ADVANCING METHODS OF IMPLEMENTING AND EVALUATING PATIENT EXPERIENCE IMPROVEMENT USING CAHPS® SURVEYS

Challenges Evaluating Patient Experience Improvement Strategies

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October 7, 2020
Rockville, MD

1

Are QI evaluations the same as, or distinct from, other types of research?

Yes

2

Threats to Internal Validity of, for Example, a "Case Study"

HISTORY --

A spurious event occurring between pre- and post-test

MATURATION --

Subjects changing between pretest and posttest, but not because of intervention (including different samples pre- and post)

INSTRUMENTATION --

A change in the measures or measurement process

SELECTION:

Pre-intervention differences between people in study groups (PERVASIVE)

3

Common Designs to Address Threats to Validity

Randomized experiment

Natural experiment

Mathematical simulation models

Quasi-experiment

4

Issues Especially Salient in QI Evaluations

Number of units (e.g., clinics) usually small

Defining the timing and levels of interventions

Intervention as planned vs. intervention as implemented

Determining measurement points

5

Current QI Approaches

- Focus on organizations and policy (e.g. economic incentives, accountability)
- Use organizational theories
- "Systems" approach based on industrial successes
- Focus on continuous, rapid changes

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Common Improvement Model in QI Studies (Continuous Quality Improvement)

- "Rapid Cycle Improvement"
- PDSA
  - Plan, Do, Study, Act

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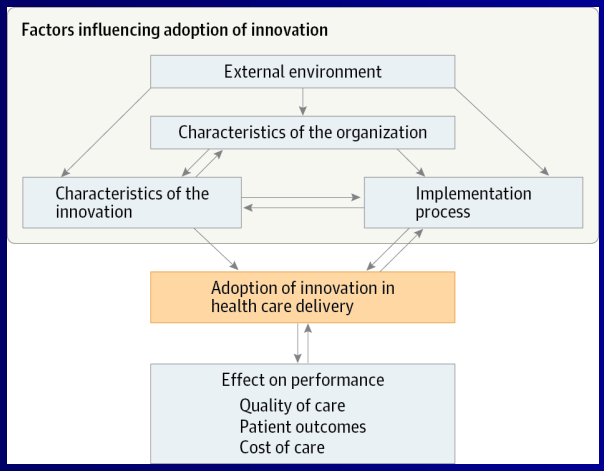
Implementation Science Perspective



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Overarching Issues

Should we emphasize starting with the maximum impact and then try to understand components or evaluate components first and then develop more complex designs?

9

A Challenge for QI Interventions

Is there a “system”?

10

Pearson Correlations Between Adjusted EQHIV Quality Measures (n=69)

	HAART	VL ND	PCP	PPD	Hep C	Pap	Flu	Visits
HAART	1.000							
VL ND	0.204	1.000						
PCP	**0.418**	0.020	1.000					
PPD	0.130	0.018	0.176	1.000				
Hep C	-0.018	0.104	0.056	**0.318**	1.000			
Pap	-0.092	0.056	0.140	**0.395**	0.048	1.000		
Flu	-0.002	0.303	0.120	0.176	0.242	0.069	1.000	
Visits	0.029	0.257	0.044	0.081	0.009	0.210	0.140	1.000

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Example of Construct Complexity: Interdisciplinary Teams

- Need to distinguish work groups from teams (Payne)
- Describing teams complex; individual, groups and environment characteristics important (Hackman):
  - Member skills, attitudes, personality
  - Group size, structure, degree of cohesiveness, norms
  - Task characteristics, reward structure, environmental stress, education and information support
  - Extremely difficult to study mediating variable of group process
- Care “teams” may span organizations; hierarchical
- Issue of relationship continuity versus expertise
- Nominal teams more common than real coordinated teams

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Summary: QI Evaluation Issues

Number of units (e.g., clinics) usually small

Defining the timing and levels of interventions.

Conceptual issues, e.g.:
-is there a “system”?
-what constitutes a team?

Intervention as planned vs. intervention as implemented

Determining measurement points and levels

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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:”
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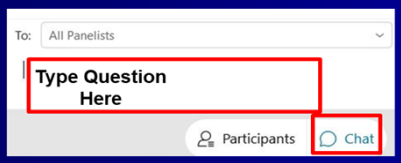

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Wharton
University of Pennsylvania

The Value of Patient Narratives for Quality Improvement: The Pilot Test of the CAHPS® Narrative Elicitation Protocol in Medical Groups

Ingrid Nembhard, PhD, MS
Fishman Family President's Distinguished
Associate Professor of Health Care Management

Acknowledgements

cahps **Team Members:**

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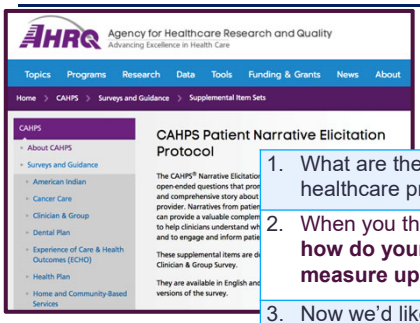
Funded by Agency for Healthcare Research and Quality (AHRQ)
Cooperative Agreement #2U18HS016978

CAHPS® Narrative Elicitation Protocol (NEP)



cahps

1. What are the **most important things that you look** for in a healthcare provider and the staff in his or her office?
2. 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**?
3. Now we'd like to focus on **anything that has gone well** in your experiences in the last 3 months with your provider and the staff in his or her office. Please explain what happened, how it happened, and how it felt to you.
4. Next we'd like to focus on any experiences in the last 3 months with your provider and the staff in his or her office that **you wish had gone differently**. Please explain what happened, how it happened, and how it felt to you.
5. Please describe how you and your provider **relate to and interact with each other.**

Wharton https://www.ahrq.gov/cahps/surveys-guidance/item-sets/elicitation/index.html 3

Project overview

Overall aim:

Assess the feasibility, value and use of the CAHPS Narrative Elicitation Protocol (NEP) in ambulatory care practices

Answer 3 key questions:

1. How feasible is the collection of the NEP in routine patient experience survey operations of medical groups?
2. What is the added value of the NEP compared to conventional open-ended questions?
3. How can narrative information be reported to practice leaders and clinicians in ways that are easily understood and useful for improving patient experience?

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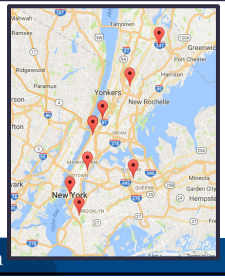
Study Setting: NewYork-Presbyterian (NYP) ACN



NYP Ambulatory Care Network (ACN)

- 32 practices across Manhattan
  - Primary care, family planning, and specialty clinics
- Located in two major campus settings:
  - Weill Cornell Medical School (east side)
  - Columbia University (west side)
- Each campus has a distinct culture and patient population
  - Cornell: Higher income, elderly patients
  - Columbia: Lower income, strong neighborhood identity; unionized staff

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Standard Collection & Reporting of Patient Comments at NYP

Collection: Press Ganey (PG) patient survey, based on but different from CG-CAHPS

- 4 composites: Access, MD Communication, Care Coordination, Office Staff
- 2 rating items: Provider Rating, Likelihood to Recommend
- 3 open-ended questions:
  1. What do you **like best** about our office?
  2. What do you **like least** about our office?
  3. Is there **anything else** you would like to share about your experience?

