cahps transcript

Creative Strategies to Improve Patient Care Experience

April 2019 • Webcast

Speakers

Caren Ginsberg, PhD, CPXP, Director, CAHPS Division, Center for Quality Improvement and Patient Safety, Agency for Healthcare Research and Quality

Ingrid Nembhard, Ph.D., M.S., Fishman Family President's Distinguished Professor, Associate Professor of Health Care Management, The Wharton School - University of Pennsylvania

Yuna Lee, Ph.D., M.P.H., Assistant Professor, Department of Health Policy and Management, Columbia University Mailman School of Public Health

Moderator

Susan Edgman-Levitan, P.A., Executive Director, John D. Stoeckle Center for Primary Care Innovation, Massachusetts General Hospital, Co-PI, Yale CAHPS team

Susan Edgman-Levitan

Edgman-Levitan (opening), Slide 1

Creative Strategies to Improve Patient Experience, a webcast presented by the AHRQ CAHPS user network. I'm your moderator today, and my name is Susan Edgman-Levitan.

Edgman-Levitan (opening), Slide 2

Our first goal for today is to provide examples for why creative ideas are needed to improve patient care experience. We also will talk about how one creative idea affected patient experience at an ambulatory setting. And next, we'll discuss how healthcare organizations can foster creative ideas amongst staff to improve patients' experiences of care. And finally, we will discuss challenges organizations can anticipate when trying to implement creative improvement ideas.

Edgman-Levitan (opening), Slide 3

We are pleased to have great speakers today, starting with Caren Ginsberg, who directs the CAHPS Division within the Center for Quality Improvement and Patient Safety at the Agency for Healthcare Research and Quality. I've mentioned that I'm Susan Edgman-Levitan, the Executive Director of the John Stoeckle Center for Primary Care Innovation at Mass General Hospital, and I'll be moderating today. We also have Ingrid Nembhard, a Fishman Fellow President's Distinguished Professor and Associate Professor of Health Care Management at The Wharton School at the University of Pennsylvania, and Yuna Lee, who is an Assistant

Professor within the Department of Health Policy and Management at Columbia University Mailman School of Public Health.

Edgman-Levitan (opening), Slide 4

Before we begin, just a few of the standard housekeeping details. If you are having difficulty hearing the audio from your computer speakers, you can change the audio selection so that the WebEx can call you back and connect through your phone instead. In the event that your computer freezes during the presentation, try logging out and logging back in to the webcast to refresh the page. Remember, though, that you may just be experiencing a lag in the advancement of the slides due to your internet connection speed. And if you need help at any time during this webcast, please use the Q&A icon.

Edgman-Levitan (opening), Slide 5

At any point throughout today's presentation, if you have any technical difficulties or have a question for our speakers, you may ask a question through the Q&A feature. Depending on the browser you're using, your WebEx screen may look slightly different from this slide. Look for the Q&A icon and be sure that the dropdown option displays all panelists for you to ask the question so our team can see it. Feel free to share your name and organization and your role when you type your question. Today's session is being recorded. A replay of today's webcast and the slides will be made available on the AHRQ website.

Edgman-Levitan (opening), Slide 6

Thank you to Yuna and thank you to all of you who have participated. So with that, let's get started. I'm going to turn this over to Dr. Caren Ginsberg, the Director of the CAHPS Division at the Center for Quality Improvement and Patient Safety at AHRQ.

Caren Ginsberg

Ginsberg, Slide 6

Hi. Good afternoon everyone, and thank you, Susan. I'm delighted to be able to present this webcast to you today. And I'd like to just spend a couple of minutes before we start to give you some context and background to what AHRQ does and a little bit about patient experience research and the CAHPS program at AHRQ so that you have some context for the work that you're going to hear about today.

Ginsberg, Slide 7

So what AHRQ is, the Agency for Healthcare Research and Quality, AHRQ is a science-based agency. And what we do is we invest in research and evidence to make health care safer and improve health care quality. We create tools for health care professionals to use to improve care for their patients. And we generate measures and data that are used by providers and policy makers and researchers and others to improve performance and evaluate the progress of the US health care system. And we feel that it's important to push our science, our research, to implementation and to get our tools and products out to you, our users. I'd just like to note, AHRQ is not a regulatory agency and, as such, we don't require any administration of the CAHPS surveys. We have a different role in the CAHPS world.

Ginsberg, Slide 8

So CAHPS stands for, you might know this, Consumer Assessment of Healthcare Providers and Systems. And it's part of a larger patient experience program at AHRQ to advance the understanding and measurement and improvement of patients' experiences with their health care. We've been around since 1995. And the technical

components of this program are overseen by what's known as the CAHPS Consortium. And the CAHPS Consortium consists of AHRQ, two cooperative agreements, RAND and the Yale University School of Public Health, and our contractor, Westat.

