



AGENCY FOR HEALTHCARE RESEARCH AND QUALITY

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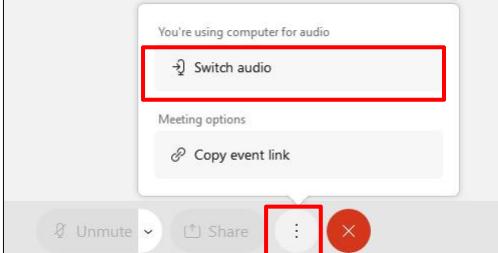
## CAHPS Research Meeting: Advancing Methods of Implementing and Evaluating Patient Experience Improvement Using CAHPS Surveys

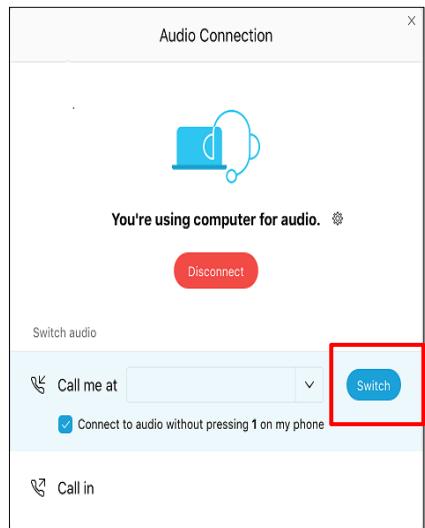
October 7, 2020  
11:00 am – 4:00 pm ET

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### Need Help?

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- No sound from computer speakers?  

- Trouble with your connection or slides not moving?
  - ▶ Log out and log back in
- Other problems?
  - ▶ Use the Chat feature on the bottom right of your screen to ask for help



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## Changing Your WebEx View

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- Select layout button at top right side of your screen
- We suggest choosing either middle option (side-by-side) or right option (floating panel)




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- ▶ Agenda
- ▶ Slides
- ▶ Speaker bios
- ▶ Participant tip sheet
- ▶ Participants list

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## CAHPS Research Meeting Overview



**Morning Panel 11:00am to 1:20pm ET**

- ▶ Welcome & Goals of the Meeting
- ▶ What Do We Know from Prior Research About How to Improve?
- ▶ Effective Implementation of Patient Experience Improvement Strategies

**30-min Break 1:20pm to 1:50pm ET**

**Afternoon Panel 1:50 to 4:00pm ET**

- ▶ How Do You Evaluate Patient Experience Improvement Strategies Using CAHPS Surveys?
- ▶ Panel Introduction
- ▶ Examples of Patient Experience Improvement Research with CAHPS Surveys

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## We want your participation!



- Clarifying Questions
  - ▶ After each panel presentation, you can type brief clarifying questions in the chat
- Moderated Open Discussion
  - ▶ To ask a question or make a comment, you can either type in the chat **OR** use the “raise hand” feature to be unmuted
  - ▶ Moderators will alternate between the chat and raised hands, as long as time permits
  - ▶ Participants will remain muted, except when the moderator unmutes those who have raised hands

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## To ask a question or make a comment

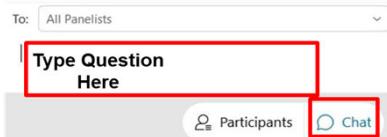
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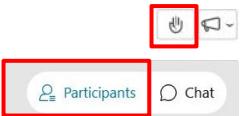
- At the bottom right, select "Chat"
- Make sure "All Panelists" is selected in the "To:"
- Type your question or comment in the box and hit "Enter" on your keyboard

To: All Panelists



**2. Raise your hand to speak**

- At the bottom right, select "Participants"
- Above the list of participants, select the very small "Raise hand" icon
- If you are called upon by name, we will unmute your line to speak
- Click the icon again to "unraise" your hand



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## Evaluation Survey

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- Please complete the webcast evaluation survey at the end of the meeting

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## Welcome from AHRQ



**Caren Ginsberg, Ph.D.**, Director  
CAHPS & SOPS Programs  
Center for Quality Improvement and Patient Safety  
Agency for Healthcare Research and Quality

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## Meeting Background and Objectives

Dale Shaller

Let's begin with a question:



**Why convene a research meeting on advancing methods for implementing and evaluating patient experience using CAHPS?**

## A few good reasons include:



- Patient experience is a **fundamental aim** for improving the U.S. health system
- CAHPS is the **gold standard** for assessing patient experience
- CAHPS is a **required metric** for many high stakes uses
- Health care organizations often **struggle to improve** their CAHPS scores
- Identifying effective improvement strategies is **hard to do**

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## Patient experience is associated with many important goals



- **Health goals:**
  - Patient adherence
  - Process of care
  - Clinical outcomes
  - Safe care
- **Business goals:**
  - Malpractice risk
  - Employee satisfaction
  - Member/patient retention
  - Financial performance

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## We need further guidance on how best to improve and evaluate



- Many improvement strategies are based on **limited evidence**
- Evidence that does exist shows **limited effectiveness**
- Evaluation research is often confounded by **real-world implementation factors** that are difficult to control

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## Meeting objectives



- ***What has been learned from prior research and implementation about factors that contribute to improving patient experience?***
- ***How can we design and conduct sound research to evaluate the effectiveness of patient experience improvement strategies?***

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## Meeting design



- **Overview:** What do we know about how to improve?
- **Morning panel:** Case studies of effective improvement strategies
- **Afternoon panel:** Case studies of improvement evaluation
- **Wrap up:** Closing remarks

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# Patient Centered Health Care Organizations: What Does It Take to Create One?

**Susan Edgman-Levitan, PA  
Executive Director  
Stoeckle Center for Primary Care Innovation  
Massachusetts General Hospital  
Co-Investigator  
Yale CAHPS Team**

**AHRQ Research Meeting  
October 7, 2020**



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## What is Patient-Centered Health Care?

The Institute of Medicine defines patient-centered care as:

“providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.”

Source: Institute of Medicine. *Crossing the Quality Chasm, 2001.*



2

## The Value of Patient and Family-Centered Care

- Patients are the only source of information about many aspects of quality.
- The patient's experience is linked to improved clinical outcomes, reduced readmissions, reduced mortality, and reduced malpractice risk and improved ability to manage chronic conditions.
- Focusing on improving the patient's experience of care requires improving the quality of work life for clinicians and staff.



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## The Value of Patient and Family-Centered Care

- Partnering with patients and families to redesign and/or improve care brings a wealth of knowledge to care that clinicians and staff do not possess.
- Partnerships with patients inspire and energize clinicians, staff, and leaders while grounding them in reality, focused on the “right” solutions.



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## Foundational Components of Patient and Family-Centered Organizations

- Governance/Leadership/Vision
- Partnerships with Patients and Families
- Human Resources and Employee Engagement
- Systematic Feedback/Data Management/Goal Setting
- Best Practices: Communication Strategies, Technology Support
- Built Environment



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## Vision/Governance/Leadership

### System Leaders Focus On:

- Placing the patient at the center of all work.
- Creation of a system of continuous learning and continuous improvement, that engages everyone in problem solving.
- Systematic removal of all barriers and excuses as to why excellence every day is not possible.
- Justly dealing with impairment/unsafe acts in practice.



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# Mass General Hospital Credo

## **As a member of the MGH community and in service of our mission, I believe that:**

- The first priority at MGH is the well-being of our patients, and all our work, including research, teaching and improving the health of the community, should contribute to that goal.
- Our primary focus is to give the highest quality of care to each patient delivered in a culturally sensitive, compassionate and respectful manner.
- My colleagues and I are MGH's greatest assets.
- Teamwork and clear communication are essential to providing exceptional care.