- **Reporting:** weekly responses to PX Office - > pdf/Excel to Practice Administrators, Supervisors, Medical Directors, ACN leadership, and "Care Champions"

SITE	SURVEY	COMMENT	VISIT DATE	SPECIALTY	Kept inform if wait >15
CU/AIM	1472830411	Very good.	1/10/2018	Int. Med.	Yes
CU/AIM	1472830411	She is kind & loving to talk to.	1/10/2018	Int. Med.	Yes
CU/AIM	1472835723	The office was very hot. Just a small fan.	1/12/2018	Int. Med.	No
CU/AIM	1472835723	The office was very clean, and everything looks perfectly in order.	1/12/2018	Int. Med.	No

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Study design

Two-phase, quasi-experimental study of 9 NYP ACN sites

- Phase 1 (1/18 – 2/19): Assess value of NEP relative to standard practice
- Phase 2 (3/19 – 3/20): Assess value of:
  1) Enhanced feedback report
  2) NEP in combination with enhanced feedback report

Phase 1 Intervention Sites (N=3)	Phase 1 Control Sites (N=3)	
• PG survey • 5-question NEP	• PG survey • 3-question PG protocol	
Phase 2 Intervention Sites (N=6)		**Phase 2 Control Sites (N=3)**
• PG survey • 5-question NEP • Enhanced report	• PG survey • 3-question PG protocol • Enhanced report	• PG survey • 3-question PG protocol • Standard report

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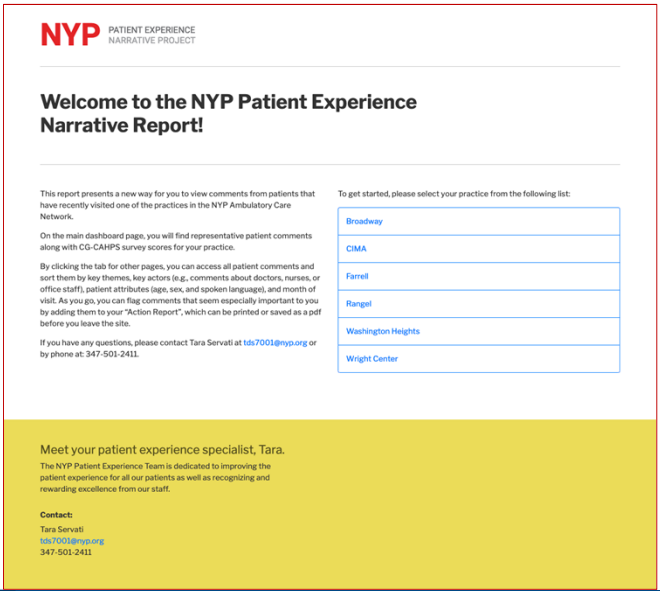
The New (Online) Report: Welcome Page



NYP PATIENT EXPERIENCE NARRATIVE PROJECT

Welcome to the NYP Patient Experience Narrative Report!

This report presents a new way for you to view comments from patients that have recently visited one of the practices in the NYP Ambulatory Care Network.

On the main dashboard page, you will find representative patient comments along with CG-CAHPS survey scores for your practice.

By clicking the tab for other pages, you can access all patient comments and sort them by key themes, key actors (e.g., comments about doctors, nurses, or office staff), patient attributes (age, sex, and spoken language), and month of visit. As you go, you can flag comments that seem especially important to you by adding them to your "Action Report", which can be printed or saved as a pdf before you leave the site.

If you have any questions, please contact Tara Servati at tds7001@nyp.org or by phone at: 347-501-2411.

To get started, please select your practice from the following list:

- Broadway
- CIMA
- Farrell
- Rangel
- Washington Heights
- Wright Center

Meet your patient experience specialist, Tara.

The NYP Patient Experience Team is dedicated to improving the patient experience for all our patients as well as recognizing and rewarding excellence from our staff.

Contact:
Tara Servati
tds7001@nyp.org
347-501-2411

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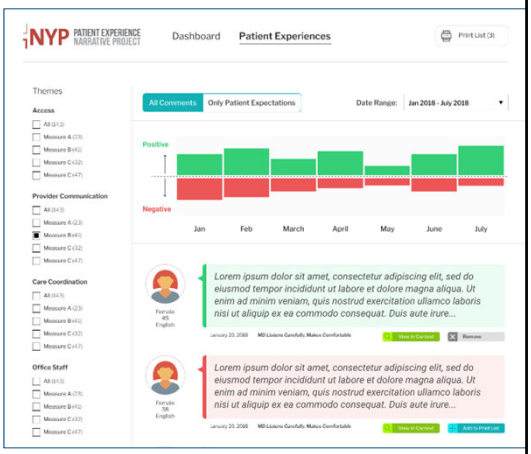

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A mix of methods to assess effects

On patient-reported care experiences:

- Qualitative analysis of patient responses to cahps NEP
- Statistical analysis of patient experience scores

On leaders' and staff's views and use of patient comments:

- Qualitative analysis of staff 1: 1 interview data
- Statistical analysis of leadership and staff survey respons
  - Frequency of useful comments
  - Comment usefulness for understanding current practice
  - Comment helpfulness for quality improvement
  - Confidence in understanding of patients and practice performance

Hypothesis: Use of NEP and new report format will lead to positive changes in patient care experiences and staff use of comments for improvement.

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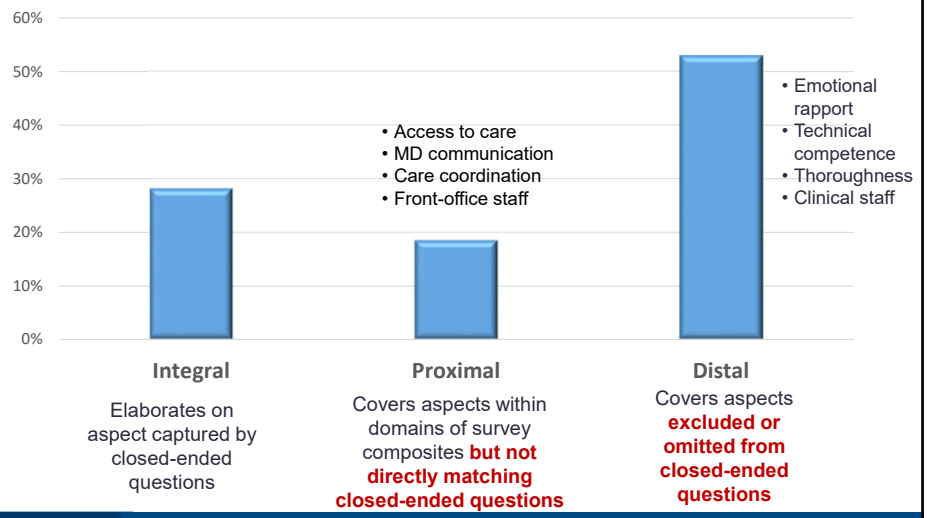
Preliminary finding

NEP elicits **distinctive** patient expectations about care

Aspects of care described by patients
Relative to CG-CAHPS Composites



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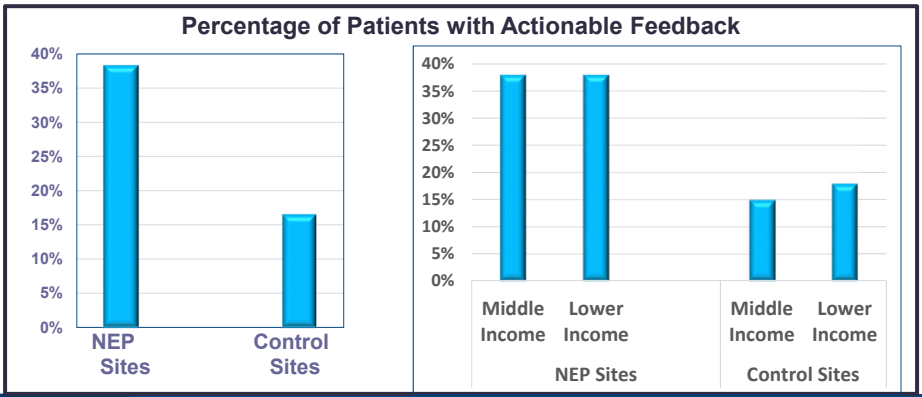
Preliminary finding

NEP elicits more **actionable** feedback across groups

Actionable feedback: conveys the who, what, when and where of the event as well as how the experience felt to the patient ➡ *informs QI*

- *Example*: "Clerks seem to be too busy when you come in. for the most part I felt rush and not listen to."



Wharton Sample size (# of surveys): Intervention sites: 2,251; Comparison sites:1,622 12

Key principles derived for future research

1. Use an experimental design with powerful sample size
2. Co-design interventions with organizational members
3. Cultivate on-site leadership and project staff support
4. Talk to users often early in implementation
5. Collect multiple types of data
6. Capture the experiences of patients and staff
7. Allow years for projects and effects
8. Choose your project team carefully
9. Talk to the lawyers early

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Lessons learned about improving patient experience

1. Right information in the right format shared with the right people is required for QI
2. Many individuals contribute to the experience…so many sources for creative ideas (patients, staff, leaders)
3. Motivation and ideas stem from success *and* failure, but negative feedback is hard for many to process
4. Individuals and organizations want to trouble-shoot *now not later*
5. Small changes can make big differences
6. Improvement requires persistence

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Thank you

I look forward to your comments!

