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Strategies for Improving CAHPS Health Plan Survey Scores

April 2016 • Webcast

Speakers

Karen Posey, VP, Enterprise Strategy & Consumer Experience, CareSource

Graham Bouldin, MSW, Manager, Data Analytics & Quality Improvement, Health Share of Oregon

Moderator

Susan Edgman-Levitan, PA, Executive Director, John D. Stoeckle Center for Primary Care Innovation, Massachusetts General Hospital

Susan Edgman-Levitan

Edgman-Levitan (opening), Slide 1

Welcome, everyone. My name is Susan Edgman-Levitan, and I am the -- one of the PIs on the CAHPS Consortium, and I will be presenting briefly and moderating our speakers today. The topic for our Webinar today is "Strategies for Improving CAHPS Health Plan Survey Scores."

Edgman-Levitan (opening), Slide 2

This is part of the CAHPS Webcast series. And CAHPS, the acronym, stands for Consumer Assessment of Healthcare Providers and Systems Program. This is an initiative that has been funded by the Agency for Healthcare Research and Quality since 1995. We celebrated our 20th anniversary last fall.

And the purpose of the CAHPS Consortium is to develop standardized surveys and related products such as the Improvement Guide, which we'll talk a little bit about today, as well as maintaining and managing the CAHPS National Database.

The CAHPS surveys are known for assessing patient experiences with care, and we have instruments that are developed to measure the experience of care in both the ambulatory setting, as well as in various types of health care facilities. And one thing just to make people aware of is that everything in the CAHPS domain is actually in the public domain, available for use by anyone.

Edgman-Levitan (opening), Slide 3

The next slide is a brief overview of our family of surveys. We have HCAHPS, which measures care in the hospital, In-Center Hemodialysis for dialysis centers, Nursing Home and Hospice care CAHPS. In the ambulatory setting, we have the Clinician-Group CAHPS Survey, which also has segments that focus on aspects of the patient-centered medical home. We have the Health Plan Survey, which is what you're going to be hearing about today. We also have a survey that looks at surgical care; the ECHO, which measures care with

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behavioral health services; a dental survey; an American Indian Survey; Home Health Care; and then an instrument that looks at outpatient and ambulatory surgery care.

Edgman-Levitan (opening), Slide 4
I also just want to call attention to the CAHPS Health Plan Survey 5.0. And what you see on the screen now is a brief summary of data from the 2015 National Adult Medicaid Health Plan 5.0 Survey results, and all the composites that reflect what is measured by this instrument. I'm not going to go through all the results, but these are the top-box scores.

Edgman-Levitan (opening), Slide 5
So our focus today is going to be an overview of the updated CAHPS Ambulatory Care Improvement Guide, and also, I think very importantly, we're going to hear from two Medicaid health plans about how they improved their Health Plan Survey scores. And they will focus on the strategies they used, how they overcame barriers, their results, and again, I think most importantly, what are the key lessons that they learned from these improvement activities.

Edgman-Levitan (opening), Slide 6
A couple of quick housekeeping comments: If you need help and you don't have any sound from your computer speakers, please join us by phone. Please see on this slide the conference ID number. If you have trouble with your connections or slides not moving, select F5 to refresh your screen. And if that doesn't work, log in and log back in. And if you have other problems that aren't mentioned here, please use the Q&A feature in the box to your right to ask for help. Or actually, it's on the bottom of the screen.

Edgman-Levitan (opening), Slide 7
To ask a question, you should click on the question icon at the bottom of the screen, and you can submit a question, type and put it into the box here, and submit it. We'll be reviewing all of the questions as they come in so that we prioritize the most common questions or things that we think are really important to address, and then we also try to respond to questions after the call. We also are going to wait till both of our presenters finish to take questions from everyone.

Edgman-Levitan (opening), Slide 8
To access the presentations, you can click on the red box at the bottom of the screen.

Edgman-Levitan (opening), Slide 9
And you can also access your event materials and download them by clicking on the little green box that's at the bottom of your screen.

Edgman-Levitan (opening), Slide 10
So I'd now like to just spend a couple of minutes talking about the CAHPS Ambulatory Care Improvement Guide. This is a guide that was first published in 2003. It's actually been one of the most popular documents or products of the CAHPS Consortium, and it's available on the CAHPS Web site, which is part of the AHRQ.gov Web site.

This is -- the CAHPS Improvement Guide focuses on ambulatory care, and it's a comprehensive resource for health plans, medical groups and other providers who want to improve their performance on the various domains of quality measured by the ambulatory CAHPS surveys.

There are three goals for the Guide. We want to cultivate an environment that encourages and sustains improvements in patient-centered care, and one thing I want to call attention to -- I think this is particularly important now, when we know that CMS is going to be looking at measures of patient experience in their new ambulatory care programs and primary care programs, so this is a really good time to become familiar with the surveys, and, I think, how you improve your scores. It also provides information that helps people analyze the results of their scores, and other forms of patient feedback, to identify strengths and weaknesses.

One of the common sort of improvement myths that we often address is when people get their CAHPS survey back, or for that matter, any patient experience data back, and they don't necessarily like the results they see, often the first thing people want to do is another survey. And that's usually the wrong thing to do. So there's a lot of information in the Improvement Guide about other qualitative methods to get input and advice from patients, both about why you may be getting the scores you're getting, and also, more importantly, improvement strategies from the perspective of consumers, patients and families that can help you improve your scores. And then finally, we highlight the strategies that we know have evidence behind them that help improve performance.

