Program Summary

CG-CAHPS Improvement Network

May 2014

Overview

In February 2013, 15 clinics across four California public health care systems joined the California Health Care Safety Net Institute's (SNI) CG-CAHPS Improvement Network, generously funded by the California Health Care Foundation, to make measurable advances in patient experience over a 12-month period. Because all California public health care systems have rolled out a modified Visit variant of the Clinician and Group CAHPS (CG-CAHPS) survey, following a standardized protocol co-developed by SNI, the ideal foundation was provided for common metrics and joint improvement activities within the Network. The participating health care systems, which included Kern Medical Center, Santa Clara Valley Medical Center, San Joaquin General Hospital, and Ventura County Health Care Agency sought to improve CG-CAHPS scores through the Network by: 1) Increasing the skills of providers and staff to effectively and reliably communicate empathy and caring; and 2) Boosting the clinics' mastery of quality improvement skills relevant to patient experience.

The program focused on two key components: rollout of *The Language of Caring*, a comprehensive training program designed to expand and strengthen staff communication skills in interactions with patients and colleagues; and a set of activities focused on measuring, understanding, and acting upon patient experience data. SNI also created and disseminated a brief Staff Pulse Survey, which allowed clinic staff and providers to provide feedback on their experience of working in the clinic.

By February 2014, the aggregate CG-CAHPS scores revealed an overall pre-to-post increase on the Staff Communication items. Aggregate Provider Communication results were varied, with some scores remaining the same or decreasing. The aggregate results on the Staff Pulse Survey revealed an increase in scores on all questions. The data suggest that the program was effective in improving communication and empathy conveyance among clinic staff: clerks, receptionists, and clinical/medical assistants.

The following document details the overall program activities; results, including challenges and a brief outline of success factors from a clinic that achieved particularly strong results; and finally, lessons learned. Hopefully these learnings can facilitate and accelerate patient experience improvements among California public health care systems and beyond.

Program Activities

Each of the 15 clinics participating in the CG-CAHPS Improvement Network designated an internal Management Sponsor, Language of Caring Facilitator, and Data/Quality Improvement Contact to lead the efforts in the clinics. From February 2013 through February 2014, the teams rolled out *The Language of Caring* modules, participated in a number of activities for improving patient experience measurement and quality improvement, and disseminated a pre and post Staff Pulse Survey.

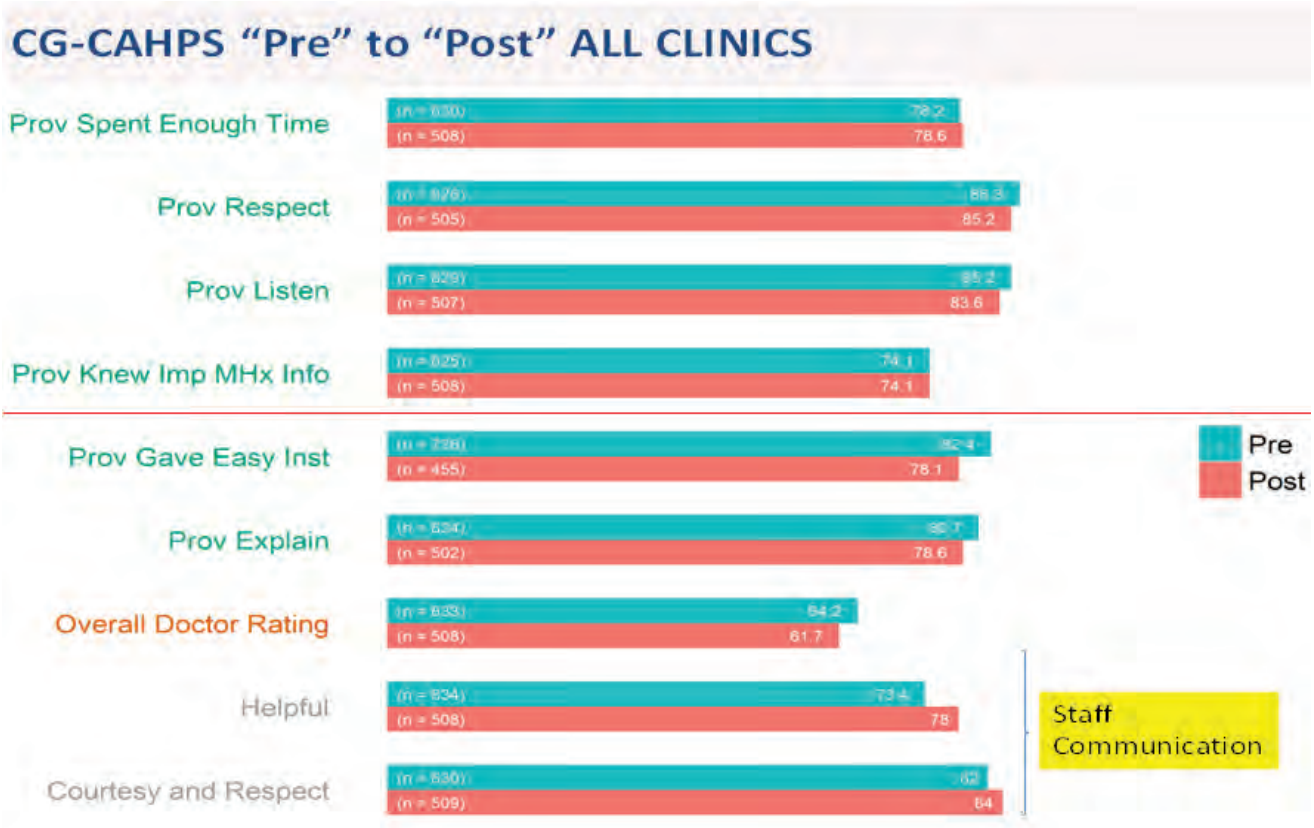
In March 2013, the teams attended all day "Leadership Kickoff" and "Train-the-Trainers" sessions in order to gain the skills and knowledge necessary to lead the program activities in their clinics. Six patient partners attended these events. From April through December 2013, internal facilitators attended monthly SNI-led coaching calls and webinars to facilitate ten sessions in their clinics (see next page). The skills were followed by specially-designed "hardwiring" activities in the clinics.

