



Implementing the New CAHPS Protocol for Obtaining Patient Comments About Their Care

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Speakers

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Moderator

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Dale Shaller

Shaller (opening), Slide 4

So let's get on with today's agenda. Following my introduction, we'll hear from AHRQ about the CAHPS program and then we'll proceed with a series of very short presentations that will first of all describe what the CAHPS narrative elicitation protocol is. And then we'll move to an outline of the context and the design of the demonstration project that the CAHPS team is conducting in partnership with the New York Presbyterian Hospital System to test the feasibility and the use and the value of the elicitation protocol with the group of ambulatory care practices.

We'll conclude the webcast with some preliminary findings from the very first phase of this demonstration and discuss our plans for moving forward. We plan to leave time for questions and answer at the end of the webcast, so again please submit your questions at any time as we go using the Q&A feature that we just reviewed.

Shaller (opening), Slide 5

We're delighted to have a really stellar group of speakers today, starting with Caren Ginsberg, who directs the CAHPS division within the Center for Quality Improvement and Patient Safety at AHRQ. Then Rachel Grob will be presenting on behalf of the CAHPS team and Rachel is a clinical professor and a director of national initiatives at the Center for Patient Partnerships at the University of Wisconsin, Madison.

And representing our demonstration project collaborators at New York Presbyterian is Tara Servati, who guides the patient experience work with the NYP Ambulatory Care Network. So without further ado I'm turning things over now to Caren. Caren?



Caren Ginsberg*Ginsberg, Slide 6*

Hi, everyone. Good afternoon. This is Caren Ginsberg. And on behalf of the Agency for Healthcare Research and Quality or AHRQ I'm delighted to welcome you to this presentation on the AHRQ Narrative Elicitation Protocol and share with you our research and work on this topic. So before we get started with the main presentation I'd like to tell you a little bit about AHRQ and the CAHPS program, so you can see how this work fits with agency priorities.

Ginsberg, Slide 7

So AHRQ is a science-based agency and what we do is we invest in research and evidence to make health care safer and improve quality and we create tools for health care professionals to improve care for their patients. And finally we generate measures and data that are used by provider and policy makers and researchers to improve performance and evaluate progress of the U.S. health care system.

And we feel that it's important to push science to implementation and to get our tools out and our products out to users. So the narrative elicitation protocol is one such tool that we're very excited to share with you. I'd like to note that, as you might already know AHRQ is not a regulatory agency and as such does not require any CAHPS surveys to be administered.

Ginsberg, Slide 8

So the Consumer Assessment of Healthcare Providers and Systems or CAHPS program here at AHRQ produces surveys and research on patient experience of care. The surveys are recognized as the gold standard for measuring patient experience and we are committed to capturing the patient's voice.

The program has been around, the CAHPS program has been around at AHRQ since about 1995 and you might have heard of the CAHPS Consortium, which is composed of the AHRQ CAHPS staff, Rand and the Yale University School of Public Health who hold cooperative agreements with us and Westat our contractor. And AHRQ relies heavily on the CAHPS Consortium for technical oversight of the CAHPS surveys, moving the field of patient experience research forward and communicating with you, our users and our stakeholders.

Ginsberg, Slide 9

We have an active research program and patient experience of care here. Our current research topics include patient experience with care coordination, shared decision making, patient engagement and patient safety as well as on best methods for collecting experience data, for example, on using different survey administration modes and using patient narrative information.

So with that I'd like to turn this over to Rachel who's going to tell you more about the elicitation protocol.

Rachel Grob*Grob, Slide 10*

Good afternoon, everybody. I am going to pick up on the Caren's wonderful framing with just a word about why narrative data matters so much. And I'm going to read you a quote from Atul Gawande's book *Being Mortal*, that I think is a real inspiration and guide star for why we would want to implement a narrative elicitation protocol.

Here's what Atul Gawande says, A few conclusions become clear when we understand this, there's cruel failure in how we treat the sick and the aged is the failure to recognize that they have priorities beyond merely being safe and living longer. But the chance to shape one's story is essential to sustaining meaning in life that we have

the opportunity to refashion our institutions, our culture and our conversations in ways that transform the possibilities for health and healthcare.

Grob, Slide 11

So it matters a lot to capture patient voice and the work that AHRQ is doing in that vein is really an inspiration to us all. We're very grateful. So what is the CAHPS Narrative Elicitation Protocol? It's a structured series of open-ended questions and it is intended to prompt respondents to tell their story. I'm going to talk a little bit more about the elements of that story in a minute.

