluctantly all found it extremely helpful. I'm actually looking for ways to grow that, because it does cost money. When you can meet a provider where they are and give them very practical advice, it's pretty powerful.

Susan Edgman-Levitan

I just want to jump in and say one thing about that. We also had an experience in the work that the Stoeckle Center was doing with providing shadowing to clinicians whose scores were not where they wanted them to be. We used some coaches, but we also used some faculty from our Department of Psychiatry who were very, very good communicators. They privately shadowed some of our physicians who were literally at the bottom of their practice and they are now the top performers in their practices. Although it does cost a little bit of money, it's well worth the effort.

One quick point I want to make that's just come in that's potentially related is someone has asked a question about what is the valid number of responses that you need to get reliable and valid data at the provider level. Typically, what the CAHPS Team recommends is you get 35 to 40 completed surveys per provider.

Debra, I'm going to move to you about your shadowing and also your patient and family advisors.

Debra Rosen

Sure. With shadowing we do it a little bit differently where we used interns that were new to the organization. We were looking at how the patient experienced the visit through their eyes. Some of the themes that we came up with was that our patients didn't know what to expect next. That was a really important take home and through that we focused on agenda setting to make sure that we knew what the patient's agenda was and make sure that that's met before the end of the visit.

Through Patient Advisory Councils, of course, they also talked about wait time. We also worked on developing our care teams and we help patients identify whose team they're on to make sure that they're well connected, not just with their provider but with their entire team. This has to do with wait time as well, when someone else is called in that they are on a different team. We actually put stickers on the patient and on the staff as to help them connect to which team they're on. It's been very, very powerful to learn from our patients.

Susan Edgman-Levitan

That's great and one quick comment about shadowing and also a method that we call a 'walkthrough'. Where you have your staff go through your practice or whatever setting you're working in as if they were a patient with a family member that people find incredibly helpful to identify all the roadblocks, all the waits that we have in the cycles of care. There's a lot of information about that and how to use those methods in the Improvement Guide.

We've got a question about how do you engage your front desk staff and your medical assistants? I would broaden that to you both talked about creating teams to work on this. If you could speak to that a little bit? Debra, would you like to go first on that one?

Debra Rosen

Sure. What we have at each of our health centers are called Practice Improvement Teams. We have the care team that's associated with the provider, but we also have Practice Improvement Teams. There we have representatives from leadership and from line staff. That includes front registration, medical assistants throughout the health center, and a provider of course. They come together and look at the data, identify best practices and implement improvement efforts. That has really been a powerful motivator for staff to know that they can make the change. They are the ones who see the systems every day. They listen to the report and data from our patients. They are the ones who are responsible for developing, implementing and evaluating the change. That's been very, very important.

Susan Edgman-Levitan

That's great. Rick, do you want to add anything to that?

Rick Evans

Yes and I love what I just heard. That's great stuff. I would add that we would focus on indicators that require the team to work together. You know, often front desk people will tell you, I'd love to tell the patients what their wait time is or where things are, but the provider has to talk to me. It's easier to yell at me because I'm the front desk staff. No one is ever going to yell at their doctor.

When you help people see that equation and work together to make something happen for patients, whether it's making sure they know what their wait time is or making sure that they understand how they're going to hear about their test results, no one piece of the team can do that. It can't be provider only. It can't be front desk only. We found that when we could help the different groups, if you will, understand what a lack of teamwork did to their performance, whether it's the provider's performance or front desk, it really brought people together and allowed us to work on things as a team.

Susan Edgman-Levitan

That's great. We've got a question that I think if I understand it correctly is asking about as you increased your scores in certain areas, especially around your patients being seen within 15 minutes, did you see that that had an impact on other domains you were measuring with CAHPS survey?

Debra Rosen

We are hoping to see that. Again, our results are in a couple of weeks. Our improvement in cycle time and particularly that question has really been over into 2015. We haven't seen the results yet. We hope that that influences overall satisfaction and experience, so we're looking forward to seeing those results.