Ginsberg, Slide 9

So I want to talk for a little bit, for a minute, about the CAHPS surveys. The CAHPS surveys are recognized as the gold standard for patient experience measurement because of the process we use to develop these surveys. First, and most importantly, the CAHPS program and survey development captures the patient's voice. We start our development with asking patients what's important to them to measure and what high-quality health care means to them. And we test all of our surveys with patients to make sure that they are understood by patients and relevant to their concerns. We also work closely with stakeholders as well in our survey development. The surveys measure patient experience of care in different settings and with health plans and with providers. And all of these different surveys, focusing on different settings, use the same process in their development. So the surveys are developed using a standardized methodology and also best practices in survey development. And the surveys, to be called a CAHPS survey, which is a trademarked name, they have to adhere to the CAHPS design principles and standards for development and testing in order to be able to use the CAHPS trademark.

Ginsberg, Slide 10

So here's some uses for CAHPS. CAHPS surveys are used in value-based purchasing. For example, for hospitals or home health care, hospice care, health plans, in-center hemodialysis facilities. They're used in public reporting. The findings are used in public reporting, for example, on the CMS compare website. For accreditation, for example, for the Joint Commission and NCQA. They're used for quality improvement. And they're used for health services research.

Ginsberg, Slide 11

I just want to tell you a little bit more about the patient experience program generally at AHRQ. We have an active research program, and some of our current research topics include topics like patients' experiences with care coordination. And you're going to be hearing more about that today. Shared decision-making, patient engagement, patient safety. We have been doing a lot of work on how to collect patient experience data using narrative protocols for open-ended questions. And we do a lot of research on survey administration modes for collecting data, the best methods and using those modes. So, with that, I'm going to turn this over to Ingrid Nembhard to start the main presentation. Thank you.

Ingrid Nembhard

Nembhard, Slide 12

Thank you, Caren. As she just said, one of the topics in the AHRQ portfolio is creative strategies to improve patient experience. The observation that we need new ideas to improve patient health care experiences in the US has been brewing for almost a decade now, if not longer. I'm going to share with you one improvement strategy that Yuna, I, and others have been studying. But before I do that, I think it's important to take a step back and answer the question “why are we seeing heightened interest in creative ideas to improve the patient care experience in particular”.

Nembhard, Slide 13

Much of the impetus is driven by a combination of belief that we can and should do more to improve the patient experience, and also a reality that health care is moving from volume-based care to value-based care. And part of delivering high-value care is ensuring a positive patient experience, not just higher clinical quality and lower cost. Currently, though, a high percentage of patients, and adults in particular, report that their patient care experiences are not what they could be. According to one fairly recent study, only 45% of adults in the US who visited a doctor in the last two years rated their care experiences as excellent. One of the big issues in ensuring a positive patient experience is care coordination.

Nembhard, Slide 14

This slide gives a glimpse of the magnitude of the care coordination issue that we're all dealing with and the imperative for care coordination. This figure shows the number of interactions that occurred in the first 80 days between when one primary care physician informed his patient about his MRI result and when his patient's tumor was resected. And what you can see here is over the course of an 80 day period, 12 clinicians were involved in the care of that patient. The patient's primary care physician who recorded all of this communicated with other clinicians 40 times, via email and phone calls, and with the patient and his wife 12 times. The patient underwent five procedures and had 11 office visits. None of them were with his primary care physician. Coordinating all of these parts of care is really a key part of the patient care experience. And while the degree of coordination pictured here isn't required for every patient, it is required for a large number of patients.

Nembhard, Slide 15

And this is particularly troubling in some sense, or compelling, because the number of patients for whom care coordination is a substantial requirement is growing. There, on this slide, you can see that the bottom chart is from a RAND study. And it shows that nearly 50% of patients will have a chronic condition by 2030, which is likely to increase the need for coordination between care providers and make it an even larger factor in patient care experiences.

Nembhard, Slide 16

Existing data suggests that coordination, though, is currently a formidable challenge. Coordination failures, care coordination failures are prevalent. 35% of patients in the US report that they've experienced a coordination gap in the last two years. And these gaps, which can be things like clinicians not knowing details about patients' care or not having test results at the time of visit, contribute to poor quality of care. We see increased medical errors, preventable hospital admissions, higher mortality rates, many issues that limit the quality of care that patients receive. And these gaps are costing the US health care system $25 to $45 billion annually by some estimates. So these are a significant issue as we think about care coordination and patient experience.

Nembhard, Slide 17

To be clear, when I talk about care coordination I'm using the AHRQ definition which says that care coordination is the deliberate organization of patient care activities between two or more participants, including the patient, involved in a patient's care to facilitate the appropriate delivery of health care services. When there's care coordination, patients receive care at the right place, at the right time, and with the right people.

Nembhard, Slide 18

In theory, if care coordination is present, continuity of care improves along three dimensions. First, there will be informational continuity, and that information from past events will inform current care. Second, there will be management continuity in that there will be a consistent care management plan across providers. And third, there will be relational continuity in that an ongoing relationship will occur between patients and providers. When there's continuity of care, patient care experiences should improve and staff work experiences should improve. And as a result of both of those things, we should see better clinical, cost and satisfaction outcomes. The question then is how do we actually improve care coordination?