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# Mass General Hospital Credo

## **As a member of the MGH community and in service of our mission, I will:**

- Listen and respond to patients, patients' families, my colleagues and community members.
- Ensure that the MGH is safe, accessible, clean and welcoming to everyone.
- Share my successes and errors with my colleagues so we can all learn from one another.
- Waste no one's time.
- Make wise use of the hospital's human, financial and environmental resources.
- Be accountable for my actions.
- Uphold professional and ethical standards.



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## Mass General Hospital Boundaries

### **As a member of the MGH community and in service of our mission, I will never:**

- Knowingly ignore MGH policies and procedures.
- Criticize or take action against any member of the MGH community raising or reporting a safety concern.
- Speak or act disrespectfully toward anyone.
- Engage in or tolerate abusive behaviors.
- Look up or discuss private information about patients or staff for any purpose outside of my specified job responsibilities.
- Work while impaired by any substance or condition that compromises my ability to function safely and competently.

Optional, depending on use:

Signature

Print Name

Date



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## Partnerships with Patients and Families

- Create formal patient/family advisory councils for major services/practices to support co-design and co-production input on all QI, redesign efforts, and patient-facing materials.
  - Pay careful attention to recruitment of diverse patients and families.
- Match the method of patient/family partnerships with the problem being solved:
  - PFAC's
  - Task forces
  - Interviews
  - Focus groups
  - Walkthroughs
- Implement *What Matters to You* interventions
  - <http://www.ihi.org/Topics/WhatMatters/Pages/default.aspx>



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*“Honest criticism is hard to take, particularly from a relative, a friend, an acquaintance, or a stranger.”*

Franklin P. Jones  
*The Saturday Evening Post*



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## Systematic Feedback/Data Management/Goal Setting

- Synthesize patient feedback for review in all senior and departmental leadership meetings and practice meetings:
  - Survey data
  - Comments
  - Patient advocacy and grievance reports
  - Letters from patients and families, and other qualitative information
- Set performance targets and monitor progress
- Create dashboards, when possible, to identify trends and high performers



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# Human Resources and Employee Engagement

- Implement clinical and non-clinical HR policies that link hiring, orientation, training, staff education, and performance evaluations to quality and safety goals which always include patient-centered care.
  - Be aggressive about managing people who do not uphold the standards, values and culture.
- Develop thoughtful reward and recognition programs for all staff, based on patient experience of care feedback and reviews from colleagues.
- Conduct regular Surveys of Patient Safety Culture to identify best practices and barriers to culture change and quality of work life for staff.



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## Preconditions for Habitual Excellence in Patient Experience and Safety

Can your workforce answer yes?

1. Am I treated with dignity and respect everyday by everyone I work with?
2. Do I have the knowledge, skills, and tools to do my job?
3. Am I recognized and thanked for my contributions?
4. Is my safety, psychological and physical, a priority?



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## Best Practices: Communication Strategies, Technology Support

- Provide service excellence, service recovery, and empathy training programs for all clinical and non-clinical staff.
- Provide diversity and equity training to address structural and interpersonal racism.
- Offer patient-centered technologies:
  - portals,
  - decision support tools,
  - educational resources,
  - websites to support patient/family communication.
- “Quiet at Night” EHR bundles
- COVID-related iPad connections to families



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## Built Environment

- Wayfinding strategies
- Safety enhancement:
  - Fall prevention
  - Medication safety
  - Standardized storage
  - Handwashing
- Noise reduction
- Staff safety
- Access to light, nature and positive distractions
- Disability friendly: wheelchair access, bathroom safety, exam tables
- Enhance patient control of environment



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*Those who say  
it cannot be  
done should not  
interrupt the  
person doing it.*

*-Chinese Proverb*

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## Resources

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- Dale Shaller *Patient-Centered Care: What Does It Take?* <https://www.commonwealthfund.org/publications/fund-reports/2007/oct/patient-centered-care-what-does-it-take>
- Gerteis M, Edgman-Levitian S, Daley J, Delbanco TL, editors. *Through the Patient's Eyes*. San Francisco: Jossey-Bass Publishers, Inc.; 1993.
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## Resources

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- Leebov, W. G. Scott, et al. (1998) *Achieving Impressive Customer Service: 7 Strategies for Healthcare Managers*, Jossey-Bass.
- Leebov, W., S. Afriat, et al. (1998). *Service Savvy Healthcare: One Goal at a Time*, Jossey-Bass / AHA Press.



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## Resources

- Webster, PD, Johnson, B. *Developing and Sustaining a Patient and Family Advisory Council*, Institute for Family-Centered Care, 2000.
- Beeson, Stephen. *Practicing Excellence*, Firestarter Publishing, 2006



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## Resources

- [www.ahrq.gov](http://www.ahrq.gov)
- [www.stoecklecenter.org](http://www.stoecklecenter.org)
- [www.ipfcc.org](http://www.ipfcc.org)
- [www.hospitalcompare.hhs.gov](http://www.hospitalcompare.hhs.gov)
- [www.ihi.org](http://www.ihi.org)
- [www.planetree.org](http://www.planetree.org)
- [www.healthdesign.org](http://www.healthdesign.org)



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## Thank You!

Susan Edgman-Levitian, PA  
Executive Director  
[sedgmanlevitan@partners.org](mailto:sedgmanlevitan@partners.org)  
617-643-3931

John D. Stoeckle Center for Primary Care Innovation  
Massachusetts General Hospital  
Boston, MA



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# Moderated Open Discussion

## Susan Edgman-Levitan

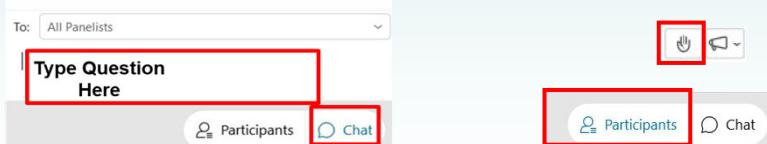
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OR



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## Morning Panel: Effective Implementation of Patient Experience Improvement Strategies

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## Panel Aims



- Explore case examples of successful improvement strategies using CAHPS data in different health care settings:
  - ▶ Health plan
  - ▶ Medical group
  - ▶ Hospital
  - ▶ ESRD/Dialysis clinic

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## Panel Aims (cont.)



- Identify and discuss cross-cutting themes related to factors such as:
  - ▶ Goals for improvement
  - ▶ Processes for improvement
  - ▶ Barriers to improvement
  - ▶ Strategies for overcoming barriers
  - ▶ How CAHPS can support improvement efforts
  - ▶ Limitations of CAHPS data in doing quality improvement work

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## Case Study Presentations



- **Health plan:**
  - ▶ Lisa Franchetti, MA, CPHQ, Member Satisfaction Analyst, Neighborhood Health Plan of Rhode Island
- **Medical group:**
  - ▶ Sam Skootsky, MD, Chief Medical Officer, UCLA Faculty Practice Group and Medical Group, UCLA Health
  - ▶ Deborah Wafer, Director, Ambulatory Operations, UCLA Health
- **Hospital:**
  - ▶ Stephanie Fishkin, PhD, Principal Consultant, Center for Healthcare Analytics, Kaiser Permanente
- **ESRD/Dialysis clinic:**
  - ▶ Kerri Cavanaugh, MD, MHS, Associate Professor of Medicine, Vanderbilt University Medical Center

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# Improving CAHPS® Performance

AHRQ CAHPS Research Meeting—October 7, 2020

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## Agenda

- How does CAHPS fit into Neighborhood's quality improvement (QI) efforts?
- Common challenges
- Opportunity identification
- Interventions
- Results
- Ongoing QI efforts



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## CAHPS and Neighborhood

- Plan Membership: Over 199,000 members
  - About 102,000 Medicaid and Dual-eligible Adults (51%)
- Medicaid: ‘Excellent’ NCQA Accreditation status for 19 consecutive years since 2001
- CAHPS Medicaid Adult results used for Accreditation
- Results reviewed by Member Advisory Committee, Quality and Operations Committee, Clinical Affairs Committee, EOHHS