Edgman-Levitan (opening), Slide 11

The -- quickly, the table of contents is, we focus on what the Guide consists of, why is it important to improve the patient's experience of care. We have a chapter "Are You Ready to Improve?" that describes a lot of the foundations that people need to have in place if they hope to be successful with quality improvement activities.

We have a section that focuses on different methods of quality improvement, because we've found over the years that the capacity to do quality improvement well is often something that especially needs to be developed and strengthened in the ambulatory care setting. We also have a section on analysis and how you decide where you're going to focus your improvement efforts, and then finally, the last portion of the Guide is -- focuses on all the different strategies for both health plans as well as ambulatory practices that can be used to improve the patient's experience.

Edgman-Levitan (opening), Slide 12

This is -- the next slide is a list of the strategies that are included in the Guide. We have a couple of new ones that I want to call attention to. One is a section on price transparency, and another is a chapter on how you cultivate cultural competence.

And to the extent possible, we try to make all of these relevant for both health plans as well as for practices. Not all are relevant for a health plan, but we know that, for example, in the interventions that are useful at the practice level, it's often helpful for health plans to understand what those are, because they can motivate and even incentivize practices to undertake some of those interventions.

Edgman-Levitan (opening), Slide 13

Okay, with that I think now we get to the main part of our show today, and that is the two speakers that we're fortunate to have with us. Our first speaker is Karen Posey, who is the Vice President for Enterprise Strategy & Consumer Experience at CareSource in Dayton, Ohio, and our second speaker is Graham Bouldin, who is the Manager of Data Analytics & Quality Improvement for Health Share of Oregon in Portland, Oregon. So with that, I'm going to turn this over to Karen, and welcome.

Karen Posey

Posey, Slide 14

Thank you, Susan. Now, and I'm excited to be here. So what we wanted to talk about today is really our framework for CAHPS and the strategies we've used to drive successful CAHPS scores.

Posey, Slide 15

So first, before we get started, though, I thought it might be helpful to get a quick snapshot on CareSource. So, roughly, we are about 1.5 million members. We are in four different product lines, and a big piece of what we also do for our members, because we want to make a lasting difference in their lives, is our foundation has been very generous, and we've given over $11 million in foundational grants.

Posey, Slide 16

So as we think about the CAHPS strategies, you know, really, we wanted to focus on -- and our framework is really three things. It's the strategic and business plan; it's the outside-in, the insights; and it's the execution.

Posey, Slide 17

So let's start with the strategic and business plan. From our point of view, it all starts there. Really, what's your strategic intent? And ours at CareSource is, we want to be the number one health plan. And specifically, in Medicaid, that's what we set out to do, and that's what we've achieved.

And I think that's really important because if today, you are running CAHPS, and there isn't a correlation back to what are we going to do, what's our strategic intent, is there anything in our strategy that talks about how we're going to improve the consumer experience, because that ultimately is what -- the result of what you see in your CAHPS results, then that could be an opportunity for improvement in your organization.

And then when you look at the business plan that you have, and for example, for 2016, what might be in that business plan to really talk about how you're going to move the needle on CAHPS? In our organization specifically, we have that we're going to improve our health plan rating by a certain amount of points or percentages by several product lines. So this is very important to us, and starting here has really been very foundational for our organization.

Posey, Slide 18

The second piece is really that outside-in, or those insights. And when we really look at that, I want to make sure that everybody has a feel for CAHPS. If you're not as familiar with it, or you might be new in your role and you're starting to get your arms around CAHPS. CAHPS is a great survey, but it's very directional. So how can you get more insight and what are those different levers that you can pull to really learn more about your consumers? So that's what we'll talk about.

Posey, Slide 19

So when we think about the whole outside-in thinking and the insights, the first piece is really what we call the CAHPS Proxy, and that's that -- that's our opportunity -- as I mentioned, CAHPS is directional. We don't know who the consumer is, and so with the CAHPS Proxy, it really gives us the opportunity to understand who the consumer is and be able to do a level of analytics.

The other big piece to this is, we get to take some of the CAHPS questions and we get to ask why. So I'll give you a great example. One of the CAHPS questions is: In the last six months, when you or your child needed care right away, how often did you have -- or, excuse me -- how often did you or your child get the care you needed as soon as you needed it?

Well, the -- as you know from CAHPS, you have the opportunity to say "never," "sometimes," "usually" or "always." What we do, is when we get a "never" or "sometimes" response, then we ask the consumer why. And that gives us a whole other level of insight that allows us to do a deeper dive and really understand what is driving the consumer's response. And that has really added a lot of additional direction for us as far as things that we can improve.

Now I can tell you, one of the things you're going to want to be prepared for is, when you start -- if you start to do a CAHPS Proxy, having that level of analytics is going to be super-important to your organization because you can't just -- and I think Susan brought this up at the very beginning. Doing the survey to do a survey is the wrong reason to do it. It's taking this insight, and what are you going to do with it? And if you can really correlate it to your claims, your grievances, your pharmacy data -- there's -- your lab data -- there's a whole host of things you can do to really learn more about the attitudes and behaviors of your consumers.