Nembhard, Slide 19

One potential solution being implemented by many organizations is nurse care coordination. With this strategy, nurses engage with patients and providers, manage the development and communication of care plans, and ensure that all care that is needed is arranged and delivered. When we look across the landscape of care coordination programs, there are largely two approaches occurring. The first, which I call the exclusive-role approach, in that approach a nurse serves exclusively as care coordinator for a panel of patients. We often see this in large health systems and medical groups. The evidence for this approach is mixed but is increasingly positive and growing.

And the second approach, which I call the added-role approach, a nurse performs care coordination in addition to other job demands. We know little about the experiences of patients served by nurses under this approach, which may be pursued more by smaller organizations and those in lower resource settings. Nurses dedicating any increased attention to these tasks may be positive for patients in need and for clinicians. On the other hand, the potential positive effects of the added-role approach may not be realized because of the inability to focus exclusively on coordination tasks. And so is was the ambiguity about whether this strategy could improve patient care experiences that has motivated the research that we've been doing.

Nembhard, Slide 20

In the research that we've been doing, we've focused on one central question. What is the impact of the added-role approach to care coordination on patient care experiences of high-risk patients and clinician experiences of teamwork? When we think about high-risk patients, we're considering patients who have complex or multiple medical and psycho-social problems, which makes them the most in need of care coordination, the most at risk for coordination failures, and the most likely to benefit from care coordination.

Nembhard, Slide 21

We set out to answer this question in primary care setting. We had been studying 12 centers in one state-wide, federally qualified health center, over 140,000 patients use these 12 centers as their medical home. These centers treat over 400,000 patients per year and they have a special commitment to the uninsured, underinsured and vulnerable population. Notably, despite these centers being resource constrained, they're still actively implementing innovation and have done so very successfully historically. At the time that we encountered this organization, the organization had just completed a self-study and determined that care coordination was not what it could be for its patients, and then decided that it would pursue the added-role approach instead of the exclusive-role approach. And they did this because its nurses were concerned about losing the interesting part of the care if their most complex patients were transferred to another nurse who would do that exclusively. And they also chose this approach because they wanted to continue to work with their patients.

Nembhard, Slide 22

The organization decided that all nurses would serve as care coordinators for their high-risk patients. As such, nurses were given greater responsibility for a really key patient group. These are the patients that are high cost for the organization and also high need. For nurses, their new role meant that they were to ensure coordinated care for these patients. And a significant part of that was leading our weekly panel management meeting with patient's primary care physicians and with mental health staff to really develop and work on the care plans for these patients. The organization implemented this role using three core components. The first, nurses participated in 23 hours of training on subjects like transition care management and diabetes management and others that you can see on the slide. Second, the organization provided nurses with what it called the playbook, which outlined care for different situations and metrics for evaluation. And then the third key part for them was that the organization created an electronic dashboard to help nurses monitor patients and activities.

Nembhard, Slide 23

We studied this effect of the added-role approach using a quasi-experiment in which what we basically did is we compared the experiences in the first six centers that implemented the care coordination program to the six centers that had yet to implement the program. They implemented the program after our study period. The centers that implemented first were actually quite well matched to the centers that served as our comparison group. And I won't go into all of the research design details in the essence of time, I'll just say that we surveyed patients about care experiences using the CAHPS Clinician and Group survey and the PCMH Supplemental Item Set. And we surveyed clinic employees about teamwork using existing scales. What I'm going to show you today are the results from the first six months of the program.

Nembhard, Slide 24

But first let me tell you how we measured. So in our analysis we focused on the program's impact on four aspects of care targeting by the program and, therefore, what we expected to be affected by experiencing the program. These are all composites within the CAHPS survey. So the first one is timeliness of care. We also looked at coordination of care, that composite, the support for patient self-management composite, and the care for mental health composite. You can see examples of questions from each of these composites here. We hypothesized that timeliness of care would increase because patients in the program would have priority access to care. Their nurse care coordinators would try to be highly responsive. Care coordination for program enrollees was to improve because nurses would ensure that enrollees' needs were being met as seamlessly as possible. Support for self-management and care for mental health were additional program foci in areas of training for nurses. Therefore, we expected that nurse efforts in these areas would be reflected in patient reports of their care experiences. In focusing on staff experience of teamwork, we used items from scales on interprofessional collaboration and relational coordination.

Nembhard, Slide 25

Because a lot of research shows that program outcomes are affected by implementation and contextual factors, we also assessed those to the extent that we could. The best available data to offer on implementation was office visit frequency. We used the CAHPS question, "In the last six months, how many times did you visit this provider to get care for yourself?" Visit frequency gives us an indication of accessibility of care, engagement with patients, and follow-up to achieve goals. We expected this to increase in the program's early months as nurses, patients and care teams worked to address outstanding care needs and patient self-management training occurred for patients.