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## Common Challenges

- Increasing benchmarks
- Growth
  - membership, lines of business, staff
- Technology
  - multiple systems
- Research challenges
  - collection of timely & actionable member feedback
  - declining response rate

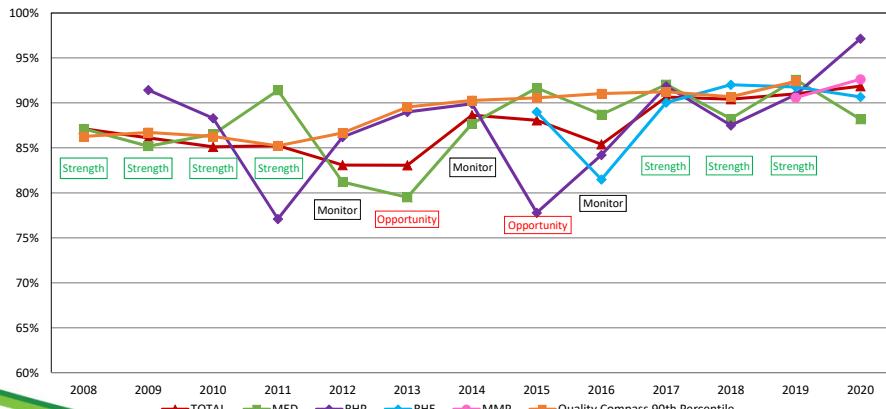


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## Opportunity Identification

CAHPS® Customer Service Composite (% Usually or Always)



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## Intervention: Measurement

- Customer Service deep dive: needed more information that was timely and actionable
  - ✓ **Supplemental weekly IVR survey (since 2016)**
    - What? 3 question automated IVR (courtesy, information, overall experience with health plan)
    - When? 24 weeks between August and January
    - How? Maximized existing contract outreach attempts
      - ~ 800 Member calls weekly with 10% - 20% response
      - Weekly results reviewed in Excel; shared poorly-rated calls with Member Services Quality Analyst
        - Listened to the poor-rated calls



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## Intervention: Process Improvements

### **Customer Service (100% within Health Plan's control)**

New hires surveyed post-30 days identified need for additional training

Feedback loop between Quality Analyst and Supervisors

Supervisors began monitoring one call out of the five per Rep per month

Modified call monitoring tool and scoring sheet (Rudeness = 0%)

Member Advocate training module roll-out

### **Getting Care Quickly (Yes – health plans can impact this)**

Began using the same On-line Provider Directory members use

Urgent Care Center search functionality defect identified and improved

Implemented Provider Directory generator (by town and/or specialty)

Began to collect member emails to distribute requested Provider Directory

New JIRA process for staff to submit Provider Directory updates



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## Results: Customer Service

Measure	2016	2017	2018	2019	2020
Customer Service Composite	85.40%	90.65%	90.42%	91.01%	<b>91.86%</b>
• Get help and information you need	78.83%	84.02%	83.83%	85.44%	<b>87.70%</b>
• Treated with courtesy and respect	91.97%	97.27%*	97.01%	96.59%	<b>96.02%</b>
Customer Service Accreditation 3-point Score (90 <sup>th</sup> Percentile = 2.61)	2.50	2.60	2.62	2.68	<b>NA</b>

\* Increase from 2016 to 2017 is statistically significant ( $p < 0.05$ ).

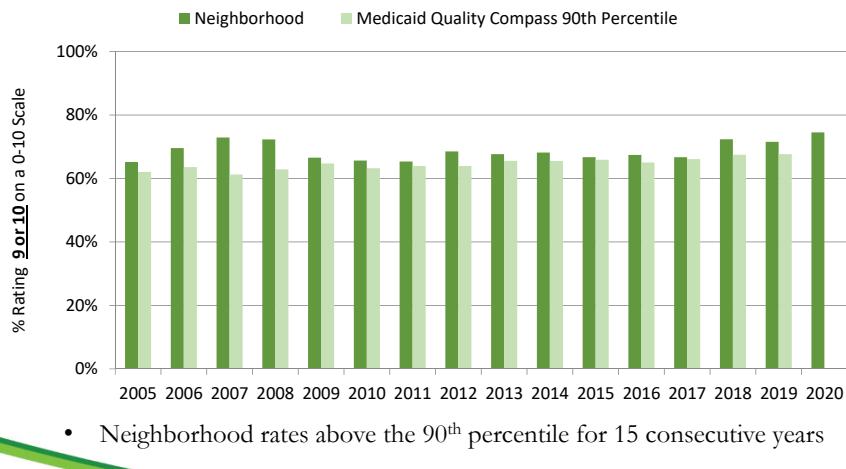
❖ CAHPS Customer Service 2017 improvements have held and grown through 2020



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## Results: Rating of Health Plan



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## Ongoing Quality Improvement

- Repeated supplemental weekly IVR surveys
- Weekly analysis of problematic incoming Medicaid member call logs over the past 90 days
- Deploying Salesforce Customer Relationships Management (CRM) software to ensure staff can efficiently access information and enable first call resolution
- Brand promise: Joint focus = Members + Providers + Employees
- **NEW!** Switch to **SMS text messaging** in October 2020, and from weekly to **daily**, with an analytical **dashboard**
- Getting closer to First Call Resolution



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# Questions?

Lisa Franchetti, MA, CPHQ  
Customer Experience Manager  
[lfranchetti@nhpri.org](mailto:lfranchetti@nhpri.org)  
401-459-6092



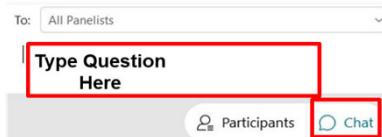
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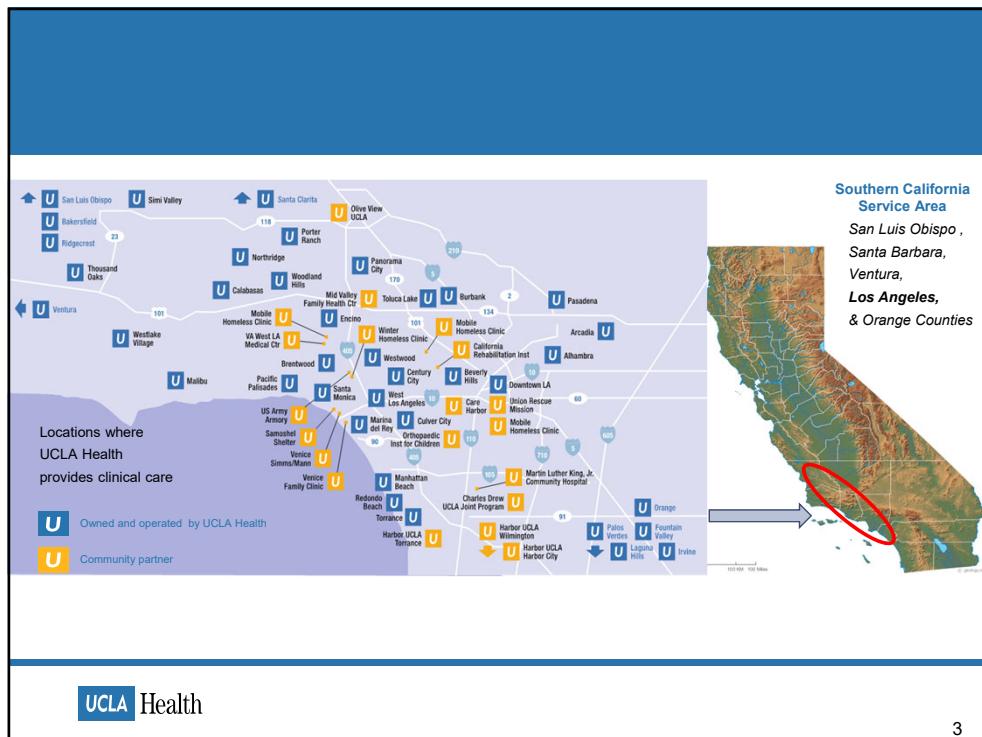