It's designed to complement the close-ended survey questions and provide additional information that you can't get with a closed ended question that helps understand, for example, why patients are assigning the values that they assign in the survey.

Grob, Slide 12

Why did we develop this protocol? Why does it matter? Well, Americans are increasingly getting information online, whatever we think of that it's happening, and the growth of these rating sites reflects that consumers are really interested in the narrative data. But the naturally occurring comments found in the wild of say a Yelp website aren't typically drawn from a representative sample of patients. And they often provide just that partial picture of physician performance, because they're volunteers and they are not thought through the way a structured set of questions invites a respondent to think through the details of their experience.

So the elicitation protocol that our team has developed in partnership with AHRQ offers a rigorous and scientifically grounded method for collecting these comments.

Grob, Slide 13

And in creating this protocol, these five questions, our team was guided by these four criteria that you see on the slide.

We were looking to elicit stories that are complete. That is they provide a full picture of what matters to patients. But they're balanced in that they accurately reflect the positive and negative things that actually happened to the patients. So that's not the same as they're 50 percent positive and 50 percent negative, but rather if I had 90 percent positive experience and a 10 percent negative experience my comments, my narrative reflects that.

We're looking for comments that are meaningful in that other people can really understand the story when they read it and we're looking for questions that can capture experiences no matter who the respondent is. So all people's experiences can be represented in narrative form.

Grob, Slide 14

Here's a screen shot of a piece that we published a couple of years ago in Health Services Research and it summarizes the methods that we used to develop this protocol. We don't have time to discuss them here, but there are CAHPS webcasts of the days of yore, which are archived and you can listen there to hear more about our methodology.

Grob, Slide 15

Here I'm going to just summarize for you the results of a process of developing questions that can elicit that complete meaningful balanced and representative story. And here's what our protocol looks like. First, we ask, what are the most important things that you look for in a health care provider and the staff and his or her office? Because before understanding what has actually happened to a patient we need to know what it is that

they want from their care. And we know this from this rounds of testing various questions. The importance of this was really clear.

We then go onto ask when you think about the things that are most important to you, how do your provider and the staff in his or her office measure up? So we get that open-ended response. Then we go onto focus about things that have gone well in experiences. We ask here in the last three months in the protocol that you would download from the website, it's six months, just like the CAHPS survey. But we did it for three months here, because of the nature of the pilot with New York Presbyterian that Tara's going to talk to you about in a few minutes.

We probe, please explain what happened, how it happened and how it felt to you in order to get that complete story. And then we asked the same question about things that you wish had gone differently. And again please explain what happened, how it happened and how it felt to you. The final question probes specifically on aspects of the relationship between patient and provider, because we know how crucially important that is to patients.

Grob, Slide 16

The value of the protocol for improvement is clear in at least three substantive areas. One is illustrating concrete and actionable examples of care that's already being measured by the survey questions, the CG CAHPS questions. We also get substance in the domains of the composite measures, communication, office staff, care coordination and access, but information that is not directly mapped onto the questions that appear on the survey.

And then we also highlight domains of care important to patients, but not included in the clinician and group survey at all. So different domains.

Gorb, Slide 17

And here we see a mapping from the work we did developing the protocol that caused our entire team to declare how nifty because those three areas, those that are integral to the CG CAHPS questions, those that are proximal in the composite domains, but not mapped on the questions and those that are distal, more far away, mapped pretty much exactly a third, a third, a third onto the results, the narratives that patients provided.

So they told us about a third integral, a third proximal and a third distal, which was pretty amazing and I think a real illustration of the potential use of the protocol when it's implemented.

Grob, Slide 18

We also looked at the narrative data emerging from responses to the five-question protocol in terms of its actionability. And we described actionability of narrative data as the extent to which these narrative contain details that for quality improvement purposes could be acted on.

And those details include things like who was involved in the scenario or the care provision that's being described, what actually happened and where did it happen? Was it in the office setting? Was it on the telephone? When did it happen? And what was the periodicity? Is this something that happened once or is this something that happens to you often? And how did what happened get brought about?

So just, as a brief illustration, a non-actionable example would be something like I love the care I get at NYP or I hate the care I get at NYP. And an actionable example might be something like the most important thing that I really feel is that I can connect to my doctor and he really cares about me as a person, how I'm doing outside, like at school. You know, it's not just all about medicine and medical issues.

So there you see somebody who's having a good experience and is very explicit about with whom the experience happened, what it was and how it unrolled in a way that felt good.