For contextual factors, we focused on three core ones, did nurses have the resources that they needed to coordinate care? Did they receive the training that they needed? And was there compatibility between care coordination and the other job demands that nurses were asked to continue doing? And these are all things that we achieved through or collected by surveying nurses. Let me share with you what we found on the next slide.

Nembhard, Slide 26

First, we found modest improvement in patient care experiences within the first six months of the program. Looking across the four areas of patient experience that I mentioned, we found that patient experience scores increased by 5% for program enrollees, whereas it remained about the same for program-eligible patients in the comparison group. So there is some increase that happened there in patient experience as a result of the added-role approach.

Nembhard, Slide 27

Contrary to what we might have thought or hoped, we observed no significant improvement in clinician-reported teamwork in the centers where nurses became care coordinators. We can maybe talk about why that might be during Q&A. On the positive side though, we didn't see a decline in clinician-reported teamwork as a result of this pretty significant change in roles within the care team.

Nembhard, Slide 28

You will remember that I said that we thought it was really important to assess whether there was evidence that nurse care coordination had actually been implemented, that is had nurses actually taken on this role and was what we were observing, was that tied to them having taken this role? We assessed that by looking at changes in the number of office visits. And we found that patients enrolled in the program reported 1.33 more office visits than those in the comparison group. That's a significant difference both statistically and practically when you consider that it's one more visit for each person that is enrolled just in the first six months period. For us, the final piece of the puzzle was how contextual factors came into play in shaping these results. We looked at these factors to gain a better understanding of whether changing them might create the possibility of greater gains and improvements long term.

Nembhard, Slide 29

When we looked at resources, we saw that they were high and seemingly not deficient. Over 75% of nurses reported having the resources that they needed. The same was true for training. Nurses believe that they have the training necessary for care coordination. Where we see the opportunity to increase the gains is by addressing role compatibility, that is aligning care coordination with other job demand. In the centers that we studied, 59% of nurses reported that, "Coordinating care for complex patients was not compatible with other tasks I'm required to perform." That suggests the compatibility is an issue that organizations will need to address in order to increase the gains from this approach.

Nembhard, Slide 30

So what do we conclude at this point about the added-role approach to nurse care coordination? First, we can see that there is some improvement for program enrollees. And that can occur within just the first six months as we saw that 5% increase in patient experience scores. We see modest improvement in patient-reported care experiences though. But I think we see opportunity. And increase in access and engagement with providers based on an increase in office visits is something else that we can conclude at this point. We don't see any

significant improvement in clinician-reported teamwork at this time, certainly not in the first six months, the results that I just presented.

That leads us to conclude that the added-role approach does hold some promise for improving patient care experiences. But organizations that use this approach will need to consider how they might align the care coordination role with nurses other job demands. That might require some shifting of tasks among care team members. And that might then start to engage the whole team in thinking about what's happening. Organizations would also need to think about how they can adjust their operations to absorb an increase in office visits. The increase in office visits that we observed is also found in studies of organizations that use the exclusive-role approach, so this is an issue no matter which approach is used. And I think these findings remind us that there's unlikely to be one magic solution. Instead, we're in a place where we need to continue to pursue creative ideas about how to improve patient experience. There are many ideas brewing in organizations everywhere. And so, that being the case, let me turn the microphone over to Yuna to share what we're learning about creative ideas for improving patient experience generally. Thank you.

Yuna Lee

Lee, Slide 31

Thank you, Ingrid. And good afternoon everyone. So as Ingrid said, given the call for creative ideas to improve patient experiences, what is a creative idea? A creative idea must be novel but also useful. And this is relevant to health care where simply being one or the other is insufficient given the dire need for improvement. In our research, we study creative ideas specifically focused on patient experience improvement. And we found that these come in many guises, some more expansive than the apps that we typically associate with health care innovation. I'm going to highlight a few examples in this slide that we found in our research. You may be surprised how familiar or even obvious they may seem to you. For example, process improvement. So you may have tweaks or workarounds that could promote better visit experiences if implemented. And, indeed, many systems are experimenting with adapting staffing and appointment scheduling resulting in lower wait times.

Patient engagement. Your staff may intuitively know what to say and how to say it when enhancing partnerships with patients. And others in your organization may learn from these ideas and approaches.

Providing holistic care. I know of one system that hosted open houses so that coordinators and their community counterparts could put names to faces and contact numbers on speed dial to promote better collaboration and care coordination in the community.

Making change stick. Creative ideas are needed to mobilize people and systems in organizations. Integrating patient-centered innovations in the organization often need some ingenuity to prevent implementation failure.

So we all have our own list of creative ideas that we wish could be implemented to improve our work. And too often these ideas remain just a wishlist in our mind. Organizations need these creative ideas so that they can spark improvement and innovation.