Posey, Slide 20

The second tool that we use is we do health partner -- we get health partner insight. And some of the traditional things, and you know, in a lot of states, quite frankly, they require the health partner satisfaction and the health partner access survey. That's the secret shopper.

But what we added in our organization was member satisfaction with providers, and that's really that 365-degree view from the members' point of view, looking at our top providers in each of our states. What do the members really think about their level of care?

And so we asked, as you can imagine, quite a few questions. And this has really helped us be able to follow up with our health partners, the ones that are really good, and thank them, and also learn what other things that they're doing that we could potentially replicate with other health partners. But the other piece to it is, it really also helps us where -- as you can imagine -- where we have health partners that may be struggling. This is another indicator for us that is something that we can take action on with our health partners.

An example of one of those questions that we asked in the member satisfaction with providers is: In the last 12 months, did you or anyone in your family, when you went to the doctor's office, did you talk about anything -- did your doctor talk to you about anything personal, or any family problems, any substance use, mental or emotional issues at all?

And what we're really trying to understand is, is the doctor really taking the opportunity to learn more about the patient or the consumer beyond what they came in for today? Because as we all know, when you think of social determinants of health, 80 percent of it is non-health-related. So how can we get ahead of that to really help our consumers? So that's been an important question for us to ask.

Another example would be: How would you rate the office staff? So again, just trying to get a feel for the simple range, zero to 10. What would they really -- what did they really think of the office staff and the job that they're doing for them?

Posey, Slide 21

And what's interesting is when we do these surveys, both on the consumer and the health partner side, we're able to get what we call key drivers. And this is really important. This is a real game-changer, when you can really get to the drivers.

And I'll give you an example: When you really can look at, from a consumer standpoint, for example, and you know what your top three drivers are -- and these are just generic examples, but looking at the specific CAHPS pieces, if you look at access to care or customer service, and you can really dive into that with your organization, that's where you can really start to make an impact on the key areas of improvement that will really make a big difference in your CAHPS scores.

Susan Edgman-Levitan
Karen, can I ask you a quick question?

Karen Posey

Posey, Slide 22
Sure.

Susan Edgman-Levitan
Can you expand a little bit on what you mean by "health partner"?

Karen Posey
Yes. That is -- that's just our term for provider, or doctor.

Susan Edgman-Levitan
Oh, okay. Okay.

Karen Posey
Yeah, thanks for asking, Susan. We just felt like "health partner" was more -- it seemed more collaborative.

Susan Edgman-Levitan
Yeah. That's very helpful.

Karen Posey
And then the third tool we use, as we are trying to improve our CAHPS scores in looking at the outside in and really diving into insights, is our advisory councils. And you know, it's interesting: There's a couple ways you can look at this. A lot of states, especially on the Medicaid side, require advisory councils. And even on the non-Medicaid side, they're not required, but we do these anyway. We see this as a huge opportunity to really learn more of the qualitative piece from our consumers.

And a lot of times, what we'll do and how we use them is -- let's take the example on the Medicaid side. What we've done is we have done work up front to understand the personas for all of our products, but specifically on the Medicaid side. We took those personas and we created three individual councils that focus on each of those personas so that we can really do a deeper dive with these consumers to understand their attitudes and behaviors as it relates to various aspects of our plan.

And so it really allows us to have focus -- like a focus group with these consumers. We have recurring consumers that come to every meeting, and we really focus on -- for example, when we get the CAHPS -- every year when we get the CAHPS results back, we share those with our consumers at the meetings, and we take deep dives in certain areas to learn more. And not only the things that we're doing well and what we can continue to do, but on the areas of opportunities, it gives us a great venue to really talk to our consumers directly about that.

So the advisory councils for us has been another great way to take those key drivers, incorporate those into what we're learning quarterly from them, as well as sharing the CAHPS results and getting those insights. So we've talked about how we kind of start with the strategies and the business plan.

Posey, Slide 23

We talked about the whole outside-in and really getting those key insights. Now, here's where the rubber meets the road. It's all about execution.

Posey, Slide 24

And the first thing we do is, having -- and I know from talking to a lot of other health plans, the relationship with the call center is so very important, and our partnership is no different with our call center, because they are really the hub for a lot of interaction with the consumer.

And so what we decided to do is we really took advantage of the CAHPS Proxy, and we looked at that and said, okay. So, now that we know who the consumers are, because that's the beauty of the proxy, when we get a positive -- if someone scores us a nine or a 10, we can follow up with them and get testimonials, which is always a positive thing. But if someone ranks us zero to three, which is a -- not a good score, right? I would view that as a poor score. Then how can we follow up right away and do service recovery?

And so we've worked with our call center and we've partnered with them, and that's exactly what we do, is once we get those back -- the scores, and if there's any low ones, which, thank goodness, there's not many, but those immediately go over to our call center and they do a level-of-service recovery. So that has been just a really nice enhancement to show our consumers that we're listening.

And then where we're going, and we're in the process of doing this right now, is having more what I call leading indicators, and that is more real-time feedback from a tool. Anytime they call the call center or they go on our Web site in the future, we'll be able to ask them -- right now we're looking at four questions. We want to keep it simple. Not everyone will do it, but if we even get a third of our consumers to give us feedback in a real-time setting, we're getting good leading indicators as far as how we're doing and where we need -- we might need to buff and polish our services. So we're real excited about that.