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To ask a quick clarifying question

Chat to type

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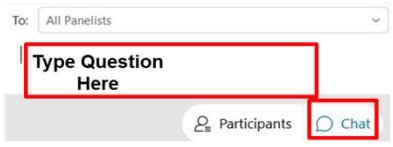

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What does it take to improve performance on health plan and CG-CAHPS?

Mark W. Friedberg, MD, MPP
SVP, Performance Measurement & Improvement
October 7, 2020

CAHPS improvement options for health plans

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Improvement through our provider network

- Try to improve the performance of providers currently in our network
  - BCBSMA has financially incentivized provider group performance on the Massachusetts Health Quality Partners (MHQP) version of CG-CAHPS for ~10 years
  - We haven't offered much technical support on patient experience, but I'd like to change that
- Network curation & steerage (assuming provider performance can't change, in general)
  - Curation: change composition of provider network, selectively retaining high performers
  - Steerage: move members away from low-performing providers, toward better performers

Improvement through direct-to-member approaches

- Seems appropriate for rating of health plan and claims handling domains
  - Try to improve our member services
  - Benefit design, marketing
- Dark arts: vendor offerings, gaming, etc.

Adult CG-CAHPS trends among AQC groups

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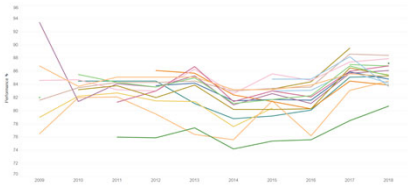
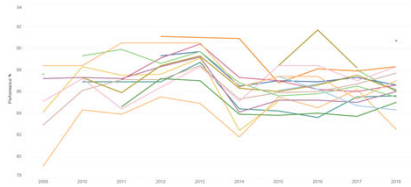
Access to Care

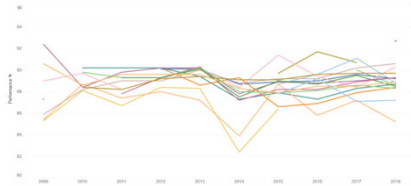


Integration of Care



Communication Quality

Knowledge of Patients



Note: MHQP survey instrument changed in 2015

What health plans could use

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We need clear distinctions between signal and noise in year-to-year CAHPS score fluctuations

- Enormous amounts of time, energy, and money are spent on the assumption that all score changes are due to true performance—and that there is no random variation
- Signal vs noise analyses are currently missing from NCQA and CMS reports to plans
- Our own analyses suggest that year-to-year plan-level score changes are mostly due to noise
- Health plans probably need larger sample sizes

Just like providers, health plans need evidence-based guidance on how to improve on CAHPS

BCBSMA Plans: Scores & Denominators

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Short Name	Measure Name	2017 Score	2018 Score	2019 Score	2020 Score	Average Score	Denominator
BCBSMA HMO	Getting Care Quickly Composite	89.6	90.6	86.0	88	88.5	237
	Getting Needed Care Composite	89.5	90.4	88.5	85	88.4	247
	Rating of All Health Care (9+10)	56.0	52.1	58.7	56	55.7	247
	Rating of Health Plan (9+10)	42.2	36.7	42.0	51	43.0	276
	Rating of Personal Doctor (9+10)	65.9	62.9	68.2	71	67.0	255
	Rating of Specialist Seen Most Often (9+10)	70.3	66.7	65.9	71	68.5	164
	Survey Item: How often did your personal doctor seem informed and up-to-date about the care you got from these doctors or other health providers?	84.4	88.0	85.5	89	86.7	166
BCBSMA PPO	Claims Processing Composite	89.1	92.1	87.9	95	91.0	
	Getting Care Quickly Composite	88.7	87.3	86.4	92	88.6	260
	Getting Needed Care Composite	87.0	87.6	89.1	89	88.2	264
	Rating of All Health Care (9+10)	56.5	53.7	53.4	66	57.4	264
	Rating of Health Plan (9+10)	47.1	45.4	45.0	54	47.9	291
	Rating of Personal Doctor (9+10)	66.5	64.3	66.8	72	67.4	262
	Rating of Specialist Seen Most Often (9+10)	63.8	65.8	69.0	69	66.9	197
	Survey Item: How often did your personal doctor seem informed and up-to-date about the care you got from these doctors or other health providers?	85.5	83.3	88.0	89	86.5	175

BCBSMA Plans: No evidence of change

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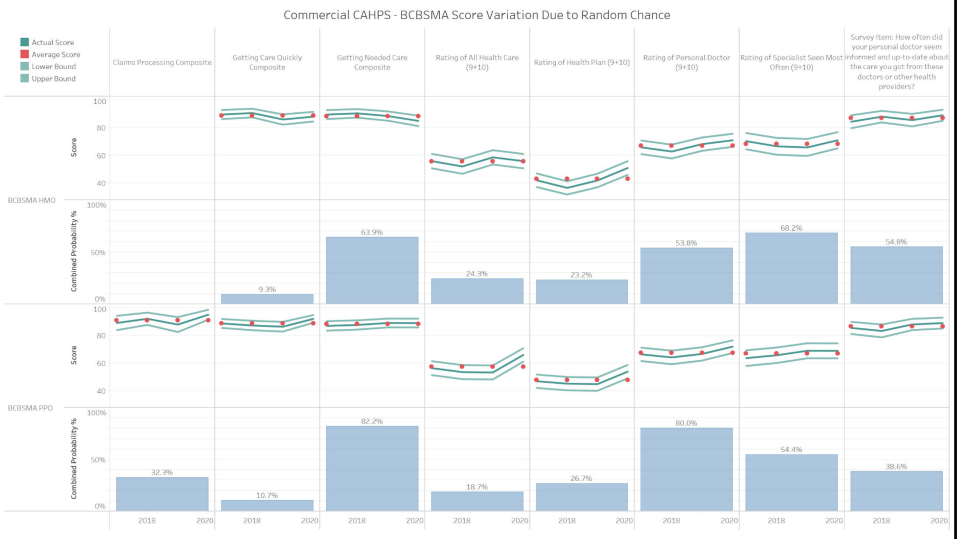

BCBSMA Plans: No evidence of change

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P-values for the null hypothesis that our performance didn't change over 4 years

Short Name	Measure Name	2017 Probability	2018 Probability	2019 Probability	2020 Probability	Combined Probability
BCBSMA HMO	Getting Care Quickly Composite	66.7%	29.3%	15.0%	68.9%	9.3%
	Getting Needed Care Composite	36.4%	36.4%	94.4%	15.0%	63.9%
	Rating of All Health Care (9+10)	96.7%	18.6%	32.5%	96.7%	24.3%
	Rating of Health Plan (9+10)	74.5%	4.3%	74.5%	0.7%	23.2%
	Rating of Personal Doctor (9+10)	70.4%	19.0%	77.5%	17.6%	53.8%
	Rating of Specialist Seen Most Often (9+10)	56.0%	79.9%	55.6%	45.3%	68.2%
	Survey Item: How often did your personal doctor seem informed and up-to-date about the care you got from these doctors or other health providers?	21.1%	71.5%	74.3%	40.9%	54.8%
BCBSMA PPO	Claims Processing Composite	48.5%	72.7%	29.5%	16.2%	32.3%
	Getting Care Quickly Composite	93.7%	28.4%	14.2%	13.2%	10.7%
	Getting Needed Care Composite	66.0%	95.2%	61.2%	61.2%	82.2%
	Rating of All Health Care (9+10)	95.2%	35.2%	19.3%	0.3%	18.7%
	Rating of Health Plan (9+10)	75.3%	30.8%	30.8%	4.2%	26.7%
	Rating of Personal Doctor (9+10)	73.9%	32.2%	95.2%	7.7%	80.0%
	Rating of Specialist Seen Most Often (9+10)	36.4%	76.3%	54.3%	54.3%	54.4%
	Survey Item: How often did your personal doctor seem informed and up-to-date about the care you got from these doctors or other health providers?	91.3%	23.1%	44.6%	23.1%	38.6%

Other health plans: did anybody improve?