Lee, Slide 32

If you and your staff, everyone from administrators to support staff to clinicians, have promising creative ideas, how can organizations foster this innovation that starts at home? So large, academic centers often have the scale to host one-off events like an innovation tournament or a hackathon where the staff submit ideas for consideration, and one idea is eventually selected for implementation. However, organizations that are smaller

or under-resourced can still cultivate creative ideas too. Our research has shown that these kinds of organizations find really creative ways to embed creativity in their everyday work. It may be protecting time in their weekly meetings to brainstorm, harvesting ideas that emerge and bubble up in their daily huddles to bring to leadership, or having leaders and supervisors emphasizing creativity in team processes. Organizations are starting with their staff for this improvement process because they are close to patient experiences, they're experienced at customizing care to patients' needs, and staff often generate simple, low-cost but effective solutions. Overall, they have ideal insights into what is needed to improve and how.

Lee, Slide 33

I will now introduce some of the research we have been doing on creativity and patient experience improvement using CAHPS. Two key questions arise from the observation that staff insights may help with this process. We first wanted to know if implementation of staff's creative ideas associated with better patient care experiences. We want these outcomes to be measured, for example, with the CAHPS Clinician and Group survey. Second, we wanted to know the key challenges of using staff's creative ideas as a source of improvement in health care organizations.

Lee, Slide 34

We tested these questions by studying quality improvement teams involved in an 18-month improvement initiative that was highly focused on improving patient care experiences. These QI teams met monthly for an hour to generate, debate, discuss and implement their own improvement ideas focused on patient experiences. So we studied 220 ideas that came from 72 improvement team members from 12 community health centers, as well as 2,201 patients cared for by these individuals. Our first data source for patient care experience was the CAHPS Clinician and Group survey. To measure staff idea creativity, we studied the meeting transcripts of the QI meetings. So you can imagine hundreds of pages of typed notes that describe the creative improvement ideas that were discussed as well as what happened to them over time, were they implemented or not? You may be wondering how creativity of ideas can be measured. We used a gold-standard assessment method for creative idea assessment in organizations. We assembled a panel of QI experts, and they independently rated each of these ideas for level novelty and level of usefulness. And then we multiplied these scores together to create a unique creativity score for every idea. And then we aggregated across all the experts to create one [inaudible 00:30:51] score per idea. Staff and organizational characteristics in our study were collected by a staff survey.

Lee, Slide 35

So our first finding was that the implementation of creative ideas is associated with better patient care experiences in primary care settings as measured by CG-CAHPS. Said in another way, implementing creative ideas matters to patient care experiences. So to study this, we collected all the ideas that were rated for creativity by the experts, we assigned high-creativity ideas as those that were rated three out of five on the creativity scale and above. For each of our 12 centers, we calculated the proportion of ideas that were implemented that were also highly creative. We used statistical approaches that we call mixed models and survival analysis to find the result that when we compared centers that did not implement high-creativity improvement ideas, centers that implemented these ideas were associated with an improved care coordination score of 1.33 out of a possible five, and an improved provider rating score of 2.15 out of 10. And this result holds even after we account for differences in patient characteristics such as health status or demographics. It holds even after accounting for center characteristics, such as patient [inaudible 00:32:31] or the percentage of patients with Medicare or Medicaid, and various measures of organizational culture. However, we can't

conclude if any one idea led to improvement. And this wasn't the purpose of this study. I can say that there was a tremendous range of ideas from the most obvious, yet novel, insights to more breakthrough, radical ideas.

Lee, Slide 36

The first challenge of fostering creativity for patient experience improvement is that more creative ideas are less likely to be implemented by organizations. So on the chart on this slide, you can see that the creativity of the idea is displayed on the horizontal axis on a scale of one to five, with five being the most creative. The likelihood of an idea being implemented is displayed on the vertical axis with a higher score meaning a higher likelihood of implementation. Taking a step back, you can see that as an idea gets more creative it's also less likely to be implemented in the organization. So what are the barriers to implementation in organizations? This can include limited time due to workloads in health care. We know that staff may not have the time, or even the opportunity, to be creative in their daily work life. Stifling organizational cultures may also be a barrier. Such cultures make ideas that depart from the status quo seem risky. And, finally, a professional hierarchy that discourages initiative by lower-status individuals also discourages their voicing of creative ideas.

Lee, Slide 37

So a second challenge of fostering creativity for patient experience improvement is that more dissatisfied staff are associated with higher-creativity ideas. On this chart, the horizontal axis describes low and high dissatisfaction with work, which in our study was measured using a Staff Experience survey. The vertical axis describes the creativity of ideas generated, ranging from one to five. You can see from the slope here that as dissatisfaction increases, creativity also increases. The issue is that, of course, no organization wants to cultivate dissatisfaction. And we're certainly not advocating for more dissatisfaction, which is of significant concern now in the health care workforce. It's natural to assume, however, that all staff may experience dissatisfaction at some point or another in their career. And we should take these findings to suggest that we just shouldn't overlook dissatisfied individuals as promising partners in patient experience improvement. In fact, those individuals who are frustrated with the way things are at work may actually be helpful and imaginative in suggesting how to make things work better for patient care. Research has shown that this matters the most to the dissatisfied workers in health care.