Grob, Slide 19

What's the prevalence of actionable narrative content in these narratives? It's really good. We've got nearly 80 percent have at least one actionable passage and 25 percent had three or more. We are really seeing a lot of that actionable data that can be used for QI.

Grob, Slide 20

And also the identification of specific actors. Most often doctors, but also a variety of other staff as you can see here and other clinicians who are part of the care experience for patients.

Grob, Slide 21

The CAHPS patient narrative elicitation protocol has been released as a supplemental item set. And here is the URL where you can find it as well as a lot of guidance and again CAHPS webinars that we did in the past that provide more detail.

Grob, Slide 22

And now I am going to pass it over to Tara to talk about the NYP project.

Tara Servati

I am the Patient Experience Specialist for the Ambulatory Care Network.

Servati, Slide 23

And just to dive into our overview, project overview, our aim is to assess the feasibility, value and use of the CAHPS narrative elicitation protocol in our ambulatory care practice, those areas that get that similar CG CAHPS survey.

And phase one of our project was to see how feasible the collection of the elicitation protocol is. Is this something that we can integrate into our daily, weekly operations? Is this something that we can think will add value to our work? And once we go over those questions in phase two, how can the narrative information be reported to our leadership in ways that are not only easy to understand but can we work on those actionable items that we get from our comments? So that's the goal for phase two.

Servati, Slide 24

Moving forward to get a little more insight on New York Presbyterian, we are a bit of a unique health system in that we have over ten hospitals, seven within the direct New York Presbyterian line. We're scattered all over New York, through all five boroughs and Westchester County. So very large and of course we are affiliated with both Columbia University and Cornell Medical Schools.

Servati, Slide 25

Looking a little more deeper into the ambulatory care network abbreviated as the ACN we have 32 practices across Manhattan and these span from our primary care to family planning as well as specialty clinics. And our two campuses are, we divide it by the east side and the west side. So Columbia University is up in Washington Heights, this is the west side campus.

And there is a distinct culture and patient population where it is lower income. We have lower response rates, a very strong neighborhood identity and the staff is unionized. Whereas at Cornell that is on the upper east side campus, higher income, more elderly patients, higher response rates. So there is a difference in the population that we see there.

Servati, Slide 26

And the way that comments are currently collected in the ambulatory care network it is done through Press Ganey, which I know a lot of people on the line here are familiar with. They're the ones that administer the surveys. It's both done via mail and email. And they collect the surveys; they interpret the surveys for those that are Spanish and Chinese. And they are the holders essentially of all of our information.

And they can provide reports to our patient experience office, but also really, it's just our home for data. So the survey that is administered through Press Ganey it is based on, but it is different from the CG CAHPS. So we have the same composites of access to care, provider communication, care coordination and office staff and those global ratings of how would you like to provide, excuse me, rank your provider and how likely are you to recommend this facility?

And there are a few differences. Rachel mentioned earlier one being that the timeframe is a little bit different, so rather than the six months it is three months and there are a few other modifications, for example, some custom New York Presbyterian questions that we wanted to add on.

And the way the Press Ganey survey is, very simply what did you like best about our office, what did you like least and is there anything else you would like to share? So very open. Those quick hits our patients can provide those quick comments.

Servati, Slide 27

And the way that our patient comments are currently reported the specialist, myself, we go through every week, we read the comments and we distribute it to our senior leadership team as well as care champions, which care champions are members of the front line staff and nursing and medical assistants who really exemplify what we hold dear to patient experience, so they are also included, because we want to keep them as informed as possible.

So the current format was simple, a PDF attachment to the email where I would create this format just to make it a little bit cleaner from the raw data files that we get and you can see the surveys are currently bundled up by the survey. So before we would just get this report out, it would just look like a long list of comments, and you wouldn't know if this came from one patient or another patient unless you were looking very specifically at the survey.

So what's done now is that we highlight it to make sure that people know when we get four maybe negative comments in a row it's actually coming from one patient. So this is one patient complaint. So this is how we are currently distributing it. And you can see on the right hand column we ask if you were kept informed about wait. This is an example of a custom New York Presbyterian question that's added on the Press Ganey survey and a question that, you know, we want to make sure that people are informed about their wait time, so that's the reason that that's add on the comment report as well.

Servati, Slide 28

Going more into the study as I mentioned so the two phase quasi-experimental study of nine of our ambulatory care network sites. And our sites were based on similarities across site, so we have a few sites at Columbia campus and few at the Cornell. And they are matched based on either their specialties or are they primary care or family planning. And we have our controls and our intervention sites. Those who are receiving those five question, elicitation protocols. And then our control sites.