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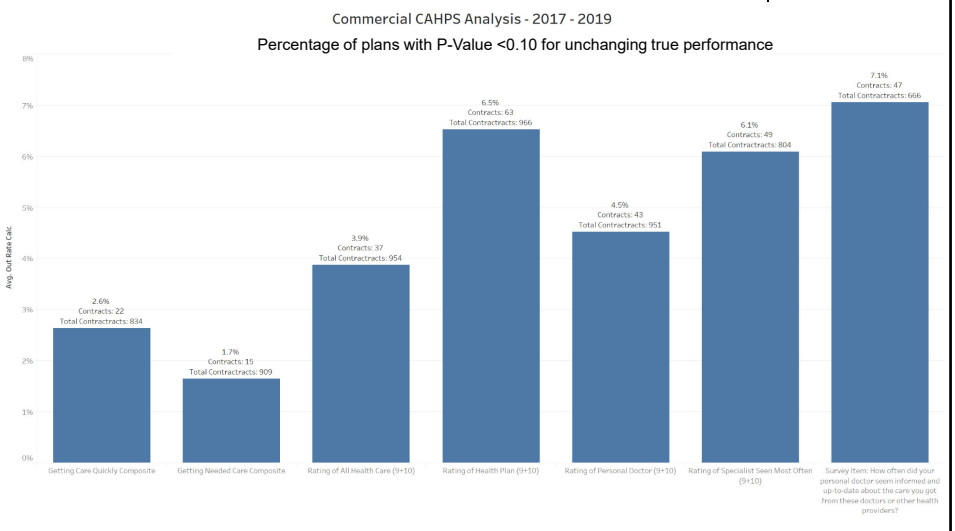

Consequences of increased weight on CAHPS

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Temptation: focus on response tendency (i.e., get members into a better mood, thinking happy thoughts when they receive their surveys)

Vendor approaches do not inspire confidence

- Some offer pre-CAHPS messaging to intended to make members feel good about their health plan (i.e., try to change response tendency)
- Some offer get-out-the-vote operations (taking response tendency as a given & trying to asymmetrically influence response rates)
  - My fear: this evil-genius approach might work
- Some are vague and probably just monetize regression to the mean
  - Plans are probably most likely to hire vendors just after particularly bad scores come in

Gaming is a concern

- Health plan decisions about oversampling might systematically affect their performance,
  - E.g., claims handling near the 100-observation threshold for reporting
  - Solution: Ban oversampling. Just increase the minimum sample to an adequate size.

What does it take to improve on CAHPS?

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For health plans, I don't know. Maybe in a few years I'll be able to share a success story

But in the meantime:

- Please increase health plan minimum sample sizes and make them uniform
- Please do not upweight CAHPS without guarding against gaming and evil genius vendors
- Please distinguish signal from noise in CAHPS performance reporting
  - This is an unfamiliar concept to many
  - As an industry, I would guess that we are wasting $100 millions chasing noise on health plan CAHPS

Appendix

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Our Approach to Calculating Score Variation due to Random Chance

Methods:

1. Take the average of all four years' Actual (Reported) Score as the true score for all four years
2. One sample Z-test on proportion for each year
3. Calculate the Combined Probability using Fisher's Combined Probability Test
   P-value for each year: p_2017, p_2018, p_2019, p_2020
   DF = 6
   Critical Value (CV) = sum(-2*log(p_2017),-2*log(p_2018),-2*log(p_2019) ,-2*log(p_2020))
   1- CDF('chisquare', CV, DF)

Limitations:

- We only have the 2019 measure-level denominator data for each plan and are using those for all years
- We do not have the 2018 or 2019 Claims Processing rate for BCBSMA HMO (H2261) so that measure is not included

To ask a quick clarifying question

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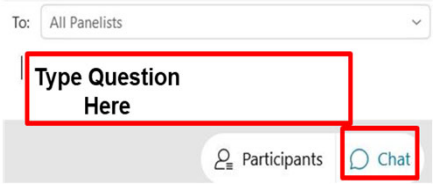


Evaluation of AltaMed's Shadow Coaching and Pay-for-Performance (P4P) Efforts to Improve Patient-Provider Interactions Using the CG-CAHPS® Survey:

Challenges and Successes

Denise D. Quigley (RAND) and Efrain Talamantes
(Chief Operating Officer, AltaMed Health Systems)

October 7, 2020

Virtually via Rockville, MD

1

Improving Patient Experiences: Shadow Coaching and P4P

- Healthcare providers must identify and target modifiable provider behaviors to improve patient experience scores
- Shadow coaching has been found to be effective in:
  - building and maintaining competencies among physicians, nurses and other staff and
  - increasing compliance with practice guidelines (Ravitz et al., 2013; Yusuf et al 2018; Poe et al 2011)
- It is unclear how providers are responding to pay-for-performance (P4P) and whether results are meeting expectations (Damberg et al., 2009)

2

AltaMed's Shadow Coaching and P4P Efforts

- P4P payments every 6 months
  - 6-month average score of provider's CG-CAHPS overall provider rating (OPR) with 0-100 possible score
- Coaching of "medium performers"
  - OPRs 45-89
  - Every 6 months eligible providers identified
    - About 30 providers coached every 6 months
- Coaching to improve patient-provider interactions
  - Half-to full-day of shadowing
  - Verbal and written feedback by coach focused on goal setting and personal improvement

3

Study Objective

- To evaluate whether
  - **coaching** improves patient experience scores
  - **incentives** improve patient experience scores
  - **re-coaching** has different effects than coaching
- To examine use and value of CG-CAHPS data for individual-level provider P4P incentives to improve physician-patient interactions

4

Study Design

- 2015—2016: Coaching pilot
- 2017—2018: Coaching implementation
- 2019: Re-coaching using a wait-list control design
  - 39 eligible providers randomly assigned to receive coaching (20) or serve as a control (19)
    - Random assignment stratified by CAHPS performance (OPR) and provider type (MD/DO/DDS vs NP/MA)
    - Re-coached: May 15–August 8, 2019
- Evaluate influence of **coaching** and **incentives** on:
  - CAHPS scores

5

Collected Provider Perceptions, Coach Feedback and CAHPS Performance

- CG-CAHPS performance
  - First phase: July 2012- June 2019
  - Future: Data through July 2021
- P4P incentive payments data
  - January 2017 – December 2018
- Provider perceptions
  - Provider survey
    - All providers: August 2018 and January 2020
    - Re-coached and controls: January 2019 and June 2019
  - Provider interviews
    - Re-coached & controls: July-August 2019 after re-coaching
- Reports of recommendations made by coaches
  - Content analysis of coaching reports: 2015 - 2019

6

Challenges Faced in Evaluation of Patient Experience Trends

- Gain buy-in from providers
  - Participation in shadow coaching and in evaluation data collection efforts
- Resources, time, and analytic sophistication
- Iterative analyses
  - To gain initial feedback and long-term impact on patient experiences
- Regression to the mean threat
- Consistent incentive payment data over time
- Small numbers of providers
  - Every 6 months for coaching
  - For randomized wait-list control design

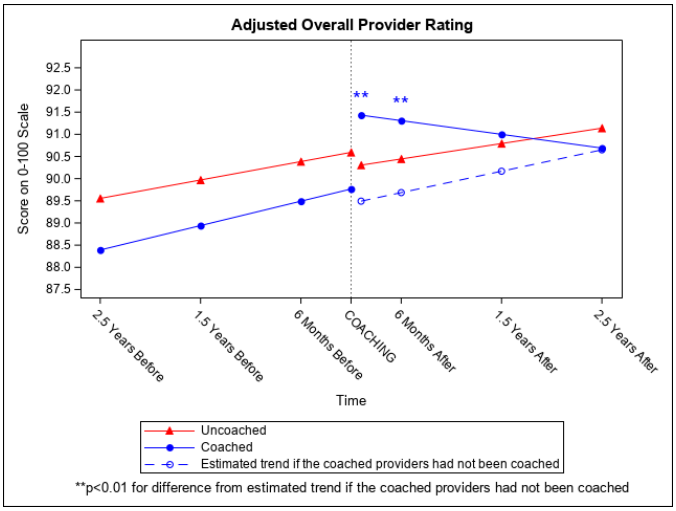
7

Modeled Patient Experience Trends Before and After Coaching

- Modeled trends of CAHPS measures over time
  - OPR
  - Provider communication composite
- Compared coached and uncoached providers before and after coaching
  - Used actual coaching date for coached and mean coaching date for uncoached
- Spline models with a knot and a possible jump at coaching date, adjusted for:
  - Patient characteristics
    - adult/child, age, gender, race/ethnicity, language, health status, education
  - Site indicator
  - Provider random effect