# Ambulatory Patient Experience Improvement

Deborah Wafer  
Director, Ambulatory Operations

Samuel A. Skootsky, MD  
Chief Medical Officer, UCLA Faculty Practice Group and Medical Group

October 2020



- **Ambulatory Network**
  - Over 190 Sites
  - Over 2000 employed physicians
  - 380 employed primary care physicians
  - 390,000 attributed primary care patients
  - Over 700,000 unique patients annually
  - Over 4 million ambulatory encounters annually
- **Hospitals Used**
  - UCLA Hospitals
  - Community Hospitals

**UCLA** | Health

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## Scope of UCLA CG-CAHPS Survey

	(counts are approximate per year)
Survey Version	CG-CAHPS 3.0 (Adult and Child)
# Surveys (Adult, Child, All Specialties)	30,000
# Verbatim Comments	25,000
# Physicians (95% Adult surveys)	950
# Office Locations	190
Year Initiated	2006
Analysis	Mean and Top Box Scored; Rolling 12 months; Case-Mix adjusted
Reporting Levels	MD, Site, Department, and whole practice

UCLA Health

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## Investments in Physicians & Care Model

### Physicians

- Ambulatory MD CICARE™ (video)
- Physician/Patient Communication Coaching Workshop
  - small group sessions with expert facilitator, focused on misaligned success, expectations, and flexibility from providers experiences with patients

### Access Initiatives

- Clinical Directors\* and all Practice Managers
- Department and Office level Physician Leadership
- Patient Communication Center (PCC) standardization of scheduling criteria
- MyUCLAhealth (patient portal) enhancements

### Patient Care Innovation Model

- Risk model based Comprehensive Care Coordination by dedicated staff
- Ambulatory Pharmacists
- Integrated behavioral health
- "Medical Home" certification
- Specialty care model adaptation being developed

UCLA Health

\*Clinical Directors are specialty-based clinical operations directors for one or more sites

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## All new faculty participate in the Physician Communication Workshop



### Patient – Physician Communication Workshop Descriptions:

- Two workshops, each 2 hours in length, taken two separate months.
- Rated highest by your peers as 'most enjoyable sessions'
- You will also receive 3 hours CME credits upon completion!

**Session A** – In this 90 minute workshop, we describe, demonstrate and practice the strategies that we see providers utilize who are able to accomplish the following three goals:

(1) Create the most satisfying visits or encounters, (2) use time efficiently and (3) develop mutually agreed upon treatment plans or solutions with high levels of adherence.

**Session B** – 90 minute continuation of session A (one month or more later), build on the habits taught in the first workshop and apply them to the encounters that most providers describe as among the most difficult and least satisfying.

- To get the most value of these programs, each participant should come prepared to share interactions they have had with patients in clinic and at the hospital, in person and by phone or email, which they find are not as effective as they would prefer.

## ART (Ambulatory Resource Team)

### What is the ART Engagement?

#### • Development of Criteria to Measure and Monitor

- Aesthetics (look and feel of practice)
- Check-in (process and interaction with staff)
- Patient Rooming (greeting and approach)
- 7 Project Managers/Coordinators to round and provide support for practices
- Identify "low performers" and work with staff to train on interaction with patients and revenue integrity

#### • Recognition and Incentives

- All Office Managers and Clinical Directors have incentives tied to performance
- Staff receive incentives and formal recognition as they matriculate thru ART program

## Investments in Office Staff

### New Hire Ambulatory Training

- All New Hires attend a standardized 2-3-week training in a safe environment.
- UCLA Patient Engagement Expectations (behaviors and culture)
- Incorporate CICARE™ into every patient interaction.
- Utilize all learning methodologies by role play and simulated exercises
- Provide new hires an opportunity to demonstrate various proficiencies from an integrated learning approach by combining , Care Connect, CORE, Ambulatory Nursing, Cash Controls, etc. into one learning environment.

## Investments in Office Staff

### New Hiring Ambulatory Training – Recent Additions

- Dedicated Training for **Clinical Care Coordinators (CCC)** – these staff are responsible for the coordination of care for high risk and complex patients. The goal is to improve the overall patient experience by assigning staff to coordinate patient care throughout one's healthcare journey.

Examples of additional training:

- ensuring patient calls are returned by clinicians
- appointments are scheduled in a timely manner
- authorizations obtained and ancillary services are performed
- test results are reviewed and communicated to patients
- ensuring patients are informed of next steps throughout the process.

## Success Factor – Integration

### Practices Established Explicit Goal to Integrate

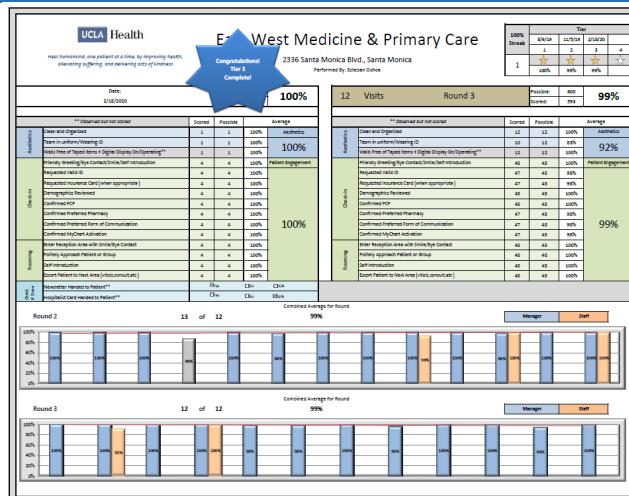
- Drivers of Success

- Engagement of Clinical Directors and Practice Managers
  - Weekly Meetings
- Weekly Review of Dashboard and Metrics
  - Hold each other accountable
  - All round in each other's practice
  - Sharing of best practices
  - Highlighting staff at various venues
- Centralization of Key Services
  - Nursing, Patient Experience, Safety, Look and Feel Appearance
  - Patient Communication Center (PCC)
  - Employee Training

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## ART Scorecard



Some of the elements that may directly affect CG-CAHPS Office Staff Scores:

- Eye contact, self-introduction, & friendly greeting
- Politely approach patient or group in waiting room
- Escort patient to next area

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# Management Performance Dashboard across Sites (Accountability and Performance)

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## Next Steps – Further Investments & Integration

- Patient Experience 2.0

- Sustain and Raise the Bar
  - New criteria
    - Involvement of Patients in development
  - New standards for “back office” staff
    - Further engagement with physicians
  - Alignment of incentives for all (clinical director, manager, office staff, physicians)

- Potential for Investment

- Better tracking and updating of key metrics
  - Refreshed Practice Infrastructure (Look and Feel)

- Roll Out of Training Program for ALL Ambulatory staff

- **Specialty care coordination & specialty specific “medical home” models**

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## Some Recent Adaptations due to COVID-19 Pandemic

- Video and telephone visits types included in CG-CAHPS survey
- Conversion to online courses
  - Physician Communication Course
  - Employee ART training and E-Learnings
- Restructuring of ART Observations, focused on CDC guidelines for interactions within public settings
  - Face coverings for employee and visitors / Social distancing
  - Screening visitors for COVID related symptoms prior to entry
  - PPE when appropriate
  - Encouraging patients to complete check-in process (including co-payment collection) via my chart portal.

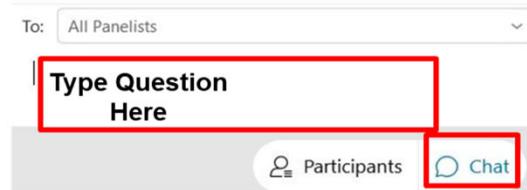
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## To ask a quick clarifying question

### Chat to type

- At the bottom right, select “Chat”
- Make sure “All Panelists” is selected in the “To:”
- Type your question or comment in the box and hit “Enter” on your keyboard



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# Effective Implementation of Patient Experience Improvement Strategies: Hospital

**Stephanie Fishkin, PhD**  
Principal Consultant, Center for Healthcare Analytics, Kaiser Permanente

AHRQ-CAHPS Invitational Virtual Research Meeting  
October 7, 2020

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## Overview of Kaiser Permanente

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## Our Mission

To provide high-quality, affordable health care services and to improve the health of our members and the communities we serve.