And we actually have almost this double control on this study you see there are some control sites that we might change a few interventions, for example, how we are delivering their comment reports. But there are

some sites where they aren't even aware that they are necessarily part of this study. They are our most basic form of control.

And so that's our phase one. And phase two it's the goal to assess the value of this enhanced feedback and the content of our elicitation protocol from our patients. So divided into these two phases we are really at the end of our phase one and now we're moving into this phase two, where we can actually see how can we deliver this information in a way that is actionable and digestible?

Servati, Slide 29

And just to give a small glimpse of this change in language on the left you see the standard Press Ganey invitation and on the right it's the enhanced invitation. And I'll just go ahead and read the enhanced invite. We especially ... the second paragraph. We especially value hearing about your experiences in your own words. The enclosed survey gives you a chance to tell us what went well and what may need improvement. We carefully review your answers and comments along with others so we can provide better care and service to our patients.

So this was again from the collaboration with the CAHPS team on changing this language to elicit that more meaningful feedback.

Servati, Slide 30

And then at the very end of the survey those questions that Rachel went over are, the comparison is shown here. Standard Press Ganey versus the elicitation protocol. And I won't read through those, since she did already. But essentially just based on my observations going through all of these comments, I have noticed anecdotally at least, that our comments are more robust, at least they're longer.

They have a little more insight about the relationship, because that is really, what they're prompted to discuss and it has been shown to have a little bit of higher response as far as direct feedback. So with that I will send it back to Rachel so she can go over the findings from phase one.

Grob, Slide 31

Thanks very much, Tara. Hi, again everybody. So we've heard a little bit about why it might be important to get narrative data about the elicitation protocol that's been developed and released as a supplemental item set and about NYP where the first demonstration project is currently rolling out. And Tara just described part of that to you. She's going to come back in a few minutes and talk a bit more about what's to come.

We are in the midst of implementation so the findings that we have to share with you today are really a teaser. This webinar is about implementing the narrative elicitation protocol and so we're really hoping that today can help those of you who are interested in thinking more about this or curious about how it's rolling out that we're going to be stimulating your questions and thoughts. We're not ready to share any definitive results yet. But we thought we'd give you a teaser and whet your appetite for the future.

Grob, Slide 32

This is based on our preliminary analysis of just part of the initial data from that first phase where we started using the five-question protocol in a subset of the practices as Tara described. And what we've seen so far in terms of understanding what's important to NYP patients again that answer to the question, what are the most important things that you look for in a health care provider and staff?

We heard from staff and clinicians at the NYP site where we conducted focus groups how important this source of information would be to them for quality improvement to develop proactive approaches that allow the clinics to meet patients around what's important to them. And what we've seen so far from analyzing the NEP data is

that about half of what we've heard is outside of the CAHPS composites about 20 percent maps onto the CG CAHPS questions and about 20 percent is in the composite areas, but not directly related to the questions.

Grob, Slide 33

So as far as additional narrative information on the questions that are being asked goes, most of that was around access to care. And things people are looking for include somebody who can speak Spanish, punctuality, and ease of communication through the Weill Cornell Connect Portal.

We also heard more than half of the statements around values, goals and what's important in health care in the MD communication domain. And here people talked about things like professional and courteous speech manner, looking for a sense of humor, looking to have detailed conversations about proper health care. One person said I can learn specific to my conditions and I want lots of attention to most important matters.

So those are some of the things that are coming through loud and clear from the NYP patient population.

Grob, Slide 34

Here's a breakdown of comments about what's important outside of those four CG CAHPS domains. And here as in most areas, when it comes to narrative data emotional rapport really rises above all else as a priority from the patient side. We heard patients at NYP talking about things like needing a caring provider, the importance of amiability. One person said relationships between provider and patient is always key. I should feel comfortable telling them about my problems or well-being.

We also heard about a quarter of folks answering the survey talking about technical competence, things like I want my provider to be up-to-date on all info available, informed, knowledgeable, providing practical medical advice or referring when they can't meet needs.

We had more than 10 percent of folks talking about thoroughness, treating all the possible health problems I have. One person said I'm appreciative; they always prescribe me what I need for each thing that is not working correct. We have nearly 15 percent of people talking about clinical staff besides the physician, and this is the office staff, this is nurses and PAs and other people who provide clinical services. And patients talked things like quote, the nurse, the other clinic and hospital personnel, they make the patients feel confident and help them greatly in their recovery.