And I would tell you something that -- if you want to do that, it's a great opportunity. But one of the things you're going to want to plan for is really working and partnering with your call center team to have a -- really put in place that infrastructure for the service recovery, because it's so important.

Posey, Slide 25

The other piece to insights to execution as kind of the second execution piece is really looking at -- we created what we're calling insights work groups. And we -- based on those drivers that I talked about earlier, we've taken those drivers and we've sought out volunteers in our organization. It's -- we have -- actually, in our organization, we have four key drivers we focus on. I just gave three as an example here in the presentation today.

But based on the four, we sought out volunteers and we have what we call an insights work group. And each of these groups are cross-functional teams that they get together on their own, and then we meet, typically monthly, to review their progress. And what they're doing is they're taking those top drivers and they're looking at how they can improve the experience based on the feedback we receive from the consumers. Or, excuse me -- yes, based on the feedback we receive from the consumers.

And what's great about that is, when they come up with ideas, they work through almost an innovation process. And they come up with these ideas, and we've created a consumer experience steering committee that meets monthly that evaluates the ideas they've come up with so that we can prioritize what are going to have the biggest impact on our organization.

And as you can imagine, the steering committee is made up of, also, a cross-functional executive team within our organization that really has the authority in all the various areas that can impact our consumers. So it really makes for a very efficient way, when the steering committee gets together to review what the insight work groups have come up with, help them prioritize so that the insight work groups can really take action on those things.

Now, the other thing that we've been doing on a quarterly basis, which I think has helped tremendously, is that these insight work groups present to our CEO, and we're going to expand that to various other members of our executive team that they're going to present to on a quarterly basis. Not only does that give them visibility for all the great hard work they've been doing, but it really gives our executives a level of understanding of what we're truly doing to impact our consumers' lives.

Posey, Slide 26

So we started today talking about how to improve CAHPS and really focusing -- you know, what we found in our organization, the two key pieces to improving CAHPS is really focus and collaboration, right? And you've heard a lot about that today.

When we really align the strategy and our business plan and use the outside-in thinking and the feedback and insights, and then we execute, this is where the results come naturally. And we're very excited to say that because we focused on these key drivers in just the various things we've done, we did achieve the number one Medicaid health plan rating in 2014 and '15.

So with that, I'm going to say thank you, and turn it back to you, Susan.

Susan Edgman-Levitan

Thank you very much, Karen. This was really interesting. So let's move right on to Graham, just so we have enough time at the end for our questions.

Graham Bouldin

Bouldin, Slide 30

Thank you very much, Susan. Hello everyone, my name is Graham Bouldin. I'm with Health Share of Oregon. I'm really excited by Karen's presentation and the way that Karen's organization was able to really push the CAHPS survey into the strategy of the organization as a real driver for improvement.

Bouldin, Slide 31

I think that with Health Share's CAHPS improvement story, we're going to reflect sort of a bottom-up approach toward improvement on a particular measure that hopefully some of you will find useful. As a little bit of context, Health Share of Oregon was created in 2012. We currently enroll about 240,000 individuals in the Portland tri-county region. We are solely a Medicaid plan; we don't have multiple lines of business.

And the coordinated care organization model is something that's largely unique to Oregon; I'm not going to go into it now, but Health Share is the largest coordinated care organization in Oregon. And for us, what that means is that we're really a collection of 16 independent health plans, which cover physical, behavioral and dental health services for our members.

The goal of Health Share as an entity is really to help align clinical and administrative practices toward triple aim for Medicaid members through engagement with community partnerships and with the health systems that serve our members.

Bouldin, Slide 32

What we're really focusing on today is the improvement that Health Share was able to achieve in the Customer Service measure. The measure, as according to CAHPS -- and I think as a little bit of a disclaimer I want to say that my familiarity with CAHPS is a little bit less, I think, than Karen's. I've been learning about it over the last couple of years and was really thrilled when they asked us to present on our improvement here.

But really, the Customer Service measure is a composite of two different measures, and two questions that are asked to our members. So the first one is: "In the last six months, how often did your health plan's customer service staff treat you with courtesy and respect?" and "In the last six months, how often did your health plan's customer service give you the information or help that you needed?"

Bouldin, Slide 33

Health Share's improvement on the first one, around "How often did your health plan's customer service staff treat you with courtesy and respect" from 2013 to 2014, it was a modest improvement from a pretty decent 92 percent to a 94 percent.

Bouldin, Slide 34

However, when it comes to being able to get the information that people needed, we showed about a 24-percent increase from 2013 to 2014. And we think that that's reflective of a number of very intentional strategies that we put in place related to customer service that are what I would like to share with you today.

Bouldin, Slide 35

So our customer service improvement story really goes back to the founding of Health Share in 2014. Our customer service was provided by an external vendor. This was a decision that was made as part of sort of standing up this new organization.

And that customer service relationship was fine; it was with an organization that knew well the needs of Medicaid members and the system, but we were creating this new coordinated care model in Oregon, and that coordinated care model, although it's showing a lot of promising results for our members, it is complex and it's new. And it represents a number of new and unfamiliar systems, both for members and for the professionals, whether those are some of the 16 health plans that I mentioned or the providers who work with those health plans to provide services for our members.

Adding to that already existing complexity, I think many of you may have experienced the 2014 Medicaid expansion as an administrative challenge. We ended up both with us as a coordinated care organization and the state broadly with a pretty significant administrative backlog, really incredible wait times, members with really high needs who perhaps were new to the insurance world, and really insufficient answers about how to respond to their questions in that complexity. And for us, that really represented a breaking point.