Lee, Slide 38

So based on this research, what strategies can we take away about fostering creativity to improve patient experience? First, embrace, don't dismiss creative ideas. How do we do this? Incentivize creative idea implementation in organizations. Foster creativity using the best method for your organization, whether it be an event or time in meetings to brainstorm. Build creativity into the culture of improvement and learning within your organization, and reward it so that it thrives in your workforce. Encourage collaborative development of ideas. Creative ideas need support to survive, and teamwork makes these ideas better. Enlist influential staff to pursue idea implementation. For example, staff who are experienced and those who are central in the organization's social network may help with implementation success. Encourage dissatisfied workers to share their creative ideas. Recruit staff who are dissatisfied to participate in patient experience improvement and care co-design. They may provide really valuable insight. Don't overlook those with divergent perspectives, especially those who are new to the organization or those who interact with patients and other teams frequently. Their exposure to new ideas may provide them with unique insights into QI. Use CG-CAHPS and other tools as part of your QI efforts. Measure patient care experiences to demonstrate the effect of ideas on improvement and to motivate further sharing of ideas.

Lee, Slide 39

To conclude, pursue creativity. Creative ideas for patient experience improvement abound. Our study alone collected 220 ideas from staff. And reports from initiative across the country suggest similar numbers of ideas. Health care professionals can be rich sources of ideas, and patients can be too. In fact, our research team is now also conducting research on patient's ideas for patient experience improvement and how to integrate these ideas into organizations. Successful patient experience improvement requires careful attention to work, implementation, and organizational dynamics. As Ingrid said, are the proposed changes compatible with existing work? Is your workforce dissatisfied with improvement? And should you focus on attending to that patient experience ideas? Our work shows initial promise that implementation of staff's creative ideas are associated with better patient care experiences, which suggests that organizations should take an expansive view of innovation in this area, everything from obvious to radical ideas, from operations to technology to care coordination. Organizations should foster creativity, with this holistic view in mind, and partner with staff to not only contribute but also implement these ideas which may help hardwire and sustain improvement. Thank you so much. I'll now pass it over to Susan to lead the Q&A.

Susan Edgman-Levitan

Edgman-Levitan (closing), Slide 40

Thank you, Yuna and Ingrid for these wonderful presentations. And thanks to everybody who's participated in the webcast. I now want to encourage you to use the Q&A box to let us know what specific questions you have. And we have a few questions that have already come in so we'll begin with those. Please feel free to add your questions. We will get to as many as we can.

So I want to start with a question for Dr. Nembhard. What are the key elements do you feel primary care offices should keep in mind when trying to implement solutions for better patient experience?

Ingrid Nembhard

Thanks everybody who's participating. Thanks. I think I would put the elements into two large buckets. The first is I think when you are thinking about key elements there are operational issues that you have to consider. One of the things that comes up pretty strikingly clear from our study of the nurse care coordination program is that operations are going to have to change. When we saw that office visits are increasing and that that's part of delivering a better patient care experience, particularly for high-risk patients in improving the coordination of care that they receive, that has implications for organizations. So if they decide to do that, they have to begin to think about how they change their operations. If they want to pursue this, how do you extend office hours? Do you need to extend them during the week? Offer weekend appointments? Additional staffing? All of those require resources. If funds are not available, then organizations have to even become even more creative and thing about ways to increase their efficiency with existing resources, like using group visits and electronic communication, things that we're seeing can really make a difference in not just the patient experience but also increasing capacity.

So operational issues are something to attend to, and I think we often attend to those. They come in different forms. So we think about some of those things like office visit time, but then we also have to think about role design for workers. And so nurse care coordination is an interesting and important example I think because it says we have to think about how we redesign work roles within the care team. And so that's an operational issue. But it then also raises what I think of as a second key element that organizations have to consider, which is that there is a relational part of increasing the patient care experience.

We think about the relational part with respect to the interactions between clinicians and between clinicians and providers. And that I think is quite important. Some of those things are not as obvious though. So in the work that we did, one of the things that I didn't have a chance to talk about is that the organization realized that there were brewing relational issues in some sense that nurses sometimes didn't feel that they had the full status necessary to execute. They still dealt with issues such as how do I speak up to my primary care provider about these things and lead this weekly panel management meeting? And so once the organization realized that, they put in additional structures such as having a coaching opportunity for nurses to learn how to have these conversations and also to help them think about how to design these care plans. So there's a relational component for sure. And there's an operational component. And I think, whenever thinking about improving the patient care experience, both of those are issues that need to be considered.

Susan Edgman-Levitan
Thank you. I now have a question for Dr. Lee, which I think is a very critical question. And that is how do we get buy-in from clinicians and support staff for working on patient experience improvement?