Grob, Slide 35

So that is a little snapshot. Here is some of the first comparative data, again preliminary, that we have generated with phase one of the project. And you can see the gray bars are from the three question Press Ganey protocol that Tara just showed you. And the darker bars are the five-question narrative elicitation protocol.

And you can see how much more the five-question protocol is generating, vis a vis communication with doctors and also that emotional rapport category. The three-question Press Ganey protocol is generating more on interactions with clinical staff, which makes sense because two of the three questions concentrate on the office, so the NEP is getting less of that relatively.

Grob, Slide 36

I'm going to spend my last few minutes here talking through some specific narratives that have been generated by patients at NYP. These first several examples illustrate aspects of the existing composite measure, but they have, we would argue, that element of actionability. So the first person says, as a new patient getting the clerk on the phone to enter and accept me in the system was extremely frustrating and difficult, despite my insurance clearly denoting the doctor's name as my provider.

So this is something that for quality improvement can really be acted on in a different way than just a low score. Similarly this point about the clerk seeming too busy, feeling rushed and feeling not listened to, these are specific things that patient experience experts like Tara and the staff she engages can work on. And similarly, the idea of an appointment delay and how long that gap is provides some very specific information and potential metrics for benchmarking and really working on quality.

Grob, Slide 37

Here are some quotes that highlight missing aspects of the existing composite measures, things that the existing questions don't probe on so much. I love the first one. Yes, they are very good, but not all the time are they nice at the front, they answer our questions but they are not always nice. Right, it's that emotional rapport that's missing there and you really get a feel for the interaction.

People talk about what they like. And positive data can be super useful. We heard again in our focus groups with the NYP clinic folks how important the positive reinforcement can be. Here's somebody saying I like it when the personnel calls me to remind me of the impending appointment I have.

Finally, somebody says I was left sitting in the waiting room for one hour after my visit was over because the desk put my discharge file in the wrong place and forgot. So this is something to do with office staff, but really around professionalism and organization of the office. Again, arguably very actionable.

Grob, Slide 38

To finish up, here are a few exemplars from domains of care that really matter to patients, but are not as targeted with the survey. Always, says this first person, during my eldest son pre-op checkup with Dr. Smith, always takes extra care in providing my child with medical attention needed and overbooked herself to attend his pre-op checkup as he was going to have his tonsils removed. So that extra touch, the attentiveness, the change in schedule in order to be there at an important moment in this family's life.

I would like that when I tell my physician that I have something to take it more seriously and find what's the problem. I have never received a call to know the results. So here the second sentence, I have never received a call to know the results is about communication, but the poor communication matters to the patient in a particular context.

And that context is wanting to be taken seriously and wanting a more serious set of steps to find problems. So it really contextualizes by talking about priorities and what matters to patients and then showing what the problem with the communication finally.

Last one, when I was waiting the shift for my flu shot, I waited a little more than I should have and the doctor went out to ask why I was still there. This made me feel good. This is going an extra mile, being attentive to clinic flow, figuring out where frustrations may be occurring and taking the initiative to address them.

Grob, Slide 39

All right. I am going to now give the ball back to Tara to talk about phase two.

Servati, Slide 40

Thank you, Rachel. So when we come to phase two we really are asking the question, how can narrative information be reported to practice leaders and clinicians in ways that are easily understood and useful for improving patient experience?

So Rachel gave us some great snapshots of comments we've gotten from patients and often when we read these snapshots sometimes we are stuck, we don't know the right way to do it or we don't know how to operationalize

or standardize these things. We're really going based on emotion. So how can we take all of those emotional responses and make it into something actionable?

Servati, Slide 41

So what we did for phase two. First, we broke this down into a few different parts where we assessed the user, and the user in this case is the practice leaders, the medical directors, those who will be using this every day. We did a design sprint which I will go over in the next few slides, prototype user testing sessions, so based on what we built out is this something that you actually think you would use, and implemented in six sites and then eventually we will do this pre and post analysis across all of our sites, looking at both our scores and the comment surveys and really just getting feedback from the people who are using it.

Servati, Slide 42

So when we're assessing our user needs the process was breaking us out into 90-minute sessions. They were conducted in January of this year. We had 29 participants total for our six different practice sites. And the people in these sessions were the same people I've been mentioning, those practice administrators, medical directors, physicians, nurses, really anyone who felt that they wanted to contribute to the patient voice and understanding how we can be better.

