

Improving Your Performance on the CAHPS Health Plan Survey.

March, 31, 2009 2:00 – 3:30 pm

Presentation

Introduction

>> Greetings and welcome to the CAHPS Health Plan Survey. At this time all participants are in a listen-only mode. A brief question and answer session will follow the formal presentation. If anyone should require operator assistance during the conference, press star-0 on your keypad. This conference is being recorded. It is now my pleasure to introduce your host, Carla Zema. Thank you, you may begin.

>> Thanks, good afternoon, everyone. And welcome to Improving Your Performance on the CAHPS Health Plan Survey Webcast sponsored by the Agency for Healthcare Research and Quality (AHRQ). This webcast will provide you with information on how to use your CAHPS Health Plan Survey results for quality improvement. We're really excited about this webcast and this is one of the topics that you have identified during our previous webcasts as being of interest to you and -- this is a highest number of registrants we've had for a webcast so we're looking forward to presenting with you with a lot of valuable information.

>> I'm Carla Zema and I serve as a consultant to support the CAHPS Consortium and User Network. One of my privileges in this role is to work with the CAHPS Quality Improvement Team.

You can listen to this webcast either through streaming audio through computer speakers or join us by telephone by dialing 1-877-445-9761. And you will need a pass code for that and that pass code is 313252. If you experience any difficulties with streaming audio, please feel free to join us by phone at any time.

I also wanted to let you know that you may also experience a slight lag in the advance of the slides. This is dependent upon your computer speed and the type of Internet connection.

Some of are you new to CAHPS and I just wanted to kind of give you a little bit of an overview. CAHPS represents a family of surveys that asks consumers and patients about their experiences with health care. The first CAHPS survey was the Health Plan Survey which will be our focus today.

These surveys were designed to evaluate patient experiences of care at both the ambulatory and facility level.

At the ambulatory level this includes not only medical groups and practices, but also other ambulatory settings such as hospital outpatient clinics, public health clinics for example. We will focus on quality improvement using the Health Plan Survey.

We will be scheduling another webcast in the fall on quality improvement using our Clinician & Group Survey. So stay tuned for more information about how you can get that information about when that webcast will be scheduled.

We have a great lineup of speakers today. Donna Farley is one of the principal investigators for the RAND Grantee Team and the leader for the RAND Team on the QI Team. She will be

presenting how to apply the process of quality improvement to the challenge of improving health plan enrollee's experience. She will discuss how to develop an effective action plan for improving enrollees' experiences as well as what drives a successful implementation of such a plan.

Dale Shaller is the lead for the Yale Grantee Team for the Reports Team and member of the Quality Improvement Team also. He's the managing director of the CAHPS Database and will be providing information on the new online reporting tools available from the CAHPS Database to identify opportunities to improve health plan enrollees' experiences. And show you the new online Improvement Guide that can help you identify strategies for improving specific aspects of enrollees' experiences.

We will be taking questions; you can submit questions any time during the webcast. And we've learned that this is the portion that you really value in our webcasts, so we want to encourage to you submit your questions throughout the presentations.

All you need to do is simply select questions from the navigation bar in the upper right portion of your screen. You will see a pop-up box, so just type in your question in text box and select send. You also have the option to send your question anonymously, if you prefer. And we love to hear from you, so send in lots of questions and comments.

If you are unable to see the slides fully on your screen and you need to scroll, you can adjust your screen resolution to 1024 by 768 which will fix this problem for you. That's specific to your display on your computer. Each operating system is a little different but you can typically do this by right clicking on desktop and selecting display modes or settings.

If you need help at any time during this webcast, select help from the upper right portion of your screen, if you are dialed into the telephone line to hear audio, you can also dial star-0.

Now let's hear from our speakers. First we have Donna Farley. She will present information on generally how to develop a quality improvement plan and what are the successful drivers of quality improvement processes. Donna?

Preparing to Implement Quality Improvement for CAHPS, Donna Farley, RAND

>> Donna Farley: Thank you, Carla. Glad to be here with everybody and looking forward to some dialogue as I go through this presentation.

This slide shows basic overview of what I plan on covering this afternoon as we talk. And I want to highlight here, as you can see from the four bullets on this slide, that my approach will be to focus on the process involved in implementing quality improvement with a special focus on patient experience of care and specifically use of the CAHPS data.

I know many of you, when you registered for the program, indicated that you were looking for ideas on implementation for problems in your area. I think an important point to keep in mind is that any given organization is unique. And therefore your QI approaches and the interventions that you'll choose to use are also unique.

Having said that, however, there are some very basic processes that QI interventions share, have in common, that we can guide -- use to guide the work that we're doing and that's the emphasis I'll be taking on the presentation as we go through this.

We will be focusing on the process of diagnosing problems using the CAHPS survey data, and using the results of that, then, to develop an action plan for addressing the problems that have been identified.

We'll be finishing up with a quick discussion of some of the key factors that are involved and need for successful implementation as you anticipate moving ahead with some of your own activities.

Now the process for implementing quality improvement. Before we start, I'd like to get a sense of how many of you are familiar with or have used the -- one of the very basic models for quality improvement. That being the PDSA cycle for improvement. You can see here on the page that we have a couple of responses. If you could vote on this and hand me -- hand us the information on the extent which you've had experience with the PDSA model, it will not only help me to know the profile of the audience a little bit, but you can also share that information with each other. So we can see where people are with using it.