Susan Edgman-Levitan

That's great. Another question that I think is important, I'd like for you both to say a little bit about how you determined what your focus areas would be for your annual improvement work, and whether you would just concentrate on areas you had focused on in the past or where you weren't doing so well. How did you choose the focus of your efforts?

Debra Rosen

If I could just start with we knew that wait time had been a problem for many years. In fact, there were some in the organization who didn't even want to measure it individually because we thought it would not be possible to improve. I think that this is a long-term problem and with all of the data, both the CAHPS data and the Point of Care data, we as an organization decided to focus on that.

I think that when the entire organization came together and said this was a priority that's when change happens. That was something that we knew was a problem for a long time, but it really took an organizational effort to focus on.

The other areas, self-management goals in particular, we knew that we needed to increase there as well. Again, the organization comes together and identifies it as a priority and then we improve, so that is what it takes.

Susan Edgman-Levitan

That's great. Another important question is can you each say a little bit about what kind of resources you have internally that help you with your data analysis and the evaluation of your results?

Rick Evans

I can say on my team here at NYP and the team at Mass General we did have two sources of support. One is we did have data expertise on our team. At NYP, I actually have two FTEs. Remember, we're 10 hospitals and lots of territory so two FTEs may sound to some like a huge amount but it ends up being pretty tight. Those two FTEs are responsible for the many dashboards and data reports we produce, both on our metrics and on our best practice process metrics.

We've also had support at NYP from something called the Value Institute, which is part of our quality shop. These are people with expertise in data management, data reporting and data analytics. They back us up and collaborate with use on producing dashboards and reports. We had a similar set of expertise in the Quality Department at Mass General. We're probably luckier than most that we have those resources.

Debra Rosen

We did use a vendor to implement the CAHPS survey and they did help us with the statistical analysis of that data. But, we are also very fortunate for an FQHC to have a very robust QI team. I believe that team is now four on that team, which is really quite remarkable, as well as our IT Department that helps us with data analytics.

We produce our own dashboards and post that on our intranet monthly. That digs down into enterprise-wide site-specific, so that each site can see the trending data at their fingertips. Everyone at all levels of the organization have access to that, so we definitely share our data and use our data in numerous ways.

Rick Evans

I would encourage though, too, whether you have a data FTE or not, you very likely have a vendor. I think sometimes we let dashboard paralysis take over and this really isn't rocket science. With the help of your vendor I think most organizations can come up with something that's actionable. I'd ask that we all not get paralyzed by that and sometimes we let that happen.

Susan Edgman-Levitan

Edgman-Levitan (closing), Slide 36

Yes, I would agree that. I also would remind everyone on the call that there is a lot of information about this in the Improvement Guide. We also have a CAHPS Help number that when people have specific questions they can call and get advice from the CAHPS Consortium.

We've got no minutes left, so I'd love for each of you to say one quick comment about another question that I think is very important. What's your top advice for engaging providers to get involved in the patient experience improvement?

Debra Rosen

I'll answer it quickly. It's really sharing the data and sharing it as compared from one provider, one care team, from one site to another has been most effective for us.

Rick Evans

I would agree and I would add make it a win/win. It's got to make the doctor's day go better as well as the patient's and there are lots of win/wins that work for everyone.

Susan Edgman-Levitan

Great. Thank you both so much. This has been incredibly informative. I just want to remind people that you can download the slides and other resources on your screen.

Edgman-Levitan (closing), Slide 37

We will have another Webinar in April that's looking at how organizations have improved the CAHPS Health Plan Survey Scores."

Edgman-Levitan (closing), Slide 38

Thank you Rick and thank you Debra, and I encourage everyone to go on the AHRQ Web site and check out the Improvement Guide.

Edgman-Levitan (closing), Slide 39

I hope you all have a wonderful day. Thanks so much.