8

Coaching Improved the Overall Provider Rating (OPR)



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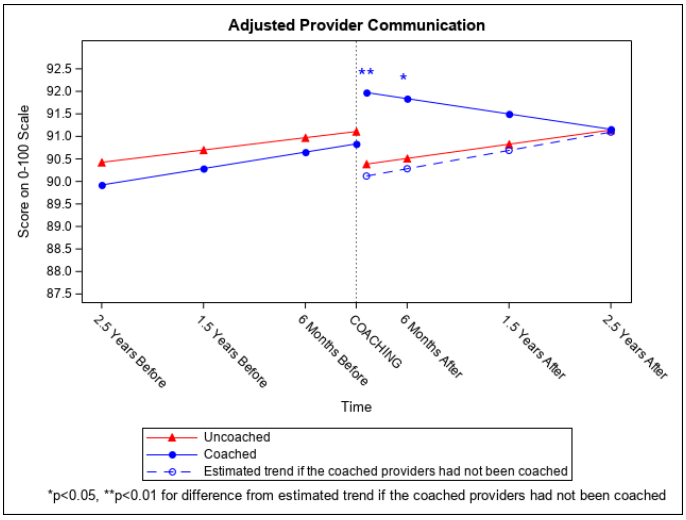
Coaching Improved Provider Communication



10

Coaching Improved Patient Experience, But Faded Over Time

- Small-to-medium jump (2 points) for both CAHPS measures at time of coaching
  - Uncoached providers had a non-significant change at time of coaching, as expected
  - Controlled for very small (0.2 point) regression-to-the-mean effect
- However, gains in scores faded
  - Gain eroded about 40% per year
  - 2-point gain disappeared by 2.5 years
- Important to assess re-coaching effect
  - Planned for early 2021
- *Recommend regularly planned, annual coaching "boosters" to maintain gains in scores*

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Similar Analysis to Evaluate Incentives Influence on CAHPS Scores

- Modeled trends of 2 CAHPS measures
- Compared coached and uncoached providers before and after incentive existed
  - Used date incentives implemented
- Spline models with a knot and a possible jump at coaching date, adjusted for:
  - Patient characteristics, Site indicator, and
  - Provider random effect
- Incentives had no influence on the trend of either patient experience measure

12

Coaching Influenced Desire to Improve & Had Tangible Recommendations

- Coaching decreased job satisfaction, but did influence providers' desire to improve:
  - Interactions with patients, Communication with care team, Coordination of information external to the clinic
- Half of recommendations encouraged existing behaviors, other half identified new behaviors
- Provided tangible recommendations, primarily for communication
- Recommendations mapped to CAHPS/Press Ganey surveys:
  - Engaging and spending time with patients
  - Listening to patients
  - Easy to understand explanations
  - Know patient medical history
  - Concern provider shows
  - Received instruction for follow-up care
  - Protecting patient safety

13

Providers Wanted More Actionable Input in Some Areas

- Providers needed more actionable input on:
  - Listening carefully, being friendly and engaging, having a relaxed and calm demeanor
- Providers wanted
  - Additional coaching
  - Training related to specific types of patients and communication for specific clinic settings

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Providers Pointed to Several Areas of Need

- Pointed out barriers related to time pressure during patient encounters
- Need to improve providers' perceptions of CAHPS' ability to reflect patient experiences
  - Stemming from low response rates and representativeness
- QI orientation and supportive leadership structure for QI exists, but could use more
- Requested more training for self (33%) and for others who work with me (36%)
- Need for tools and best practices to:
  - Communicate lab/test results to patients (44%)
  - Discuss best practices with other providers (36%)

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Lessons Learned

- Focus on incrementally improving culture and system
- Embed provider education and coaching into organization's long-term professional development
- CAHPS data is effective for benchmarking, measuring change, counseling and evaluating providers' efforts
- CAHPS and Press Ganey items are not always specific enough for tangible behavior change recommendations

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AltaMed's Principles for Success

Implementation:

- Gain provider buy-in
  - Value of patient experience data
  - Need to improve self/behaviors
  - With shadow coaching
  - Data collection for evaluation
- Ensure incentive payments are linked to CAHPS

Process:

- Focus on providing tangible, actionable behavior changes
- Market efforts for all providers to improve

17

Study's Principles for Success

Evaluation:

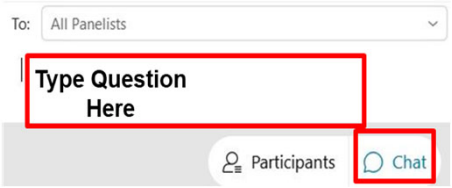
- Use pre-post trend analysis
- Include case-mix adjustment and other control variables
- Focus on level of the intervention (e.g. provider)
- Use randomized experiment
- Evaluate efforts across multiple outcomes

18

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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Examples of Patient Experience Improvement: Veterans Health Administration

Jennifer Purdy: Director, Patient Experience Directorate, Veterans Experience Office

Jim Schaefer: Director of Surveys , Analytics & Performance Integration

Virtual Research Meeting Sponsored by AHRQ
Oct 7, 2020

What is Patient Experience (PX)?

VA DEFINITION

The sum of all **interactions**, shaped by the organization's **culture**, that influence Veterans' and their families' **perceptions** along their healthcare journey.

VA SHEP Program

Survey of Healthcare Experiences of Patients

VA has surveyed Veterans about their care since the mid 1990's, utilizing CAHPS protocols since 2010.

- → **MODE:** SHEP was mail only prior to FY16; now includes email/web (except for HCAHPS/Inpatient – Medicare rules)
- → **SAMPLE:** SHEP contacts 1.8 million Veterans each year
- → **RESPONSE RATE:** SHEP's return rate is approx. **35%**

1995: VHA National Survey program established in response to Executive Order 12862 – Setting Customer Service Standards.

2001: VHA Inpatient and Outpatient Surveys administered through the SHEP program.

2009: SHEP Program implemented CAHPS questionnaires for Inpatient and Outpatient Surveys.

2012: SHEP Program implemented PCMH survey to assess PACT program.

2015: SHEP Program implemented Specialty Care Survey and Community Care Survey. Also established Veteran Insights Panel.

2016: SHEP Program added online survey option for PCMH and Specialty Care surveys.

2017: Public Reporting of VA Inpatients (HCAHPS) results on CMS Hospital Compare. SHEP Program expanded to include Advanced Analytics and Consultation Services.

SHEP – Over 1.8 Million Surveys Sent Annually

Survey Instruments	Mode of Administration	Average Number of Surveys Sent Monthly	National Response Rate – FY2020 (Oct 2019 – Mar 2020)
Inpatient (IP)	Mail Only (HCAHPS Protocol)	14,500	36%
Patient-Centered Medical Home (PCMH)	Internet & Mail	65,000	35%
Specialty Care (SC)	Internet & Mail	54,000	34%
Community Care (CC)	Internet & Mail	10,000	30%

SHEP | Overview of Driver Analysis

What is a Driver's Analysis (DA)?

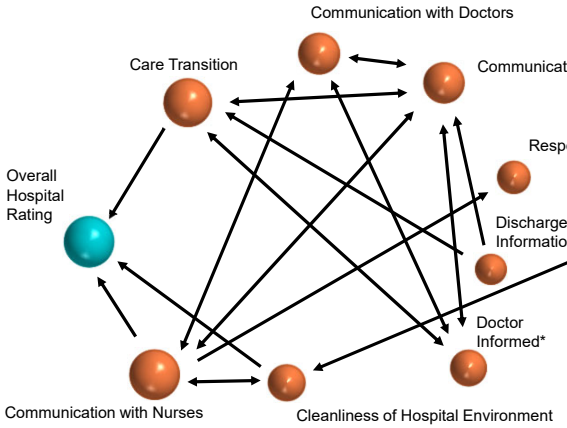
Quantitative technique used to evaluate the impact of various aspects of patient experience (i.e., "***drivers***") on overall patient experience (i.e., "***outcomes***").