And of those topics we discussed it was how do you feel about our current comment report, they gave us some great feedback, what do you think about this narrative content. So it was really their first introduction to learning about these new questions and did they have any response to it. And eventually as the user what do they want to see, what reports do they want to see, what do they think would be best or easiest for them to actually make action.

Often the frustration I feel that comes from a lot of our health care leaders is really that idea of I feel stuck and how can we give them a platform to unstuck them.

Servati, Slide 43

And what we found in our focus groups is that what they want is really an easy way to look at these key themes. Can we look into the actual comments, but can you just say, hey, we've had 200 comments about wait times; I want to understand it a little bit better.

They also want to be able to indicate the valance and frequency of some of those themes, but make sure that those outliers still are mentioned or at least still visible. And can we link their survey scores to our target indicators, which is three questions that are chosen from the survey to make essentially as our goals. Do these match with our goals?

Can we link them to patient demographics and visit dates? Visit date is an obvious one, because we want to make sure that, you know, if there was a bad week or we had two physicians out that week let's see if we can pinpoint where the problem was. But the patient demographics, this is also because of our unique and very, very broad patient population is there a way to understand our patient populations a little bit better and adjust the experience based on their needs?

Next, can we provide comparisons to peer groups? Which was already done to some extent as far as percentile rankings, but can we look at it within NYP, say I'm a family planning practice; I want to compare myself to all the others? And, of course, we want to see trends over time, is it possible to have a link for helpful tips. So I've noticed there's a problem about wait times, can I just click on a button and you send me to a website that talks about service improvement?

And finally, those that get individual, I call them shout outs when they're positive, but include names for positive comments and can we remove names for those negative comments, because these reports are given to so many people, I don't want them to say oh, well, Tara has gotten three negative comments about how bad she's doing. We don't want to really spread that negativity around the practice, so can we make sure that those are still acknowledged by leadership, but not made public for others to see?

And finally, we need this to be a print ready summary snapshot. We want it to be user friendly, and by that we mean visually pleasing, it's very easy for users to get lost in the mess that is raw data and really poorly constructed websites. And one thing we heard time and time again is please, please we don't want a new password. We have to log in through 12 different systems; I don't want a new password. So this is all that we heard and we really took a lot of the feedback very seriously in our design sprint.

Servati, Slide 44

So a design sprint is essentially a five-day virtual period to create a prototype based on the feedback. And this was done in partnership with Wowza, Inc. They're a creative design firm in Minneapolis and they have been a wonderful partner in not only helping us pinpoint exactly what we want this interface to look like, but also look at the user, look at all of the things that they need to go through.

And it was a very intensive process, but one that was very helpful in just understanding what we want to finally create.

Servati, Slide 45

And part of that design sprint came out this idea of a promotional campaign. And this was something that Wowza put together. Patients get better when we listen. We're listening here. And labeling it as a patient experience narrative project. And the idea with this poster was not only will it be up in our patient areas but also in our staff areas.

So by kind of ingratiating this idea that we are listening, encouraging people to look at more comments, encouraging people to take action based on these comments, it starts at such a subconscious level and by having these posters around not only do patients ... it also can maybe help patients have a higher response rate for our surveys, reminding them that their feedback is valuable.

Servati, Slide 46

And from this came the actual dashboard. So I will preface to say this is one of our first iterations of what this dashboard could look like. We are going through a few other things to make sure that this is not only viable for New York Presbyterian, and sustainable, but really what I'm about to show you, these next few slides, are the goal of the dashboard.

So right when you click you'll get an email, the practice administrator would get an email, you'd click on it, and it will direct you to this website. And all of this data is made up, so you'll see some duplicates, but let's say Canal Street Practice right away we see overall sentiment looks a little more positive, we have our responses laid out, 1249 insights.

So one thing I'll point out here is we have 434 surveys. Those are the number of people who responded. But from that, we have 1249 insights. So in all of these comments we can get multiple insights.

Servati, Slide 47

And drilling a little further down you can see it's divided by domain. So in the access category actually we're doing pretty well. In the provider category, we need a little bit more improvement or whatever it may be. And

that is also broken down by CAHPS, by a comparison to the nation, our national percentile, positive, neutral, negative comments and then some snapshots of some comments that did stand out in that report.