1. Jumpstart Training
2. Heart-Head-Heart Communication
3. Practice of Presence
4. Acknowledging Feelings
5. Showing Caring Non-Verbally
6. Explaining Positive Intent
7. Blameless Apology
8. Gift of Positive Regard
9. Caring Broken Record
10. The Skills Combined

From April through October 2013, participants attended webinars focused on data and measurement on the following topics: Setting Aims, Patient Shadowing, and the "Poker Chip Method." SNI also provided individualized support to teams around data and measurement, including site-visits to clinics, coaching on quality improvement methods, interpreting CG-CAHPS results, and demonstrating the Patient Shadowing and "Poker Chip Method"—a point-of-care means of gathering patient input about the quality of health care services, which may complement formal CG-CAHPS surveys. The "Poker Chip Method" was implemented on a trial basis in seven of the 15 clinics.

In January 2014, the program concluded with an all-day Capstone Event where clinic teams and patients attended to showcase their implementation and improvement efforts, review results, and outline plans for sustainability.

Results: CG-CAHPS



As shown in the previous page, the aggregate overall top-box scores on the Staff Communication items increased. "Were clerks and receptionists as helpful as you thought they should be?" increased from 73.4 to 78%. "Did clerks and receptionists treat you with courtesy and respect?" increased from 82% to 84%. These results align with the fact that in most clinics, the primary audience present and engaged during skills rollouts were clinic staff including receptionists, clerks and medical assistants—many of whom have front-end interactions with the patients. These results are especially significant given the recent evidence[1] that "first impressions" are critically important in defining the overall patient experience.

The aggregate Provider Communication scores remained the same or decreased. In some clinics, the teams struggled to involve providers in the skills sessions and consequently, the program had relatively little effect on those providers and their practice. Alternatively, Provider Communication scores increased in a few clinics where providers were engaged in the skills rollouts, as will be demonstrated through a case example of Ventura County Health Care Agency's Santa Paula clinic (see page 5).