The "***outcome***" in SHEP data is the **Overall Hospital Rating** measure (IP) and the **Rating of Provider** measure (PCMH and SC), while the "***drivers***" are the remaining HCAHPS measures and CAHPS measures, respectively.

DA helps identify intervention or leverage points for improving PX and informs clinical and operational action planning.

SHEP Driver Analysis | Inpatient IPSOS Bayes Net (IBN) Structural Map

VA National

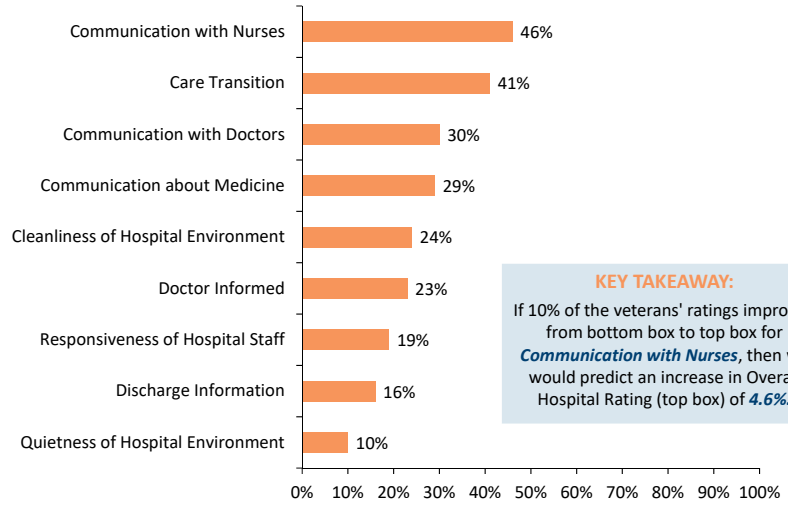


* Q34 Doctor Informed: "During this hospital stay, how often did healthcare providers seem informed and up-to-date about the care you got from other providers at the hospital?" is not an official HCAHPS reported measure.

Communication with Nurses, Cleanliness of Hospital Environment, and ***Care Transition*** have direct impacts on ***Overall Hospital Rating.*** ***Communication about Medicine*** influences other composites, therefore making it a fruitful point of intervention to help increase ***Overall Hospital Rating*** scores.

SHEP Driver Analysis | Inpatient IPSOS Bayes Net (IBN) Impact Scores

VA National



KEY TAKEAWAY:

If 10% of the veterans' ratings improved from bottom box to top box for ***Communication with Nurses***, then we would predict an increase in Overall Hospital Rating (top box) of ***4.6%.***

Patient Experiences

VA | U.S. Department of Veterans Affairs

SHEP Driver Analysis | PCMH Attributable Effects

Loss	VA National	Gain
34.7	Q23 Provider Knew Important Medical History	17.5
10.2	Q18 Seen within 15 Minutes of Appt	14.8
50.0	Q20 Provider Listened Carefully	14.7
15.9	Q34 Discussed Prescription Medications	14.7
45.0	Q25 Provider Spent Enough Time	14.4
46.4	Q19 Provider Explained Things	13.9
38.1	Q22 Provider Gave Easy-to-Understand Info	13.4
55.2	Q24 Provider Showed Respect	12.1
14.1	Q38 Provider Discussed Taking Care of Health	11.5
20.4	Q27 Provider Followed-up with Test Results	11.4
15.0	Q36 Provider Up-To-Date on Specialist Care	10.4
21.7	Q37 Provider Discussed Health Goals	10.3
19.0	Q42 Helpful Office Staff	10.0
14.0	Q9 Appt for Routine Care as Soon as Needed	9.7
7.4	Q30 Discussed Reasons Not to Take Rx	9.5
13.8	Q29 Discussed Reasons to Take Rx	8.6
18.7	Q10 Got Info on What To Do If Needed After Hours Care	8.5
7.4	Q14 Office Hours Medical Question Answered	8.2
13.3	Q40 Provider Discussed Worries/Stress	8.0
7.7	Q8 Appt for Urgent Care as Soon as Needed	7.5
7.9	Q41 Provider Discussed Probs/Mental Hlth/Subst Use	6.9
24.8	Q43 Courteous and Respectful Office Staff	6.3
3.9	Q7 Days Wait for Urgent Care	5.8
1.4	Q12 Got After Hours Care	5.6
21.4	Q31 Provider Asked What was Best	5.4
16.3	Q17 Received Reminders Between Visits	4.0
15.4	Q39 Provider Discussed Depression	4.0

Loss: Overall Provider Rating score would decrease ***55.2*** percentage points if nobody responded top-box to ***Comm: Provider Showed Respect***

Gain: Overall Provider Rating score would increase ***17.5*** percentage points if all patients responded top-box to ***CareCoord: Knew Medical History***

Patient Experiences

VA | U.S. Department of Veterans Affairs

VETERANS PATIENT EXPERIENCE

Phase 1: (FY17) Build

- Define PX
- Design PX for VHA
- Gain Trust & Pilot Toolkits

Phase 2: (FY18) Deploy

- Leadership Engagement
- Employee Engagement
- Orchestrated Touchpoints

Phase 3: (FY19) Coach

- Assess Facility Needs & PX Maturity
- PX Culture
- Outcomes

Phase 4: (FY20) Build

- Standardize Across VHA
- Strengthen Skills
- Accountability Outcomes

VETERANS PATIENT EXPERIENCE

Patient Experience Journey Maps

Human Centered Design (HCD) is a design and management framework for producing solutions to issues or problems that involve the human-perspective in all facets of the problem-solving process. During a discovery sprint, interviews across the country in various geographies, genders, races, life stages, military branches, and eras of service provide insights into bright spots and pain points, while baselining moments that matter in the journey receiving healthcare service delivery.

WHAT IS A JOURNEY MAP?

Journey maps visually display a common set of moments that Veterans experience before, during, and after receiving healthcare or interacting at the VA. They identify ideal situations and opportunities for improvement.

Current Journey Maps: Outpatient, Women's Outpatient, Hospitalization, and Discharge

In-Development: Care in the Community, Emergency Medicine, Telehealth, and more!

Implementation of PX Foundational Tools

VETERANS PATIENT EXPERIENCE

VA PX — A framework and tools to help you enhance the Veteran Patient Experience

WECARE Rounding | Standard Phone Greeting | Employee "I Choose VA" Name Badges | Own the Moment | Red Coat Ambassadors

WHAT'S IN A VA PX TOOLKIT?

A toolkit is a set of information to assist VHA leaders understand the benefits of patient experience and offer strategies, tactics, and tips for implementing and the value of a targeted campaign, initiative, program, or solution at a facility. Toolkits are often accompanied by reference materials and promotional materials to assist in socializing the item for implementation.

The Own the Moment (OTM) Veterans Customer Experience workshop: Teaching customer experience standards, the VA WAY, through three guiding principles.

This workshop improves on good customer service by providing ease, effectiveness, and adds a third dimension of emotion.