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We are one of America's leading health care providers and not-for-profit health plans.

23K+ physicians deliver high-quality care to Kaiser Permanente members



12.2M people

get care + coverage from Kaiser Permanente



\$84.5B revenue



218K + employees

improving the health of people + communities



40

Hospitals

+



712 medical offices

63K + nurses

are at the center of our care

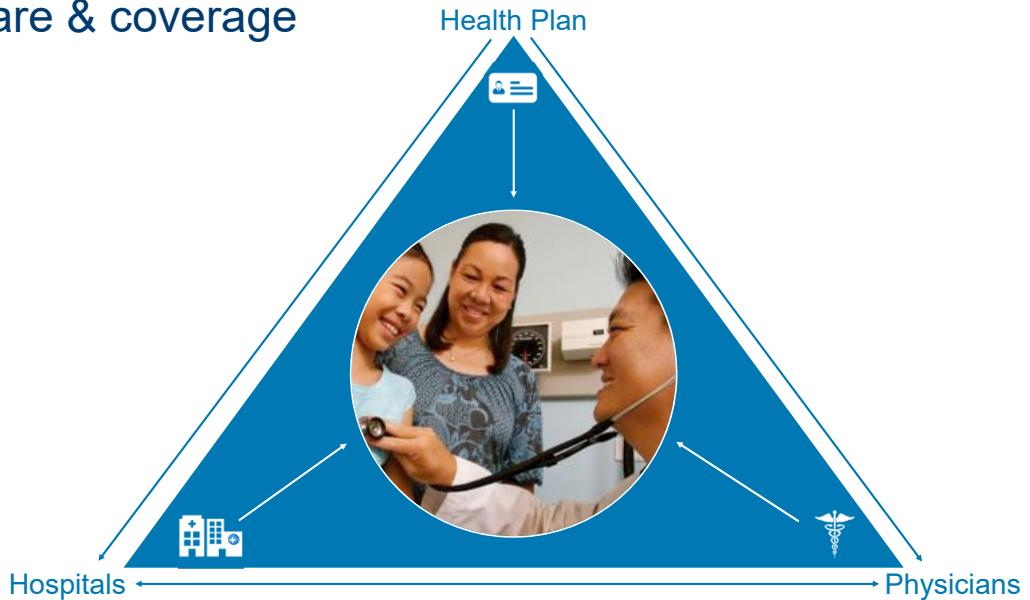


Source: 2019 Annual Financial Results ([Link](#))

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Our integrated model includes both care & coverage



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## HCAHPS Case Study: Medication Communication

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# HCAHPS Case Study: Medication Communication Composite

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- 12. During this hospital stay, were you given any medicine that you had not taken before?**

Yes  
 No ➔ If No, Go to Question 15

- 13. Before giving you any new medicine, how often did hospital staff tell you what the medicine was for?**

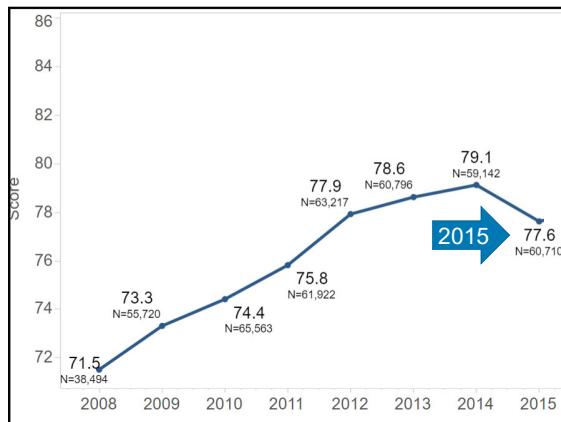
Never  
 Sometimes  
 Usually  
 Always

- 14. Before giving you any new medicine, how often did hospital staff describe possible side effects in a way you could understand?**

Never  
 Sometimes  
 Usually  
 Always

## Opportunity: Medication Communication

Enterprise Annual Composite Linear Mean Raw Score



CY2015  
Medication  
Communication  
Star Score  
by Hospital

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## Processes for Quality Improvement

- 
- Gap analysis
  - Interdisciplinary, multi-site team
  - Informed by industry *and* internal insights
  - Pilot study
  - Playbook with workflow

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## Removing Barriers to Quality Improvement

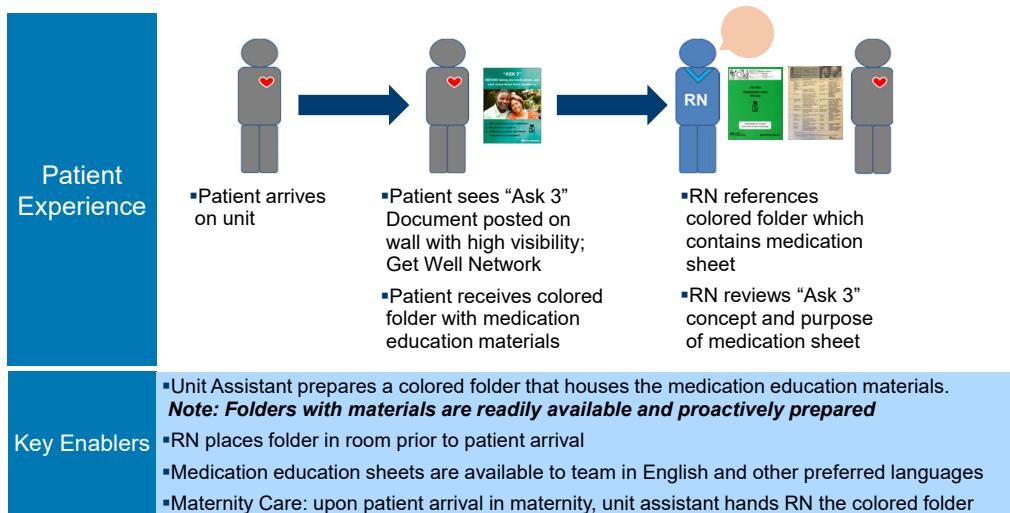
- 
- **Allow all stakeholders a voice in the process**
  - Local buy-in
  - Cross-regional buy-in
  - Cross-entity buy-in
  - **The earlier these groups are engaged, the better the process**

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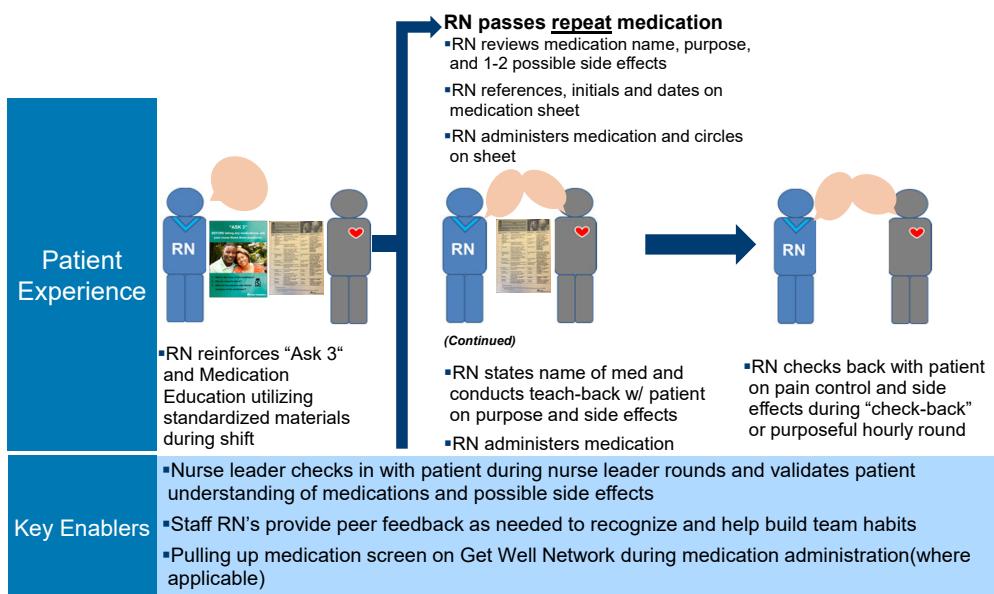
## Practice Workflow: Unit Arrival

This diagram highlights the specific touchpoints where patients are impacted by the practice while the actions themselves can be easily incorporated into existing workflows such as medication passes, and hourly rounding.