Yuna Lee
Thank you. Thank you so much, Susan. And, again, thank you to all of those who are participating in the webcast today. I think this is such an important and rich question. I'll first of all start with some insights from the work that I've described in today's webcast, and then end with some reflections from the research team with regards to other projects that we're doing. First of all, I think that, just to reiterate some of the findings from this portfolio of studies, I think providing protected time for staff to work on improvement and to be creative while doing it is really important. We often assume that individuals who aren't engaged and who haven't yet bought in to improvement don't seem to be interested. But research actually says that the opposite is true, that often frustration is with patient care and the system and the workplace is the number one source of dissatisfaction and frustration for many health care providers. And the staff have an opportunity to contribute to improvement. That can be really positive, replenishing and invigorating, even when the task itself is really challenging. As I mentioned before, I think paying attention to those who may not be the usual suspects involved in QI and encouraging their participation and reassuring that they have something valuable to add to these efforts is really important for buy-in.

And then thinking one level above to the work. How do we embed improvement into daily life? We want to activate individuals to notice the ways that patient experience can be improved on a daily basis. And then, finally, I think as it relates to this webcast, measurement and data really matters. We found CG-CAHPS and other CAHPS instruments to be really useful tools for QI and for buy-in. These tools provide us with a starting point which can highlight any gaps. And with data you can see your performance change over time, and that can be really activating. So if you're interesting in implementing creative ideas, I think you have to think about these ideas that you're evaluating, are they novel and useful? But you also have to think about how to frame any insights that you're gleaning from your staff to leadership. How do we present and frame these ideas, and how do we engage with leaders? And I know that Ingrid, in particular, has done a lot of research on framing and leadership for the purposes of buy-in.

Susan Edgman-Levitan
Thank you. One very quick question to answer is will the slides and a recording of the Webex be made available? And the slides and replay for the webcast will be posted on the AHRQ website, or you an email cahps1@westat.com for a copy of the slides now.

The next question I'm going to pose to Dr. Nembhard, which is what is the association between staff satisfaction experience and patient experience?

Ingrid Nembhard
Thanks. So that's an important question. And I think it's one that we can look not just within health care, but we can outside of health care to find that there is a pretty strong correlation between staff experiences and patient care experiences. There's a formal framework for it. But, in the essence, what we know is that when staff are more satisfied, they, one, participate and engage in more quality improvement activity, at the same time, as Yuna was saying, dissatisfied staff can also be important for creative ideas. But what we know is that staff satisfaction, when they're more satisfied they engage in quality improvement, not just in the structured efforts but in the daily quality improvement activities that make experiences better. They dedicate more effort, and therefore patients tend to have better patient care experiences. We see this in other industries as well, where we see that there are studies of staff and workers and employees in other settings, and it's one of the most robust findings that I think we have in organizational research, is that to the extent that our workforce is satisfied, the persons with whom the interact also receive better experiences and are more satisfied.

Susan Edgman-Levitan
Yeah, and I'm just going to add a tiny bit to that. Because in all of the research that we've done and all of the case studies that we've developed looking at really high-performing organizations from the perspective of patients, we'd never seen one, no matter what the setting, no matter what type of organization, that scored really high on their CAHPS surveys that wasn't also a great place to work. And I think the message is that our staff can't take care of their patients if they're not being supported and taken care of by the organizations where they're working.

Another I think very important question is, and this is for Dr. Nembhard, is can you say a little bit more about what type of nurse played the role in care coordination? Were these MA's, LPN's, RN's or other types of nurses?

Ingrid Nembhard
These were RN's. So part of the organization's decision was that they wanted nurses working to the top of their license. And they thought that that was really important. So an interesting issue around this, right? So as they were thinking about how to structure this and even make this an even more robust, version 2.0 of nurse care coordination, they actually shifted from calling the program the care coordination program to calling it the chronic disease management program, and they were chronic disease management managers, these nurses. And they thought that that was important because they wanted to emphasize and add status to the relationship that the nursing skill was actually quite important and that a high-level of skill was necessary to coordinate care for high-risk patients. So MA's were not part of this, and lower-level license of nursing. Now, the important thing though, as we think about role compatibility, one of the things that they started to observe is that some of the activities that nurses were doing needed to shift to medical assistants and others in order to allow for that role compatibility that I was talking about, so that this does become a team effort. But they did begin with RN's as the primary person responsible for care coordination.

Susan Edgman-Levitan
Thank you. And I'm going to add a little bit to that because in my setting here at Mass General and across our system, we also have nurse care coordinators. And what we found is that the people that were the most successful in the role were nurses that were former ICU nurses, very experienced nurses that understood how

care works across the continuum. But they're also supported by community resource specialists, social workers and others and other people on the care team.

Another question that has come up that I think is important is, and this is for Dr. Lee, can you say a little bit more about the barriers and idea killers and coaching and training that is important to advance the idea sharing and actually, more importantly, the action on ideas that people want to implement?