The three-hour workshop is geared for all VA employees and volunteers and offers some continuing education credits. Implemented through a train-the-trainer model at each facility

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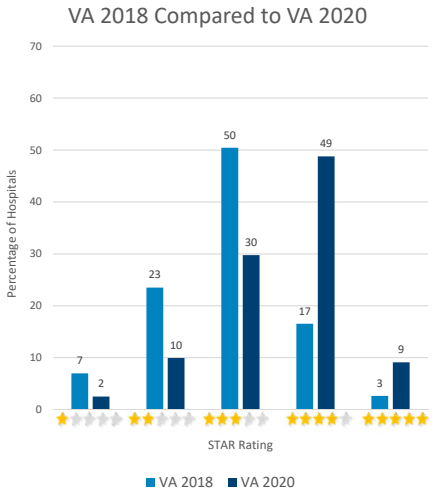
PX Toolkit Library

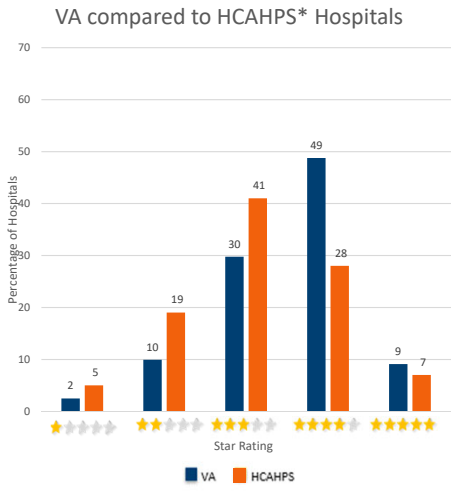
Click a link below to access a toolkit:

- Caregiver Support Guide (PCMH, IP, SC)
- Commit to Sit (IP)
- Change of Provider Letter (PCMH)
- Discharge Checklist (IP)
- Employee Recognition (PCMH, IP, SC)
- Green Gloves (PCMH, IP, SC)
- Hourly Nurse Rounding (IP)
- I Choose VA Employee Badges (PCMH, IP, SC)
- Interdisciplinary Team Rounding (IP)
- Journey to Discharge Hospitalization Journal (IP)
- Messages for the Moment (PCMH, IP, SC)
- My Life My Story (IP)
- Own the Moment (PCMH, IP, SC)
- Patient Communication Whiteboards (IP)
- Pre-visit Checklist (PCMH)
- PX Change Agent (PCMH, IP, SC)
- PX Communications Plan (PCMH, IP, SC)
- PX Road Show (PCMH, IP, SC)

ChooseVA — VA VETERANS EXPERIENCE OFFICE — 12

SHEP HCAHPS Star Rating - Communication with Nurses





* based on July 2020 Release - N=3478 Hospitals with Star Ratings (includes VA data) Patient discharged from Oct 2018 to Sept 2019

Patient Experiences

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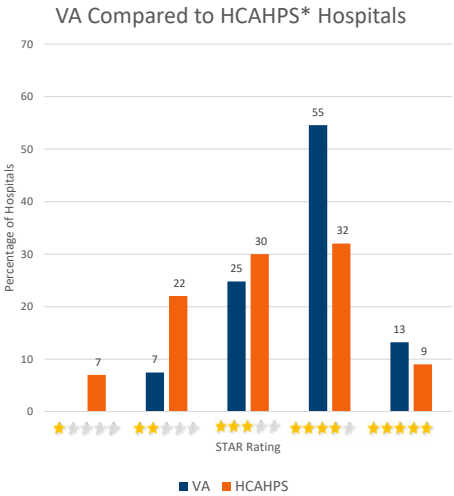
SHEP HCAHPS Star Rating - Care Transition



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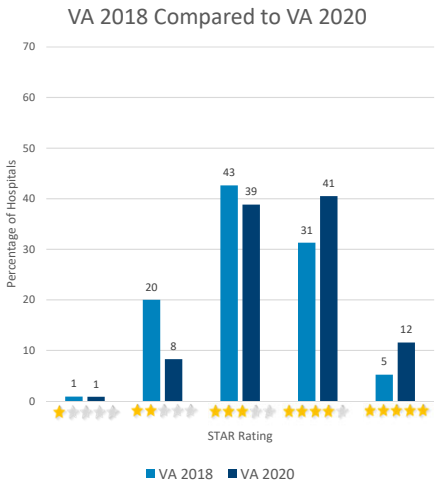
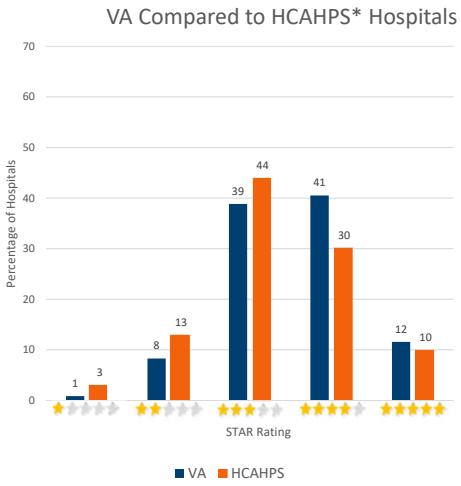
SHEP HCAHPS Star Rating - Overall Rating of Hospital





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Patient Experiences

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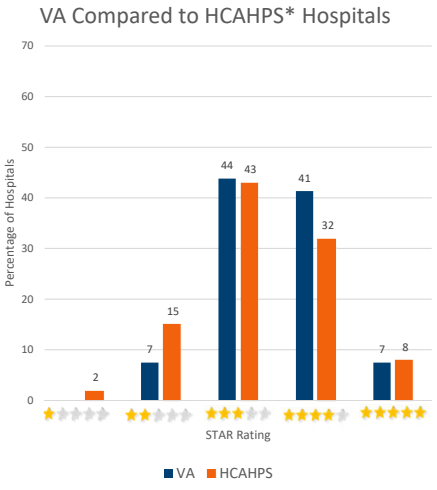
SHEP HCAHPS Summary Star Rating



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Patient Experiences

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LESSONS LEARNED

Leadership and employee engagement is key

- Foundational goal of the organization
- Patient experience baked into the organization's culture

Understand what is important to patients

- Human centered design
- Journey maps of key touchpoints (Moments that Matter)

Turning data into action

- Key drivers help to narrow the focus
- Understand patient/staff interactions, processes, and key touchpoints
- Develop and deploy toolkits for quality/process improvement and standardization across the enterprise

Celebrate successes!!!

Questions?

Thank-you!

Jennifer Purdy: Director, Patient Experience Directorate, Veterans Experience Office

Jim Schaefer: Director of Surveys , Analytics & Performance Integration

To ask a quick clarifying question

Chat to type

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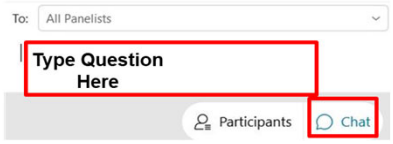


VA U.S. Department of Veterans Affairs 19

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

October 7, 2020

Natalie McNeal, MBA, MHA
Wellstar Community Hospice

Wellstar

1

Our state-of-the-art facilities include:

- **11** HOSPITALS
- **300+** MEDICAL OFFICE LOCATIONS
- **9** CANCER CENTERS
- **55** REHABILITATION CENTERS
- **3** HOSPICE FACILITIES
- **1** RETIREMENT VILLAGE
- **21** IMAGING CENTERS
- **15** URGENT CARE LOCATIONS
- **5** HEALTH PARKS

Every day, our team of **24,000+ healthcare professionals** provides personalized care for patients at every age and stage of life.

Wellstar

2

Nationally ranked and locally recognized for our high-quality care, inclusive culture, and exceptional doctors and caregivers, Wellstar Health system is one of the largest and one of the most integrated healthcare systems in Georgia.

As a not-for-profit health system, our passion for people extends beyond our system and into the communities we serve.

Wellstar

3

Enhancing the Patient Experience

- Listen Carefully re: Care Problems
  - Measureable and Moveable
  - Hospice Core Value
  - Being heard significantly impacts the experience

Performance Indicators-Starting Point 68.6

Goals: Threshold 83.8% Target 85% Max 88.5%

4

Wellstar

Performance Improvement Design

Wellstar utilizes the A-3 Lean methodology

Pros-Plan, Do, Check, Act cycle; root cause analysis; structured format with easily viewable progress; document utilized throughout the process

Cons-can be overwhelming/complex; must have a culture that does not punish; problems can't be viewed as a burden

5

Wellstar

WELLSTAR

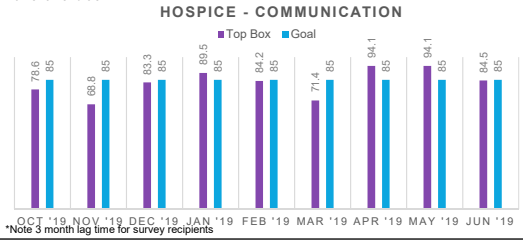
Executive Sponsor: Natalie McNeal

Start Date: 11/2018 ***Revision Date: 07/01/2019*** ***Revision #: 5***

Project Title: WELLSTAR HOSPICE: PATIENT EXPERIENCE

Background: Patient Experience Scores for TQ Cobb, TQ Mountain, and Home Hospice were below desired levels.