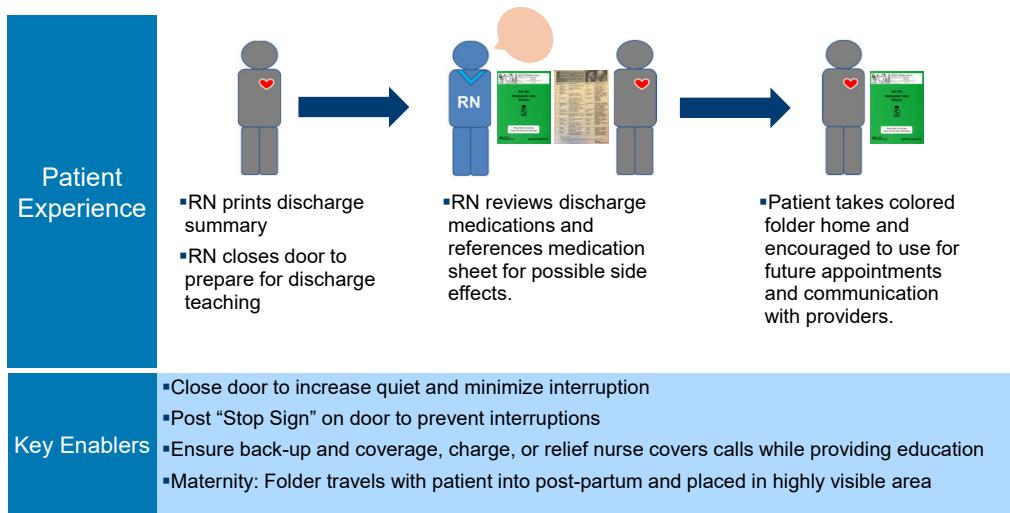
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## Practice Workflow: During Stay



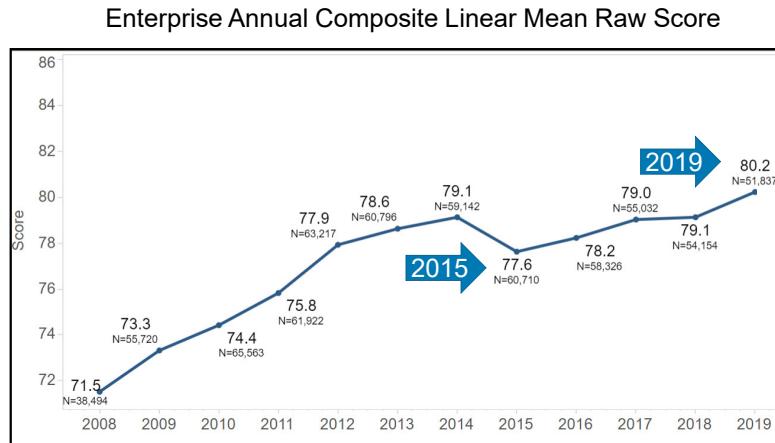
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## Practice Workflow: Discharge



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## Impact of Playbooks and Workflow on the Medication Communication Composite



CMS Star Score by Hospital

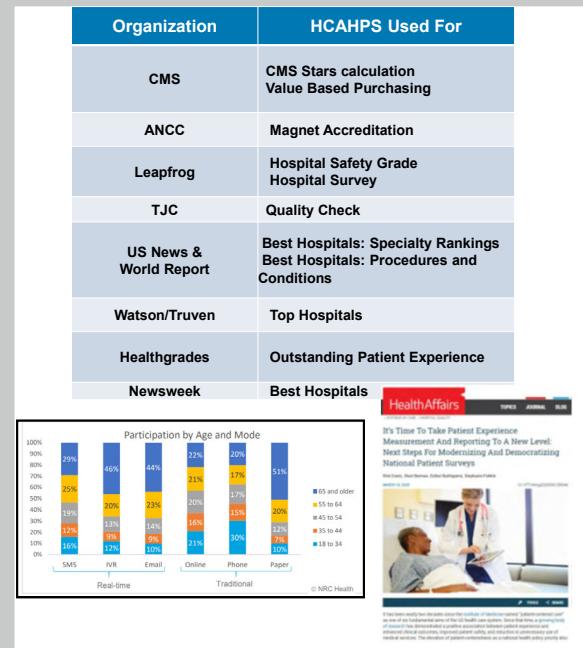
	Medicine Comm				
	Oct16	Oct17	Oct18	Oct19	Jul20
KFH	4	4	4	4	4
3	2	2	3	3	3
2	2	2	2	2	2
2	2	2	2	2	2
2	3	2	2	2	2
3	2	3	2	3	3
3	3	3	3	3	4
2	2	2	3	3	3
2	2	2	2	2	3
3	3	3	3	3	3
3	3	3	3	3	3
2	2	2	3	3	3
3	2	2	2	2	3
3	3	3	3	3	4
3	3	3	3	3	4
3	3	3	3	3	4
4	4	4	4	4	4
3	3	4	4	4	4
3	3	3	3	3	3
3	3	3	3	3	4
3	3	3	3	3	3
3	3	3	4	4	4
2	3	3	3	3	3
3	4	4	3	3	3
3	3	3	3	4	4
3	3	3	3	3	3
2	2	3	4	4	4
3	2	3	3	4	4
3	3	3	4	4	4
3	3	3	3	3	3
3	3	3	3	3	5

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# Advantages and Limitations of HCAHPS Data on Quality Improvement

- **Advantages**
  - Provides targeted national focus on key care experience domains
  - Provides national benchmarks
  - KP: HCAHPS incorporated into local, regional, and national goal setting
  - HCAHPS is the key inpatient experience measure for many accreditation & public accolade organizations
  
- **Limitations**
  - Relative performance measurement of Star Rating
  - Lack of “real time” feedback
    - PDSA (Plan-Do-Study-Act) of care experience initiatives vs HCAHPS QAGs re: other care experience surveys
  - Representative respondents
    - Declining response rates, approved survey modes
  - Survey length and domains
    - How to balance information hospitals need with survey fatigue?