Servati, Slide 48

And the other key themes. Those are for those areas where we don't necessarily have a question about it in the CAHPS survey or the Press Ganey survey. People like to share a little bit more about their experience. Maybe they had a hard time with security. Maybe they were waiting too long and there isn't a question about that. Maybe the waiting room itself wasn't a good environment. There are no environment of care questions on the survey. So this would be an example of other themes.

And at the bottom one thing that was mentioned. That's me. I'm waving hi to you from over the phone. The idea of, you know, you're going through all of this data, but me, Tara, I am your patient experience specialist, I am here to help you, I'm here to support you. And I am a content expert, so I'm here to make sure that anything that you have a question on, you know that I am an access point.

So that's why we felt it was important to add that just when you're going through this data a lot things might be confusing, you might need a little more help creating a new workflow or a new operation within your practice, so just to let you know Tara is here for you.

Servati, Slide 49

And just going a little bit further, we can even break this out into, we can look at date ranges, we can look at individual questions.

Servati, Slide 50

And if anyone is fluent in Latin they can see here that the idea is that we'd be able to click on an individual comment and look at their entire survey responses. So their entire, excuse me, narrative responses.

So one question might be what has not gone well or in this specific case it would be is there anything else you would like to share about your interactions with the provider that you think could have been better. And we could look at those questions and see how the rest of their experience was.

So this is important to make sure we know all of their content, we know exactly the whole journey and the whole snapshot. So although some comments might be a little more alarming or even more positive than others, we want to make sure we can capture everything.

Servati, Slide 51

And finally looking ahead at our next steps, it's to analyze our patient comments survey. So this was a survey that we administered across those nine sites that are a part of this study to just see a baseline for the value of those narratives. Are they even aware that there is a weekly comment report? Do they do anything about it? Is there a meeting to discuss it? Etc. So we took this baseline survey and we will be doing a post survey after, but the next step is to roll out this enhanced feedback report in the sites in November. And we are finalizing this new dashboard or this new interface really for delivering these comments.

And, of course, we're going to continue the collection of this data and provide update content to feedback reports, so is there any way that we can kind of improve as we go? And we're going to ask that question, administer that survey one more time at the end to see was this valuable to you. Were you able to make changes, what changes, etc.?

So this is just an overview of the study itself. And I want to pass it back over to talk about our questions, any questions you might have and answers that Rachel and I can provide.

Shaller (closing), Slide 52

Well, Tara, thank you so much for that very condensed, but clear and informative review of the feedback reporting mechanism that's currently in development for NYP. And also to Caren for positioning AHRQ's perspective on this research and this application. And also, Rachel for a very, very informative sort of review of the elicitation protocol, how it's designed and structured and what we're beginning to learn from it.

Shaller (closing), Slide 53

So we do have time now for some questions. And just to remind you about the process for submitting a question through the Q&A box shown here, you type your question into the box, submit it to all panelists so that we can all see it. And we have already received a number of questions and I'm going to start Rachel and field one to you.

Early on in the webcast, we were asked if a practice could ask these questions, the elicitation protocol questions without actually implementing the survey itself.

Rachel Grob

Thanks, Dale. Yes, you are free to use the questions as you wish. As you can see, the demonstration project that we organized was having survey questions and the narrative questions asked together. And our results from this were most on the sort of value added as Tara put it, but certainly, you are very free to use the questions on their own and see what you get.

Dale Shaller

Great. Another question, Rachel that I want to direct to you is the application of this protocol to other potential health care settings. For example, we had a couple of questions regarding is this something that could be applied in a hospital in conjunction with HCAHPS or in home health care CAHPS. Can you comment on how the CAHPS team is moving the ambulatory version of the elicitation protocol into testing in other settings?

Rachel Grob

Sure. Yeah, that's a really good question. We are fortunate to be working with AHRQ on developing a narrative elicitation protocol for child HCAHPS right now and we'll be developing one for cancer care starting in a couple of years.

We think that the ... we're grateful that the groundwork has been laid for what it takes to rigorously develop and validate a set of questions, but care settings are distinct and so we think that the questions that are developed in the outpatient setting can't just be used as they are in other settings, because they won't get at the aspects of care that are being experienced, for example, in a hospital.

But we're using the same methodology and we're hoping to be able to go much more quickly with these, because it took us a while to figure out how to go about developing narrative questions with rigor matching the rigor that's used to develop survey questions. And now we've got our methodology down and we're rolling out protocols for other settings.

Dale Shaller

Great. Thanks so much. And I have a few questions now, kind of queueing up here, and I'm going to try to capture as many as possible. Directing to Tara, and I know we're still in the implementation phase with your organization, but do you have a sense of the response rate for the surveys and the percentage of those respondents who are going onto answer the open ended questions?