Current Condition:



*Note 3 month lag time for survey recipients

Goal: Listen Carefully re: Care Problems

Threshold 83.8% Target 85% Max 88.5%

Problem Analysis:

See Fishbone

- **Not identifying and connecting with person who gets the survey**
- **Who is getting surveyed (? Patient stays <48hrs)**
- **Communication processes within the Hospice clinical team**
- **Staffing & Census Challenges**
- **Survey language different than staff language**
- **Lack of Provider continuity; relationship building**

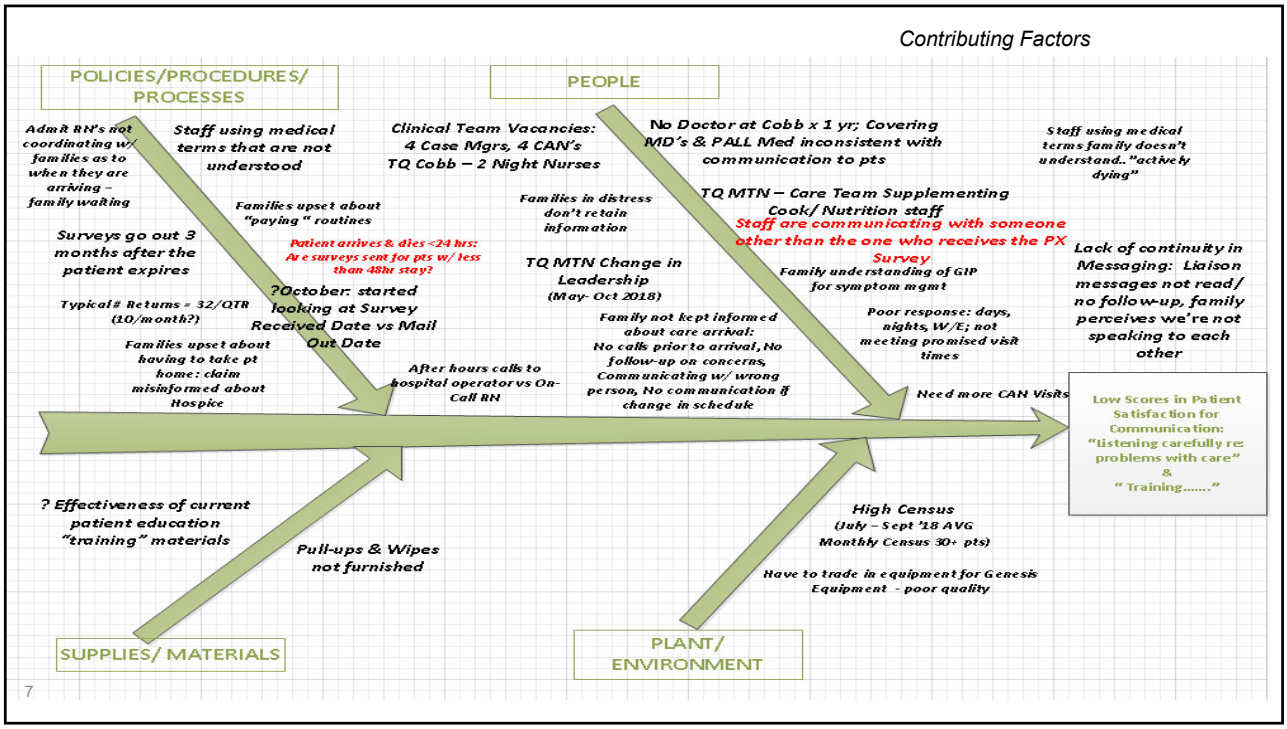
Countermeasures/Action Plan/ Solutions:

DO (Improve)

Problem/ Issue	Action/ Solutions	Owner	Due Date
Need team member feedback on PX scores	Managers meet with Teams for input	R. Messer, N. Jarrell, A. Helton	Completed
Key words in the PX Survey are not in the language typically used by team members.	Pull out key words that need to be socialized with team members, leaders and medical staff Incorporate key words in a manner caregivers are comfortable using "not scripted text" ex: training vs education, "listening", "it's my privilege"	J. Dudley Laura	Completed
Families unclear about medication side effects; don't recall "training"	Compile the list of top ten meds (pain); Create sheet for E Kit. Purchase CAM cards to supplement medication education /"training" Staff Education rollout	N. McNeal	Completed
Staff are not always speaking with person who will complete survey	Staff to check address box in remote client to see who is receiving survey and communicate with them. Inservice for SW staff: "Who will receive Survey?" Document in EPIC under HCAPS recipient. Document in hyperspace – sticky note	J. Threadgill	Ongoing and occurring
Clarify who is getting the survey: does this include < 48 hr stays	Contact Jason & CAHPS	J. Dudley	Completed
Communication with families over scheduling	Clinicians Call families 1st thing in the morning & update with any changes	Manager	Working on – update at next staff mtg to

Results: Patient Experience score for FY19 year end is 84.5%

6



Countermeasures and Action Plans:

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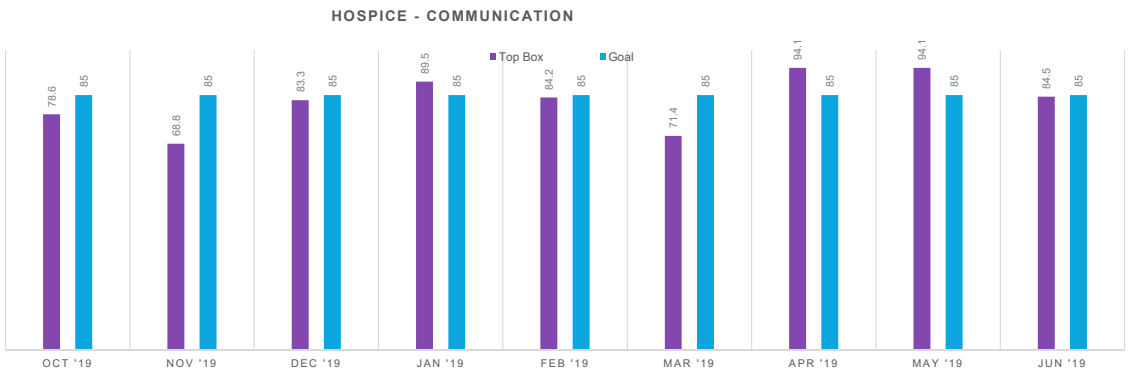
Outcomes and Data Evaluation



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Issues and Challenges in Data Evaluation

- Patient is not the person surveyed in Hospice CAHPS
  - Person surveyed may not have been the primary contact for the hospice team throughout dates of service
  - Person surveyed and patient may have different goals
- Lag in time of survey sent from last date of care
- Listen Carefully re: Care Problems is not evaluated by all survey recipients
- Bereavement firsts-emotional fluctuations
- Hospice days on service impacts scores

Wellstar

Key Principals for Success

- We had a lean expert guiding our team throughout
- Practice, Practice, Practice
- Keep focus on process improvement and off of people failure
- Recognize causal factors in addition to the root cause
- Set attainable goals

Wellstar

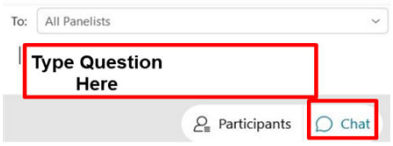
To enhance the patient experience, we must focus on each person we serve as an individual. What seems like a simple measure, such as listening, has a multitude of factors for each respondent that will impact their score. Without understanding each person we serve, we will not be able to sustain improvement and provide the best end of life experience possible for our patients and their loved ones.

Wellstar

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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Wellstar

Afternoon Panel: Moderated Open Discussion
Paul Cleary

AHRQ Agency for Healthcare Research and Quality

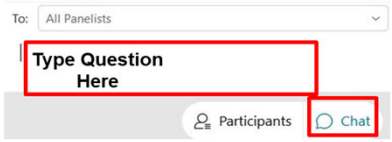
1. Chat to type

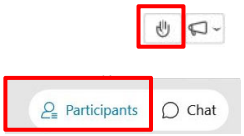
- At the bottom right, select “Chat”
- Make sure “All Panelists” is selected in the “To:”
- Type your question or comment in the box and hit “Enter” on your keyboard

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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Closing Remarks

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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Thank you!

Please complete the meeting evaluation.

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