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Thank you

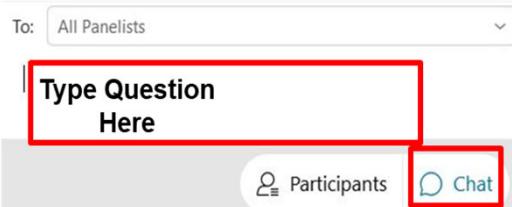
Questions:  
[Stephanie.A.Fishkin@kp.org](mailto:Stephanie.A.Fishkin@kp.org)

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- Make sure “All Panelists” is selected in the “To:”
- Type your question or comment in the box and hit “Enter” on your keyboard



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# Implementation of Patient Experience Improvement Strategies: *End-Stage Kidney Disease*

October 7, 2020

*Advancing Methods of Implementing and Evaluating Patient Experience Improvement Using CAHPS® Surveys*

Kerri L. Cavanaugh, MD MHS

Associate Professor of Medicine  
Division of Nephrology & Hypertension  
Co-Director, Center for Effective Health Communication  
Vanderbilt University Medical Center



1

## Disclosures

- Grant funding: NIH, AHA/PCORI, Department of Defense
- Consulting: Responsum Health



2

# Objectives

- Brief review of in-center hemodialysis patient experience (ICH-CAHPS)
- Discuss patient experience improvement strategies for in-center hemodialysis
- Examine barriers and evaluate solutions to program implementation

## Introduction & Clinical Background



Johns Hopkins – Baltimore, MD  
In-center hemodialysis physician, 2004-2006



Vanderbilt University Medical Center– Nashville, TN  
In-center hemodialysis physician, 2007- 2013  
Vanderbilt Dialysis East  
Vanderbilt Dialysis Clinic  
Medical Director, VDC 2010 – 2018  
~110 in-center hemodialysis; ~90 home dialysis  
~65 staff (physicians, nurses, dietitians, SW, tech)



Tennessee Valley Healthcare System, Nashville VA  
In-center hemodialysis physician, 2007 - present

# 2008 Conditions of Coverage

20370

Federal Register / Vol. 73, No. 73 / Tuesday, April 15, 2008 / Rules and Regulations

**DEPARTMENT OF HEALTH AND HUMAN SERVICES**
**Centers for Medicare & Medicaid Services**
**42 CFR Parts 405, 410, 413, 414, 488, and 494**
**[CMS-3818-F]**
**RIN 0938-AG82**
**Medicare and Medicaid Programs; Conditions for Coverage for End-Stage Renal Disease Facilities**
**AGENCY:** Centers for Medicare & Medicaid Services (CMS), HHS.
 
**ACTION:** Final rule.
 

**SUMMARY:** This rule finalizes the February 4, 2005 proposed rule entitled "Medicare Program; Conditions for Coverage for End-Stage Renal Disease Facilities." It establishes new conditions for coverage that dialysis facilities must meet to be certified under the Medicare program. This final rule focuses on the patient and the results of care provided to the patient, establishes performance expectations for facilities, encourages patients to participate in their plan of care and treatment, eliminates many procedural requirements from the previous conditions for coverage, preserves strong process measures when necessary to promote meaningful patient safety, well-being, and continuous quality improvement. This final rule reflects the advances in dialysis technology and standard care practices since the requirements were last revised in their entirety in 1976.

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**42 CFR Parts 405, 410, 413, 414, 488, and 494**

**[CMS-3818-F]**

**RIN 0938-AG82**

**Medicare and Medicaid Programs;**  
**Conditions for Coverage for End-Stage Renal Disease Facilities**

**AGENCY:** Centers for Medicare &

Medicaid Services (CMS), HHS.

**ACTION:** Final rule.

**Requires evidence of:**

**Training in all aspects of the dialysis experience (patient education)**

**On-going integrated care planning,  
with patient participation**

**Requirement to include 'patient satisfaction' as a component of QAPI**

- strongly recommend ICH CAHPS
- emphasizes the IOM 6 PCC dimensions
- surveys placed in the public domain

VANDERBILT UNIVERSITY <https://www.cms.gov/Regulations-and-Guidance/Legislation/CFCsAndCoPs/Downloads/ESRDfinalrule0415.pdf>

7

## Seminars in Dialysis

### PATIENT-CENTERED QUALITY OF CARE IN DIALYSIS

**Patient Experience Assessment is a Requisite for Quality Evaluation: A Discussion of the In-Center Hemodialysis Consumer Assessment of Health Care Providers and Systems (ICH CAHPS) Survey**

Kerri L. Cavanaugh\*†‡

\*Division of Nephrology, Department of Medicine, Vanderbilt University Medical Center, Nashville, Tennessee, †Vanderbilt Center for Kidney Disease, Nashville, Tennessee, and ‡Vanderbilt Center for Effective Health Communication, Nashville, Tennessee

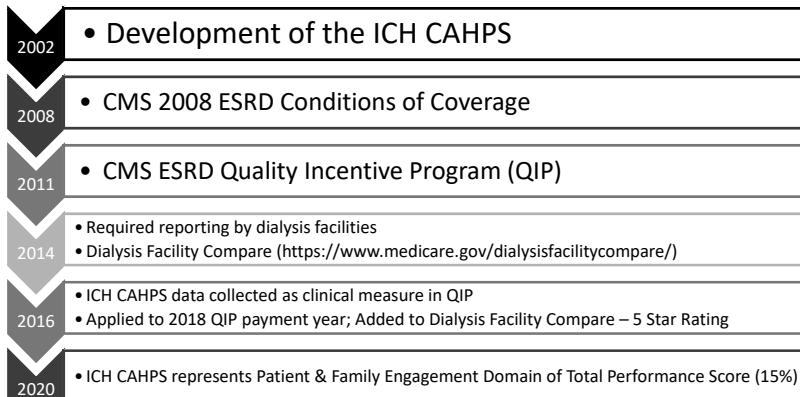
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Seminars in Dialysis, Vol 29(2); Mar-Apr 2016, 135-143

8

# ICH CAHPS

*Brief Review of Timeline & Content*

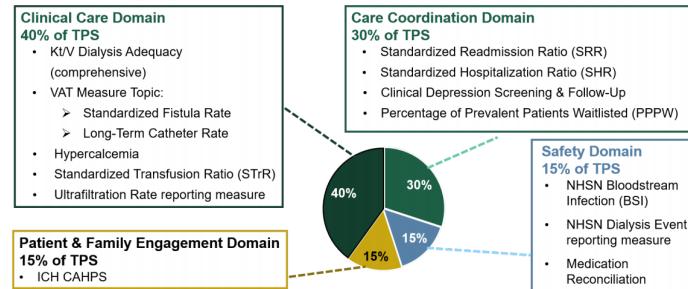


# ICH CAHPS

*Brief Review of Timeline & Content*

## PY 2022 & PY 2023 Measure Set

A facility must be eligible to receive a score on at least one measure in any two domains to receive a Total Performance Score (TPS).



# ICH CAHPS

## Content

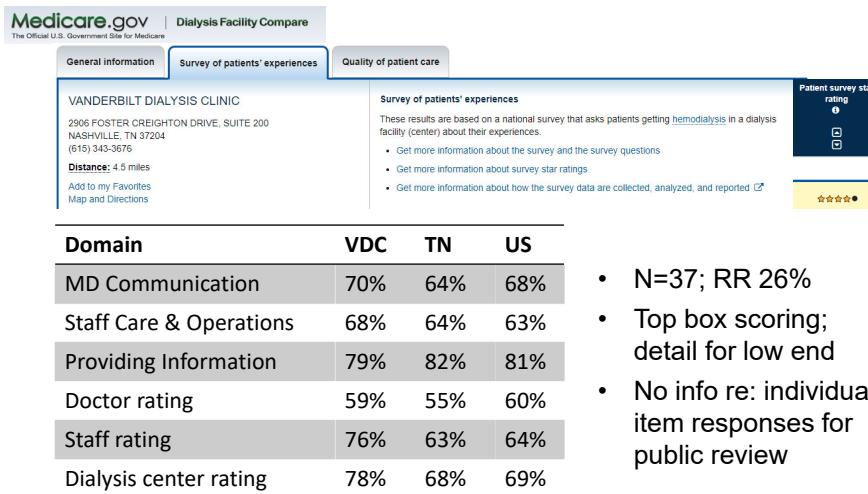
Core set 62 items; 35 contribute to scoring in 6 domains

Domain	Item content
Nephrologists' Communication & Caring (6)	Listen, Explain, Respect, Time spent, Cared, MD up to date (y/n)
Dialysis Center Care & Operations (17)	As per MD, Comfort, Privacy, Asking Qs, access pain, checking, staff managing problems, professionalism, nutrition Qs, labs reports, on time, cleanliness of unit, satisfaction with managing problems
Providing Information to Patients (9)	Access care, received/reviewed info re: rights, home care, emergency in unit, treatment options, transplant eligibility, peritoneal, involvement in options discussions
Global rating items x 3 (0-10)	Doctors, dialysis staff, dialysis center