Tara Servati

Yeah, that's a great question. So one within ambulatory care, our response rates are generally quite low. They're about the same as emergency department response rates, and they're even different for us with each campus. So on our west side campus where identified the lower income, strong neighborhood identity, predominantly Spanish speaking, our response rate is only about five to six percent. And on our east campus where it's more just, their literacy rates are even higher there, more affluent, predominately White population, but not entirely, our survey responses are about 11 percent.

So there are differences as to why, you know, we have hypotheses as to why we account for these differences in response rate, but of those who received the survey with the elicitation protocol, I don't have the numbers. That's something that hopefully Press Ganey can provide to me about of that percentage do we have higher response rates.

Dale Shaller

Right. And that is something that I know the study team doesn't tend to look at as we go. So let me ask you another question and sort of condense this into a question regarding whether the five questions have generated any sort of pushback from respondents because of the potential length and it might be taking too much time and effort to complete.

First of all have you had any sort of feedback directly that that's the case with the five-question protocol?

Tara Servati

That is a great question. And actually the feedback that I've been getting I haven't gotten any feedback about this is too long; I don't want to answer this question. The feedback I have been getting is you're not asking enough about other parts of the care. So it's a completely provider focused survey and the responses I've been getting is why do I need to talk about, just talk about the relationship with my provider, I want to talk about the staff or I want to mention this comment.

So the differences I've seen in feedback has been I would mostly like to talk about other things, not just focus on my relationship with the provider.

Dale Shaller

One more question, Tara, to you, before I go back to Rachel. For the questions that are completed, and we have both a mail and an email version of the administration, is there any limitation in the number of characters that a respondent can use in responding to the web portion or the web version of the survey?

Tara Servati

Not to my knowledge. And I've had comments that, you know, I've had to actually shrink the font a number of times to make sure it will fit in the Excel format. I've gotten, you know, up to a full typed page response. So if there is a limit, then I would have to think it's over 1,000 characters or maybe 500 words, because I've seen, or 1,000 words even, of seen quite lengthy ones.

Dale Shaller

Great. Rachel, early on there was a question posed about the construct of a protocol and the question is why not have the five questions asked directly about the kinds of actionable items that you mentioned in terms of who, what, when, where? Why aren't those questions just explicitly asked in the protocol question wording?

Rachel Grob

Our desire here, sort of going back to the Atul Gawande idea is to invite people to tell their complete and balanced stories in a way that's meaningful for other people. We have tried to stay away from a sort of drill that

would be, well, now tell us who and now tell us what and now tell us where, but rather to invite people to tell the story as Tara just mentioned, people have things to say that aren't asked about on surveys and we wanted to provide a platform for drawing that story out.

We've been delighted that those actionable elements do really emerge in a complete story that's told in response to a structured set of questions. I don't think we felt the need for that drill down. But I'd be happy to chat more about any ideas people have. As I said we're continuing to develop protocols for other settings, hospital and cancer and so forth. So perhaps we will.

We know more about actionability than we did when we started this. We have more data from our data. But we're certainly not lacking for actionable content using the protocol we have.

Dale Shaller

Thanks again, Rachel. And also Tara and Caren. We're running out of time now and I just want to make the point that we are in the process of still implementing the demonstration project. A number of questions have been oriented to results available and when will further information be available in terms of site to site comparisons. And all of that is going to be compiled as we move forward over the next several months.

Shaller (closing), Slide 54

At this point I want to basically encourage all of you, if you have not already done so, to sign up for CAHPS news and announcements through subscribing to the GovDelivery listserv, which you can get to at the URL shown here. That is one really good way of staying in touch with us and to receive information about new publications from the CAHPS team including what will be done in follow up to the conclusion of this demonstration project.

Shaller (closing), Slide 55

And finally I want to let you know that there are a number of ways to keep in touch with us through email at the address shown here, through the 1-800 telephone line and always at the CAHPS website, which is shown here as the URL.

One final note you will receive a link to an evaluation survey that pops up at the end of the webcast when you sign off, so please complete that survey, because your feedback as with all feedback is important to us. So remember to click on the submit survey when you're done.

And I just want to say thank you again to all of you for joining us today and again to our panelists, Caren Ginsberg, Rachel Grob and Tara Servati for an excellent overview of the CAHPS narrative elicitation protocol and its implementation within the New York Presbyterian system. Thank you so much and have a great rest of your day.