Results: Staff Pulse Survey

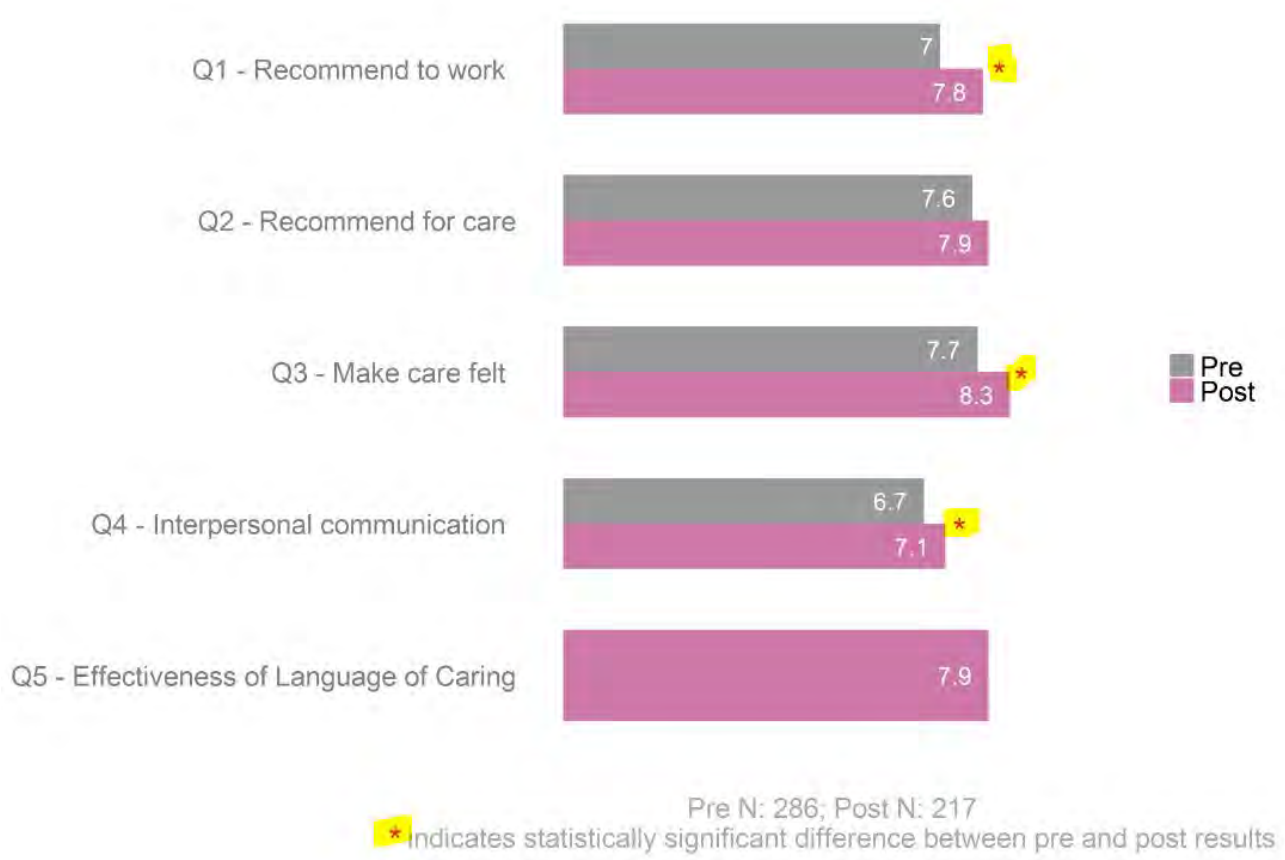
In addition to patient experience scores, the Network also aimed to increase staff experience, as health care staff experience has been found to be closely linked with the experience of patients. The clinic administrators disseminated the Staff Pulse Survey in each clinic to providers, nurses, medical assistants, receptionists and clerks. The survey consisted of the following four questions, on a scale from 1 (lowest) to 10 (highest).

1. How likely are you to recommend your clinic as a *place to work* to a friend or relative?
2. How likely are you to recommend your clinic as a *place for care* to a friend or relative?
3. How effective do you feel in *making your care* felt by the people you serve?
4. How would you rate the quality of *interpersonal communication* among the staff?

The following question was included on the "post" measure: "How effective was the *Language of Caring* program in improving the patient and staff experience in your clinic?"

[1] See, for example, J.D. Power and Associates, 2012 National Patient Experience Study; and Gawronski, B., et al., 2010, Generalization Versus Contextualization in Automatic Evaluation. Journal of Experimental Psychology

Pulse Survey Results ALL CLINICS



These aggregate results show an increase in scores on all four questions. The differences are statistically significant (at $p < 0.05$) for questions 1, 3 and 4. The staff perceived their own experience, and their enthusiasm about the clinics for employment and care, as having improved over the 10-month period.