Finally, another crucial variable here is that we as a health plan, I think many of us experience the changes that come with benefit changes and additions to benefits. So for us, a couple of really key additions were the addition of an entirely new medical transport vendor, as well as dental services. So all of those factors combined to show us, from an anecdotal perspective and from an on-the-ground member feedback perspective, that we needed to improve our customer service approach.

Bouldin, Slide 36

So what we did is we took customer service in-house in July of 2014 and hired a team with 10 individuals who were trained on the specific needs of Health Share's membership. And we really wanted to put technology at their fingertips in a way to help them most quickly address the needs of our members, and also to best understand the complexity of the system.

The initial focus was really on reducing that complexity, and the challenge for members during that chaotic time. And I realize that many of you listening don't have the opportunity of completely rebuilding your customer service team or customer service approach, but I think that a lot of the values that our customer service team used could be applied anywhere.

Bouldin, Slide 37

One of the things that we'll be talking about here is a reference to the AHRQ CAHPS Improvement Guide. The link is at the bottom of this slide. And there's two really main areas of recommendation when it comes to customer service here that we'll be referencing.

The first is having a deep knowledge of what constitutes high-quality service from the perspective of your members and patients. If -- me as a manager of quality improvement, if I have my own opinion about what represents high-quality service, that doesn't matter nearly as much as the opinion and the perspectives of our members. And I think that Karen really highlighted the need to get that direct member feedback.

The second one is the -- having service standards that clearly tell your staff what is expected of them and what their interactions with patients and members should look like.

Bouldin, Slide 38

So what did Health Share do? Well, first of all, we hired a special group of customer service professionals. And they really are pretty amazing people. I've had some chance to spend time with them and with their manager. They have strived to understand what good service means to members, and that means hiring to a team culture. The manager of our customer service team has a really strong value and a belief that having medical background or experience is really useful in a customer service team, but equally important is the ability to empathize and to connect with members as they call and have questions about their unmet needs.

One of the things that I asked about when I was trying to understand some of her process improvement approach was: How is she hiring to that team culture? And she brought up one specific question that she's using in interviews, and that question is: "Tell us about an unsuccessful phone call. In retrospect, how would you do it differently?"

And what she's looking for there is not a perfect answer, but it's really the ability to identify the experience of an unsuccessful phone call, what is it that might create an unsuccessful phone call, and the ability to be self-critical. And really the ability to not be perfect. I think there's a recognition that all of us are humans trying to do the best we can in this complex system, and if you're somebody who's able to acknowledge some of your own faults or challenges, then that's going to be a real opportunity for growth as they learn what our system and what our members need.

Bouldin, Slide 39

Continuing on some of the qualities of what this customer service team have, they have a real passion for our community and for our membership. An overwhelming sense that this system is a complex one, and I think any system that anyone is working in is complex, and if we don't think that, then we probably need to ask our members again.

The challenge I think anybody who's used health services or who has had to understand what a prior authorization is or what a referral is, that's a level of complexity and jargon that we may all be really familiar with, but that our members often struggle with. And so we as a customer service team have taken it upon ourselves to try and make that system easier to understand.

Health Share has also invested a number of resources and a fair amount of time in learning about a number of cultural considerations to take into account. We're acutely aware of the propensity within the Medicaid population to have experienced early childhood -- adverse childhood events, what are known as ACEs, and the culture of poverty. And combined, this really leads us to assume -- to lead with a trauma-informed approach. And that really leads to us trying to have a lot of attention toward tone of voice when we're dealing with members, and also doing -- going the extra mile in terms of trying to make their experience more positive.

That also includes personalizing, getting the member's name and using it during the call. And then, although the member generally calls with one need that's most clearly explained, often there's a whole range of needs, including confusion about how to, perhaps, access a specialist, or enrollment questions about family members, kids, partners, etc. And so we always anticipate that our members have many needs and we'll always ask, "Is there anything else I can help you with?"

We also want to ensure that we're giving our members time to speak, and one philosophy that our customer service team has is really empowering the customer service representatives to solve the problems in the moment. We would rather that a member feel like the person that they're speaking to is empowered to make change on their behalf than to have to go through an additional layer of bureaucracy to say, "I need to ask my supervisor about this," or "We need to check in and we'll get back to you eventually." The supervisor of that team, her approach really is to bring proposed solutions to the supervisor, not just problems.

Bouldin, Slide 40

The other recommendation here is really around setting standards and measures and targets for this work. And this is something that our team is incredibly proud of. We have high-level standards, including that all of our transfers are warm transfers, and we aim for one-call resolution, which means that we want the member to call, not have to get off the line, not have to re-dial, and by the end of that call we want them to be satisfied, even if that means that we need to transfer them over to a provider or to a partner health plan.

We also want to -- we give special attention towards coaching members to ask specific questions when they're transferred to another system. So if a member is transferred to the State, who manages Medicaid enrollment in Oregon, we want to coach them on exactly the types of questions that they should be asking given the problem that has been presented to us, and we believe that that helps to overcome some of the barriers that they might otherwise experience.

As I mentioned, we want all of our customer service representatives to have readily available information, and so we created a SharePoint library that most of them have pulled up at all times during the working day. And then also, we have a philosophy around returning all voicemails daily, and that those voicemails take priority over paperwork.