Yuna Lee
That's a great question. I'd be happy to elaborate. So I think when we think about this process, we should think about the generation of the ideas and the barriers that could be associated with that. And then, separately, the implementation of the idea, what actually happens when an idea is being voiced and it's carried forward towards implementation. So I think at the early stages, we know a lot of organizational dynamics that may prevent many people from voicing a creative idea in the first place. We know that many people have ideas but they may feel interpersonally risky sharing their ideas, because by definition creative ideas are different from the status quo and they have a level of uncertainty to them. They may not work. And there may be a perception within the organization that anything that deviates outside of the structured protocol isn't welcome. So I think if under certain conditions we're interested in staff's creative ideas, we have to create an environment when we're speaking and discussing improvement that can allow for the invitation of these ideas that may be different to what you're already doing.

And then when we think about implementation, we should note that having an idea is one thing but actually implementing it is really a social and political process as much as any. So ensuring that we have the advocacy and the support of others in the organization is really important. Certainly within health care there are so many competing demands, so do you have people that you can collaborate with to ensure that an idea continues to be championed over the successive weeks and other people that can advocate for ways to integrate those ideas into existing improvement infrastructure and workflows? How could we ensure that these ideas don't get rejected because they seem to be incompatible and so uncertain, and in many cases just more effort than they're worth? So I think understanding the different barriers at every stage of the process, from the second that they're formed in someone's mind to how they're implemented, are really important within organizations.

Susan Edgman-Levitan
Thank you. Dr. Nembhard, a quick question for you. Can you let people know which CAHPS measure or measures demonstrated the 5% increase in the intervention group? And how long after the intervention implementation did we measure with the CAHPS survey?

Ingrid Nembhard
Yes, so the 5% was across... So for what I presented, it was across those four areas of timeliness of care, care coordination, self-management and care for mental health. So we treated it as a composite. And the reason we did that is that we found that they were very highly correlated. And so separating them in the statistical models didn't make sense. So it was across. We treated those four as a measure of patient care experience. And that 5% increase was seen within six months.

Susan Edgman-Levitan
Thank you.

Ingrid Nembhard
And that was six months after the training had occurred. And so it had actually been in practice in the organizations for that period of time.

Susan Edgman-Levitan
Okay, thank you. The next question is were primary care physicians or specialists included as members of the QI and care coordination teams, and how were their ideas incorporated? And I think this is one for Yuna and for Dr. Nembhard.

Yuna Lee
I apologize. I actually missed the beginning of the question

Susan Edgman-Levitan
The question was were primary care physicians and/or specialists included as members of the quality improvement activities or the care coordination teams? And how were their ideas incorporated?

Yuna Lee
Well I can certainly speak to the QI team. So we did have physicians as part of the QI teams. I think it's important to note that these teams were multidisciplinary. So across the 12 sites we ensured that there was equal representation across all roles, so physicians, nurses, behavior health providers and medical assistants. And their ideas were integrated because they were participating with everyone else. So it was a really egalitarian structure in terms of participation.

Ingrid Nembhard
For the nurse care coordination program, by design there were nurses. There were not specialists in the traditional way. The weekly panel management meeting could include dieticians. It could include dentistry, but not specialists like cardiologists or endocrinologists. These were specialists that were within or disciplines that were within the primary care setting.

Susan Edgman-Levitan
Okay, thank you. Another question that's come in that, because we're almost out of time, is... And I think this is for Dr. Nembhard. Can you share a little bit about the demographic makeup of the patients in your study and the caregivers?

Ingrid Nembhard
What would be most useful to you? So there was a pretty fair distribution across patients. Because I said we had high-risk patients, these were patients that had two or more emergency visits within the past 12 months or had diabetes diagnoses, mental health diagnoses. I won't give particular percentages because I think that won't be helpful, but because we were in community health centers, there was a fair proportion of patients that were Medicaid patients or Medicare dual-eligible patients, underinsured. We had a very diverse demographic panel in terms of patients that were white, black and across the age ranges as well, Hispanic and non-Hispanic. So it was a really diverse population of patients that were involved.

On the staff side, we had representation of, in terms of the staff survey results, we had representation from both the primary care providers, nurses, medical assistants and behavior health providers responding to the survey.

Edgman-Levitan (closing), Slide 41

Okay, thank you. Unfortunately we're out of time for anymore questions or answers.

So I want to thank Dr. Nembhard and Dr. Lee for these wonderful presentations. And I also want to encourage everyone to subscribe to our govdelivery listserv if you have not already done that. And this way you can stay up to date on all things CAHPS and receive announcements for upcoming webcasts. We have several in the works. And to subscribe, go to the link that you see on this screen, subscriptions.ahrq.gov/accounts/USAHRQ/subscriber/new.

Edgman-Levitan (closing), Slide 42

I want to thank everyone for attending today's webcast. You may contact us at the CAHPS user network at any time via email at cahps1@westat.com or our toll free phone line at 1-800-492-9261. And you can also access the CAHPS website at www.ahrq.gov/cahps/. If you didn't get your question answered today, please reach out to us at the email address I just mentioned, the cahps1@westat.com, and we will try to get you whatever information you may need. I want to thank everyone for participating, and hope you have a great rest of your day. Thank you.