Additionally, respondents rated the "effectiveness of the Language of Caring in improving the patient and staff experience in their clinics" highly (7.9 on a scale of 1-10.) This corresponds with the informal feedback SNI received throughout the work of the Network, which is that the vast majority of participants greatly appreciated the program and felt it made a tangible difference in improving communication with their patients and among staff.

Challenges

There were numerous challenges and points of variation which may have influenced the experience of patients, providers and staff, and impacted the results. Challenges included the variation among participation and implementation of the Language of Caring, the depth of programming and skills uptake, the amount of leadership support, and level of engaged staff and providers. For example, some internal trainers regularly attended SNI's monthly facilitator prep webinars and coaching calls, and carved out ample time to prepare for the session rollouts, while others were allowed little time away from their regular duties to prepare.. Additionally, some clinics emphasized "hardwiring" activities to sustain the skills, while others struggled to reinforce the skills into clinic processes and fully engage the staff. Further, competing priorities were a daily reality in all of the participating clinics. However, the more a clinic managed to purposefully infuse the *Language of Caring* skills into all clinic operations, the more likely the clinic was able to succeed in transcending the perception of burden.

Case Example

Ventura County Health Care Agency's Santa Paula Medical Clinic is an example of a clinic in which both the CG-CAHPS and Pulse Survey metrics significantly increased. Santa Paula faced many challenges throughout the course of the program, including limited time and resources, competing priorities, and challenges implementing their new electronic health record. However, because the program was actively supported and driven by the Medical Director, Clinic Manager, and local facilitator who was a physician, the staff and providers persevered and succeeded in increasing their CG-CAHPS scores on all six items of Provider Communication, Overall Rating of Provider, and on both items of Staff Communication. Scores improved on all items of the Pulse Survey as well.

SNI has identified the following to be key success factors for Santa Paula Clinic:

Strong leadership support: Santa Paula's Medical Director and chief executive fully supported the Language of Caring and believed leadership engagement was necessary in order to integrate and sustain the skills in the clinic. She allowed time for facilitators to prepare for the trainings, attended the trainings, and personally consistently modeled the skills with patients and staff. Strong leadership support and role modeling is exemplified in her own words, "*I explored my own responses and actions and saw how staff was mirroring my words and emotions…I learned how to mentor staff…if leadership uses these skills it will filter down to staff and continue to be used...*"

Physician-driven: The internal facilitator was a physician leader who influenced both staff and providers to participate in her trainings and use the skills in their interactions with each other and patients. The skills were modeled from leadership, down to providers, and to front-office staff. The Pulse Survey reveals an 8.6 score (on a scale of 1-10) on the "Effectiveness of the Language of Caring," suggesting confidence and unity among both providers and staff that the *Language of Caring* is effective.

Adequate Preparation: The facilitators spent adequate time planning each rollout. This included customizing the presentation templates with clinic examples, sending emails prior to the trainings encouraging staff to think about the module in advance, asking staff to come to the trainings prepared with their own examples, and selecting appropriate hardwiring activities for each skill. Additional time spent preparing resulted in a more successful rollout, as staff and providers participated and were more engaged because the skills and examples were tailored and relevant in their local environment. Also, there was greater attendance in part because the facilitators scheduled the trainings and notified staff and providers in advance. Additionally, leadership allowed the facilitators to close the clinic so staff and providers could focus their attention on the trainings.

Flexibility: The facilitators adapted to the needs of the clinic and were undeterred by challenges. This perseverance and flexibility in adapting to the needs of their clinic helped them succeed in the program despite many unexpected challenges.

- They initially held their trainings in the morning, but found that staff and providers were restless and less engaged. Thus, they moved the sessions to 4:30pm, as staff and providers were able to "unwind and relax" after a long day.
- The facilitators realized that storytelling and role-playing resulted in greater interaction and participation than simply watching the video clip and discussing the skills, so the facilitators incorporated storytelling and/or role-playing in each rollout.
- When there were technical challenges, which made them unable to play the training videos, the facilitators were ready to act the scenes out instead.
- At times the staff were unable to stay on track and complete each module during the recommended times. Instead of skipping the module entirely, the facilitators combined the modules and held "super sessions," ranging from 45 minutes to1.5 hours per session.