Finally, we created a member navigator role, which is really intended to deal with exceptional needs care coordination. If a call comes into the center and there's -- it's just too complex to manage in one call, we transfer that to our member navigator, who does a lot of intensive work with both providers, health plans and members.

In terms of measures and targets, we aim for 80 percent of all calls being answered within 30 seconds, and we've achieved that benchmark a number of times and do that quite consistently. And also aim for a less-than-3-percent abandonment rate. And abandonment rate really means people who call and neither leave a voicemail nor have their call picked up. We're able to track that through our data system. And we want to have less than three out of 100 calls meet that threshold. And then currently, we're at about an 83-percent one-call resolution rate.

Bouldin, Slide 41

So some of the ideas and key lessons learned really is about being transparent around performance. So we're reviewing performance measures with the entire customer service team on a monthly basis. As with all change initiatives, having leadership buy-in is really critical, and what we do currently is the customer service team shares their data with the -- Health Share's executive team on a quarterly basis where that's reviewed and questions are asked.

We also want to make performance visible. I know that many customer service units do have video boards that might show wait times and other things. We really use that to help optimize coverage and to increase team cohesion. If somebody needs a break, of course, we want to ensure that those breaks don't hinder the member experience.

And then finally, in terms of specific lessons learned here, we're talking about celebrating team successes. And the team really has a cohesive approach toward celebrating those.

Bouldin, Slide 42

So one really important thing that this group has done is they have taken to sharing company-wide stories of complex cases where navigation and customer service were essential. This really helps drive into the organization knowledge that what customer service does is absolutely critical to our mission.

And so that means on every Friday, and it's been largely consistently every Friday, we're -- the customer service team is collecting and then sharing a number of member success stories, often five to seven of them, just in a brief paragraph, that highlight particular experiences that members have, some of the challenges they have perhaps before they reach customer service, and then ways that customer service was able to overcome those barriers. That message goes all the way up to our CEO and to our quality assurance department and to IT and everyone else, who read it and get quite a bit of connection to the on-the-ground experience.

We also partner, as Karen mentioned, we also partner with our community advisory council to shape some of our organizational values. We also encourage our staff to do ride-alongs, as they come onboard here at Health Share, to spend some time with customer service, to listen to some calls, to listen to some of the challenges that our members have, with the goal, again, of really infusing that knowledge of what our members need throughout the organization, primarily with customer service but driving it into everything else that we do.

And Health Share has put a real implicit focus on the linguistic and special health care needs of our membership. Our Medicaid population is a diverse one here in Portland, and it's something that we need to attend to. And that's led to a really strong organizational focus on cultural competence among staff. We've had -- every other month we have mandatory two-hour all-staff meetings that have been focused on issues from poverty to implicit bias to equity in Oregon, privilege and power, and trauma-informed care, among other things.

So with that, I'm going to wrap it up and move on to any questions. But again, I really appreciate the opportunity to share some of the work that Health Share's invested a lot of time and resources into.

Susan Edgman-Levitan

Bouldin, Slide 43
Thank you so much. These were both really interesting and informative presentations.

Edgman-Levitan (closing), Slide 44
Graham, because you're sort of up, I'm going to ask you a couple of questions that have come in about your presentation, and that I think are fairly straightforward. The first one is: What is the average call length for your customer service reps, and is there a standard they aim for?

Graham Bouldin

Yeah. As I mentioned, they -- generally they're aiming for just a couple of minutes per call, and that's not a metric that I highlighted here. The -- what -- they're trying to move people through as quickly as possible, but with the recognition that often these calls are going to take additional time.

So one of the things that I left out of the presentation was, when you do things like warm hand-offs from customer service to other organizations, you really do run the risk of having a much longer -- if you're also, as a customer service representative, doing that warm hand-off, you run the risk of having a long wait time yourself and being off the line there pretty quickly.

So in general, I think that we're aiming for just a couple of minutes, unless there's a warm hand-off involved. And if it gets especially complex, they'll move it on to the patient -- or member navigator.

Susan Edgman-Levitan

Okay. Another related one is: What strategies do you use to reach the Medicaid population to get responses to the CAHPS survey in the first place? So, in essence, how do you help boost your response rate?

Graham Bouldin

That's a great question that actually I'm not as poised to answer. And part of the reason for that is because in the state of Oregon, the CAHPS are administered for all of these coordinated care organizations by the state of Oregon. So those strategies around getting high return rates, I know it's something that the state spends a lot of time working with their vendor on, to get that response rate that becomes a statistically significant sample, but unfortunately I'm not able to speak to those strategies myself.

Susan Edgman-Levitan

Okay. Another quick question, I think, is: You mentioned the training for your staff and that you -- part of that focus is on understanding the impact of poverty and trauma. Can you say a little bit about what you mean by the trauma-centric training?

Graham Bouldin

Sure. Those are all part of a cultural competence and health equity series of trainings that we have done. We're doing those every other month as sort of a lunch-and-learn opportunity for all staff.

The idea is that -- when Health Share was formed, part of our real high-level strategic goal was to meet the needs of -- specifically of the Medicaid population. And when you look at the Medicaid population, you recognize that there's a real disproportionate use of certain types of services. There's very high cost services, intensive service delivery when you look at what might be called high utilization in that population.