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# Dialysis Unit Report



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medicare.gov/care-compare

12

## Dialysis Unit Report

- Summary of performance during the time annual cycle of administration for individual items
- Within the key domains, identify particular components that may be driving higher or lower scores
- Engagement of all members of the dialysis unit to review the results, and develop strategies to address at various levels

## Engagement Strategies

*ICH CAHPS specific*

### Patients & Family

#### Awareness & Education

- Importance of participation
- Privacy of results

#### Reporting Results

- Letter to each patient
- Staff conversations
- Bulletin boards/posters

#### Evidence of Impact

- Key to increasing confidence that participation matters

### Facility Physicians & Staff

#### QAPI (Monthly)

- Leadership & Champions
- Annual data review
- Set program goals

#### Program

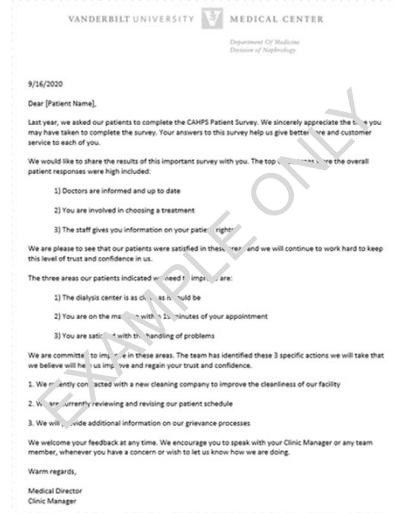
- Domain driven usually
- Leveraging organizational initiatives (dialysis; hospital)

#### Physician & Staff

- Informed in staff meetings of results, discuss proposed plan, seek input
- Identify and establish champions
- Iterative review over defined timeline

## Example of Patient Letter

- Expectation to be shared annually when results available
- Acknowledge successes
- Recognize improvement areas with specific plans
- Encourage continued dialogue



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Dear [Patient Name],

Last year, we asked our patients to complete the CAHPS Patient Survey. We sincerely appreciate the time you may have taken to complete the survey. Your answers to this survey help us give better care and customer service to each of you.

We would like to share the results of this important survey with you. The top three areas were the overall patient responses were high included:

- 1) Doctors are informed and up to date
- 2) You are involved in choosing a treatment
- 3) The staff gives you information on your patient rights

We are pleased to see that our patients were satisfied in these areas and we will continue to work hard to keep this level of trust and confidence in us.

The three areas our patients indicated we need to improve are:

- 1) The dialysis center is as clean as it could be
- 2) You are on the machine within 15 minutes of your appointment
- 3) You are satisfied with the handling of problems

We are committed to improve in these areas. The team has identified these 3 specific actions we will take that we believe will help us improve and regain your trust and confidence.

1. We recently contracted with a new cleaning company to improve the cleanliness of our facility
2. We are currently reviewing and revising our patient schedule
3. We will provide additional information on our grievance processes

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## Supplementary Data

- Mechanisms for patient grievances
- Internal patient satisfaction surveys performed annually at different time
- Facility-based patient support groups
- Staff feedback/ monthly meetings
- Continual prioritization by leadership

## Attributes of a health literate organization

“Health organizations that make it easier for people to navigate, understand and use information and services to take care of their health”



## Health Literacy Universal Precautions Toolkit



**AHRQ**  
Agency for Healthcare Research and Quality  
Improving Excellence in Health Care • www.ahrq.gov

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<http://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/literacy-toolkit/index.html>
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In Practice
AJKD

**Using Patient Experience Survey Data to Improve In-Center Hemodialysis Care: A Practical Review**

Taimur Dad, Megan E. Grobert, and Michelle M. Richardson

Patient experience is an integral aspect of the care we deliver to our dialysis patients. Standardized evaluation of patient experience with in-center hemodialysis started in the United States in 2012 with the In-Center Hemodialysis Consumer Assessment of Healthcare Providers and Systems (ICH CAHPS) survey. Over time there have been a few changes to this survey, how it is administered, and how it fits within the Centers for Medicare & Medicaid Services End-Stage Renal Disease Quality Incentive Program. Although the importance of this survey has been growing, knowledge of this survey among nephrologists has lagged. We provide a review of the survey development and how its use has evolved since 2012. We discuss in detail research done on this survey to date, including survey psychometric evaluation. We highlight gaps in our knowledge that need further research and end with general recommendations to improve patient experience within hemodialysis facilities, which we believe is a worthy goal for all members of the dialysis team.

Complete author and article information provided before references.  
*Am J Kidney Dis.*  
 76(3):407-416. Published online March 19, 2020.  
 doi: 10.1053/j.ajkd.2019.12.013  
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## Additional Dialysis Specific Strategies

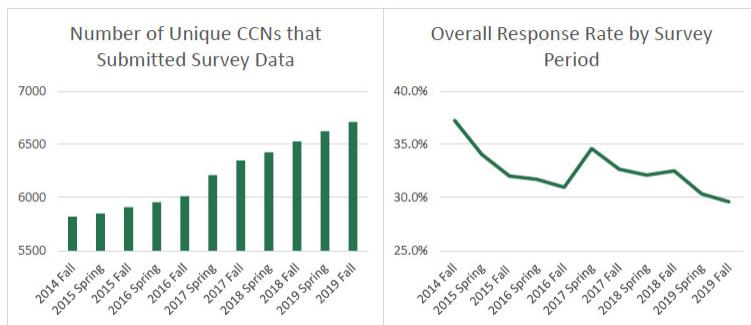
- Physician and/or staff  
*Communication & Caring*
  - Providing Information  
*Innovation in format & content*
- \* Continuing education & training  
*NephroTALK*
- \* Sitting at chairside
- \* Authentic relationships
- \* Online resources, videos  
*Collaboration with kidney health advocacy organizations*
- \* Peer mentorship programs

Schell JO, Arnold RM. NeproTalk. Semin Dial Nov-Dec, 2012; 25(6):611-6  
Bennett PN et al. Semin Dial. 2018 Sep; 31(5):455-461

## Barriers

*Nephrology/Dialysis 'Community' Level*

### Response Rates



*Concerns regarding disparities in characteristics of those that do respond vs. not  
Survey burden & total number of items*

## Take Home Points

- Patient Experience characterization with the ICH CAHPS is a required component of dialysis care
- Increasing acceptance and endorsement from the nephrology community, dedicated inclusion in QAPI (local) and dialysis organizations
- Aside from the comprehensive ESCO CMS program no formal research studies testing strategies to increase patient experience metrics

**Thank you**

**Let's discuss!**

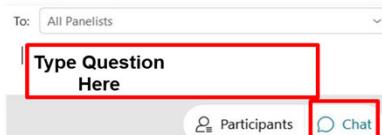
[kerri.cavanaugh@vumc.org](mailto:kerri.cavanaugh@vumc.org)

 @KCavanaugh\_MD

# To ask a quick clarifying question

## Chat to type

- At the bottom right, select “Chat”
- Make sure “All Panelists” is selected in the “To:”
- Type your question or comment in the box and hit “Enter” on your keyboard



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## Morning Panel: Moderated Open Discussion Dale Shaller



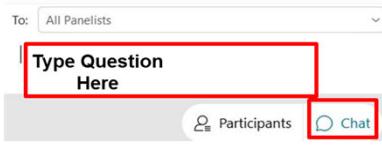
### 1. Chat to type

- At the bottom right, select “Chat”
- Make sure “All Panelists” is selected in the “To:”
- Type your question or comment in the box and hit “Enter” on your keyboard

OR

### 2. Raise your hand to speak

- At the bottom right, select “Participants”
- Above the list of participants, select the very small “Raise hand” icon
- If you are called upon by name, we will unmute your line to speak
- Click the icon again to “unraise” your hand



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