Integration of Skills: The facilitators and leadership integrated the program into their daily work and did not view or frame the program as an additional task or burden. Instead, they used the skills as part of their work, and encouraged the staff to do the same. For example, the implementation of their electronic health record posed numerous challenges. The staff and providers were coached in using the *Language of Caring* skills to help diffuse various stressful situations which occurred in the weeks following the rollout. As a result, the staff and providers were able to communicate effectively and empathically with each other and with their patients, which enhanced the experience of both and was reflected in stronger staff and patient satisfaction scores.

Lessons Learned

A facilitated network of 15 primary care safety net clinics working together over 10 months to strengthen empathy conveyance and data-driven care can succeed in improving select dimensions of patient experience, as well as the overall experience of provider and staff. In the Network, improvement was reflected in the Staff Communication composite of the CG-CAHPS survey, and on all dimensions of the Staff Pulse Survey.

Strong leadership support was found to be a foundational factor of success. Greater results were seen in clinics where the leaders were engaged. Clinics that allocated ample resources and time—both in terms of the clinic staff's adoption and practice of the new skills—succeeded in the program. The program was effective in reaching the clinic staff: clerks, receptionists, and clinical/medical assistants, as clinic staff generally had strong buy-in with the *Language of Caring*. They were the most reliably present during the training sessions, and in many cases, drove most of the skills rollout activities.

SNI has not seen a corresponding increase in the across-the-board Provider Communication scores. This is at least in part due to the fact that providers, on the whole, have been less involved in the program than the clinic staff. SNI deployed a variety of strategies to encourage providers to participate in the program, including hosting a set of additional webinars specifically tailored to provider needs, advising clinics to designate "physician champions," and encouraging providers to attend the trainings and incorporate the skills in provider-patient interactions. However, most of the providers struggled to balance their clinic duties with the program and consequently did not participate in the trainings. It is important to note that those clinics where the program was either led by providers and/or the providers significantly participated in it showed an increase on Provider Communication and Overall Provider Rating scores on the CG-CAHPS. Thus, in order to truly improve health care communication--and ultimately patient care--the skills must be used and sustained by all—from front line staff, to providers, to leadership.

Another lesson learned is that in order to conduct effective continuous improvement and spur data-driven care, clinic teams must engage with their data. The ability of public health care systems to generate CG-CAHPS data will not automatically lead to better care at the front line. The clinic teams must receive the data, and the teams must have the skills and time to interpret the data, as well as the license and capacity to purposefully act upon them in a process of continuous improvement. This is not easy to achieve, and in reality, many clinic leaders and teams do not make regular, effective use of their patient experience data. The barriers cited often include work overload, competing priorities, disconnect from the quality improvement department which is often the point of aggregation and dissemination of patient experience surveys, the complicated and often confusing nature of the reports, and difficulties navigating the vendor Web portals. The success of an initiative, such as the CG-CAHPS Improvement Network, hinges both on the strength of the pathways for the patient experience data to reach the front-line leaders and staff, and on their capacity to utilize these data in every-day quality improvement.

As part of building a data-driven culture of quality, public health care systems should strive to promote the capacity of leaders and front-line staff members to engage with their own data in a timely fashion, understand and interpret it accurately, and appropriately take improvement action based on the results. Various incentives for local leaders to access their vendor portals, including designing these portals to be intuitive and user-friendly, and providing frequent coaching opportunities around their use, are some of the practices that can increase the likelihood that patient experience data will be used effectively for quality improvement.

Conclusion

The four systems that participated in our Network were eager to work on accelerating improvement using CG-CAHPS as the common metrics platform. They recognized the focus on empathy conveyance skills as an appropriate vehicle for improvement in their safety net environments and saw improvements in staff communication and Pulse Survey scores. Though it is always difficult to be certain about the impact of a single program, especially given the complexity of the local health care environments facing public health care systems, our interpretation of the CG-CAHPS data is supported by the objective and anecdotal evidence gathered from the clinics throughout the implementation activities. Notably, the improved pre-to-post results on the staff Pulse Survey demonstrate improvements from the perspective of the clinics' staff.

The seed has been planted and most clinics plan to continue enhancing communication with their patients and among staff. Ultimately, the efforts must be sustained internally through the systems' leadership, staff and providers.

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California Association
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