And as we've unpacked that experience that members have, we see over and over again the impact that trauma has on people's ability to engage with the systems that are there to serve them, and to use those services in a way that we might deem sort of "appropriately."

So in general, I think that the primary care system, and frankly, the behavioral health system and dental system, have a long way to go in terms of forming themselves and shaping themselves into a system that really is meant to address the needs of people who have experienced trauma and challenges with their own -- with other things related to social determinants of health.

So taking that as a starting point, we've had a real organizational focus on infusing knowledge of -- at a basic level, knowledge around even the neurodevelopmental impacts of trauma on the developing brain, all the way up through the impact of poverty on people's sort of self-efficacy or ability to interact with the world, and especially interacting with complex systems, that I think has been really quite meaningful. So we're trying to train the staff on what the impact of trauma is, and then to start infusing that into the way that we think about how we engage and communicate with our members.

Susan Edgman-Levitan
That's wonderful. Thank you. So a question for both of you that came in: You both talk about your call centers. And so I'm going to ask you to keep your answers brief because I want to make sure we get to some more of the questions, but: Are both of your call centers in-house? And do you know if it is allowed to use call center providers that may not be -- that may be out of state or even out of the US for these kinds of services?

Karen Posey
Great question, Susan. Graham, why don't you go ahead and go first?

Graham Bouldin
Sure. Yeah, our call center is in-house; that really was part of our story. I'm not sure about the ability to have vendors who are out of state or out of country, although I know that some of the vendors who we use for other services do have call centers that are not located in the state.

Susan Edgman-Levitan
Okay.

Karen Posey
And ours is in-house as well. We do supplement a little with a partner. We could not, based on our individual provider agreements by state, we could not do anything outside the country, and depending on the state, some do require that it has to be in that state. So honestly, it depends --

Susan Edgman-Levitan
Okay.

Karen Posey
But I can tell you it's all within the U.S., and it is -- the majority of it is in-house.

Susan Edgman-Levitan
Okay.

Graham Bouldin
I think -- just to speak really quickly, Susan.

Susan Edgman-Levitan
Yeah?

Graham Bouldin
I just wanted to -- I think that Karen and I both really highlighted the importance of having that tight relationship with customer service. And so, I would imagine that that's very hard to achieve if that customer service team is really far removed from the sort of hub of your organization. It's hard to probably get that synergy, although probably not impossible.

Susan Edgman-Levitan
Yeah. I think I would agree. Another question, I think for both of you, is: Do you share your CAHPS results with the state Medicaid agency? And if so, do they use them for health plan payment adjustments or the state's managed-care quality-improvement strategy? Karen, would you like to go first?

Karen Posey
Sure, happy to. Yes. Well, it's interesting. Yes, we absolutely share with the states, and they -- depending on the state. Some are more progressive than others. But we have one state specifically that is very eager to post those, and it's very important for them to post out on their Web site and whatnot how each plan is -- how we all rank.

Susan Edgman-Levitan
Okay.

Graham Bouldin
For us here -- sorry.

Karen Posey
And then -- oh, I'm sorry. I apologize. I was going to answer the second piece. And yes, when it revolves around quality, yes, a lot of states are getting very progressive on that. And they really look at CAHPS as a key component on quality, and that's going to dictate a lot of things. Several states are moving very aggressively in that area as far as what we could receive as far as additional consumers in the future with enrollment and whatnot, based on our quality scores.

Susan Edgman-Levitan
Okay, thank you. Graham?

Graham Bouldin
Yeah. In Oregon, as I mentioned, the state is actually the ones who are doing the CAHPS survey, so they have the results centrally and then disseminate it to the coordinated care organizations. So they have that, and much of it is displayed publically.

Oregon also has a pretty intensive incentive measure or quality metrics program that is part of the CCO package that I described earlier. Two of the measures out of the 17 that coordinated care organizations can work toward are directly related to CAHPS. So one of them is the Access measure and the other one is the Patient Satisfaction measure. Those, for us, both have a couple million dollars apiece potentially attached to them on an annual basis that we need to work toward improving.

Susan Edgman-Levitan
Okay. Thank you. So Karen, I'm going to go back to you. We got several questions about your use of the term "proxy CAHPS survey," and so I'd like you to elaborate on what that actually means and how you do that. And many of the questions also focused on, if this is not an anonymous survey, how do you think that affects your results if patients know that their survey results are not anonymous?

Karen Posey
Great questions. Well first of all, yeah, the CAHPS Proxy is -- it's the CAHPS survey, but we've -- what we've done is we've focused on the key composites and the key drivers of CAHPS. As you can imagine, health plan is a big one, because that's kind of the double bonus. So we look at those key drivers. And then every year, we will tweak the proxy based on those key drivers.

But to clarify, it is pretty much -- it mirrors CAHPS. It -- to a certain degree, focusing on the key eight composites. There are some questions, obviously, we don't ask because, depending on which CAHPS, whether it's Adult, Child or Child CCC, some of those -- I think with Child and Child CC are rather lengthy. We try to keep ours to a manageable number to really get the consumer insight. So that's really what it is, and how we use the drivers. What was -- is there any other pieces that I can answer?

Susan Edgman-Levitan
There was a question -- I think there was some confusion about whether your use of the CAHPS Proxy was an anonymous survey or whether it was something linked to other data where you could see who was saying what, based on the survey results.

Karen Posey
Oh, yes. Yes. My apologies. Yes, you did ask me that as well.

Susan Edgman-Levitan
That's okay.

Karen Posey
Yes. CAHPS -- we do know who the consumers are. And actually, we haven't -- the consumers like that, and I'll tell you why. It gets back to the red and green alerts I talked about earlier. Consumers want to know that they've been heard. And it's interesting, when we follow up with consumers that ranked us very well and talk to them about their experience with our company, we learn a lot from the testimonials, as well as we learn just as much from the red alerts when we're not doing well.

So we've never -- consumers, believe me -- well, here's the other interesting thing I will tell you. What's good news for us, and I'm really happy about where we are and where we're going from a maturity standpoint, is that actually, the CAHPS and the CAHPS Proxy are extremely well aligned, meaning the feedback is consistent. We know what we've got to fix, and so we're aggressively fixing that. That's a good situation to be in. So we don't have any challenges with consumers being worried that we're going to -- we know who they are. That's never been a concern.

Susan Edgman-Levitan
Okay. The next question is one that I'm actually going to also respond to, because it's become something that I'm increasingly concerned about. And the question is: Do you ever find misalignments between your operational administrative data and your CAHPS experience measures, specifically with respect to customer service, through your CAHPS access scores versus your administrative data?

And my quick response to that is that my day job is -- I'm the Executive Director of the Stoeckle Center for Primary Care Innovation at Mass General, and am very involved in a lot of our process improvement work and our PCMH activities across the partners' health care system. And we use the Clinician-Group CAHPS Survey, and we were finding that our practices were getting very poor access results. We have a huge access problem in primary care in general in Massachusetts, but our internal administrative data showed that our access was perfectly fine.

And when we really dug into it, what we found is that some of our administrative staff, and even our front-desk staff, had learned how to gain the administrative data. So they were submitting very positive administrative data, but that when we actually looked at this much more closely, what we discovered is that our CAHPS data was actually the real data that reflected what our true access issues were.

So I don't know whether Karen, you or Graham have had issues with that, but if you have, if you could say a little bit about how you reconciled differences between your CAHPS scores and your other administrative operational data.

Karen Posey
Susan, we haven't had that opportunity.

Susan Edgman-Levitan
Good.

Karen Posey
So I don't know if Graham has and he wants to speak to it, but yeah, we haven't.

Graham Bouldin
No. Our access -- our CAHPS Access data, it's important to us, and we do try and look at multiple sources for data around access, but it's something that we're continuing to develop, I mean, especially given some of the contextual changes that I highlighted related to Medicaid expansion. We also are feeling a real access pinch in some areas, although I think we've weathered it quite well. But any disconnect between CAHPS data and administrative data, I think, given the frequency of our receipt of CAHPS information, it's just not something that we've been able to reconcile.

Susan Edgman-Levitan
Okay. Well, one of the things I learned after this happened with us is that in talking with other systems about the practice-level data, we discovered that this was not necessarily an unusual problem or issue. So now we really -- our practice is really focused on what the patients are telling them, about access at least, and not just what the administrative data might show.

So we have time, maybe, for one more question, and I'm going to ask you both to say a little bit about: How do you actually catalog the kinds of questions that you're getting in your call centers so that you can identify more effectively how to deliver information to your members that may help avoid some of these calls? Does that make sense?

Graham Bouldin
I can start with that, sure.

Susan Edgman-Levitan
Okay.

Graham Bouldin
We have a pretty robust tracking system, sort of like an electronic medical record but for customer service. And that has a number of fields where they -- every call comes with a corresponding note, which we can of course mine in sort of a qualitative way.

But we're also documenting categories of calls, and those are then rolled up on a monthly basis, even on a weekly basis, and able to be analyzed so that we're looking at, are these calls related to confusion around

benefits, or with which health plan somebody is assigned to, or concerns around getting access to a particular provider type, things like that, that then can -- we can go back and look at.

So I think it's setting up the data collection on the front end, at the point of service, and then through the back end, being able to then pull it out and use it in a more meaningful way.

Susan Edgman-Levitan
That's great. Karen, would you want to --

Karen Posey
Yeah, that is great. And what I would -- yeah. Be happy to comment. Yeah, two things: One, I talked about briefly something we're getting ready to implement, and that is more early indicator, leading indicator with the real-time analytics or real-time surveying and analytics when people call the call center so that we can start to spot certain trends of consumers that are unhappy, whether it be at our call center or our Web site. So I think that's going to add a whole new level of awareness for us, which I'm real excited about, and there's a lot of goodness that'll come from that.

But I think the other piece to it is, yes, we do track, and I -- we work on reports where we look at the top reasons people are calling. And I'm a part of our digital strategy team as well, so how can we -- what we're trying to do is take these top reasons consumers call, and what channels can we use to provide additional information to our consumers, i.e. self-service? And so personally, I see huge opportunities to provide more self-service tools to the consumers to start to eliminate the reason why people have to call.

Susan Edgman-Levitan
That's great. Well, I think we are out of time. Thank you both for two very informative and thought-provoking presentations. Congratulations on all your great work in this area.

And with that, thanks to everyone on the call. I have seen a question -- well, I'm seeing it's being answered, about how to access the slides. So with that, I think we're going to end now. And thanks to everyone; I hope you have a great day.

Karen Posey
Thank you.