This is a -- as many of you know, a fairly basic model. It's carefully defined but can be applied in a number of quality improvement activities and interventions, and almost every one of the standard methods that you are probably aware of, including lean and six sigma and a number of others, have these components in it.

We're still gathering counts here at this point. I'm going to wait just a few minutes. It looks like quite a few of you, almost half of you, have actually used the PDSA model. But let's see, we're still getting counts in terms of the use of it.

So let me share this with you, with what we have at this stage of the game. The numbers may go up as we go. But you can see that a good half of the people have in fact used the model. And there are some that aren't familiar with it. So I will be taking a little time just to put the basic components in place, that will provide a framework for the rest of the discussion on the process of developing an implementation plan for improving performance on patient experience of care.

The basic PDSA model is plan, do, study, and act. And I think the key thing here to recognize is that it is a cycle. You don't just do this once. It's a continuing process. You learn from each cycle. And use that information then to guide your next steps and your implementation activity.

This theme you will hear all the way through my comments this afternoon.

The PDSA cycle also recognizes and emphasizes it's important to start a strategy on a small scale. If you make mistakes, and you will, it's better to do it on a small scale and learn from that, before you attempt to do a larger implementation where you could really get into trouble if you get negative feedback from it.

Another integral part of it is measurement. That if you're testing on the small scale, you really have to have that measurement capability in place.

I'm going to talk through this cycle, focusing largely on the planning stage, because that's going to be a big part of my presentation today.

The developing of the action plan starts with the identification of the issues that you want to address. This sounds simple, but it often isn't. And I think that that's why I'm going to be spending quite a bit of time in the next few slides helping to walk through an example of how you can look at the CAHPS data and use that information to identify the issues and come to agreement with, as a group, with where you need to go and in what order.

The CAHPS data only goes so far, however, and we've gotten that feedback from quite a few people. Health plans, even as early as CAHPS 1, 10 years ago, were saying that there's not enough information in the CAHPS survey to be actionable for quality improvement. And there's a lot of truth in that. The CAHPS survey has a different purpose than just drilling down for quality improvement. But it is a good starting point on which you can build additional information using other relevant tools such as other surveys, observation studies, focus groups, to dig into some of the issues that you think might be happening in your organization.

This is a good example where the uniqueness of the organization comes in. You really have to apply it to your own situation.

And from that, then, the next step is to move forward on developing a realistic action plan. That is the second step in the process. The “Do” step which is to begin to introduce planned changes. And plan changes. And in that, the small scale test is most pertinent here, in the “Do” step. This is your opportunity to explore ideas that you've developed as a group perhaps during your diagnostic stage in terms of what interventions might work. And in many cases you'll find an intervention you try will work extremely well. In other cases for a variety of reasons, another one might not work well. But this is an opportunity to test it on a small scale.

Another strength of this approach is starting on the small scale is that it gives you an opportunity to engage some of the leaders in your organization. Those who already see the value of the work and are interested in working with you to test interventions with them first.

Coming out of those tests, their feedback and their subsequent support of the quality improvement actions really helps to bring other people on board as well.

This, by the way, is another theme you'll be hearing from me throughout my talk. The importance of engaging people, engaging the stakeholders and developing a process and a set of actions that they can take ownership in and really engage with as part of the organization.

The next step, then, is to study. You've done the small scale tests, and now it's time to take a look at the data and see how well those interventions that you've been implementing are working. And in doing this, you can work with those partners, those leaders who have been willing to participate in a voluntary capacity and testing some of them.

This step also highlights the importance of the monitoring and measurement aspect of QI work. Good data give you that objective feedback that you need on your progress. And it is one of the aspects of quality improvement that many organizations drop the ball on. That don't -- they don't spend sufficient time in developing the measures that are needed to really check how they're doing. And I will be revisiting this issue in a later slide.

Another point I think is critically important is that it is not only okay but expected that you will have to do midcourse corrections. This step in essence recognizes that by saying that you would attempt something, study it, and then either expand it or go back and make revisions based on what you've learned in that studying.

There is nothing wrong with midcourse corrections. Better yet, there's probably something very good with them, because it recognizes that you're not going to get it perfectly coming out of the box. And I think as you work in your organization, those of you who already have had experience with this are very familiar with this, that message needs to be kept in front of everybody as you go through.

It's not -- it's hardly ever possible to anticipate in advance how people are going to react to changes, and these steps give you a chance to learn that empirically and manage it as effectively as you can.

Finally, the last step is to act. Once you've got a good intervention, you may have a training program or you may have a new form that works well or you may have a new appointment scheduling process that you've tested and it works well. Now is the time to take that to a bigger scale.

This step ultimately leads to integrating those changes into the ongoing operation of the organization. This is when you make it real.

I advise, however, to be patient. That often it takes several rounds of quality improvement actions for this to happen. We have a case study that we have developed working with the health plan that Dale will be talking about in his presentation, that shows that it took them two or three rounds before they finally got a completely successful set of interventions to improve the health plan's customer service.

So with this background, I'm going to walk through a five-step process that really fleshes out the basic components in the PDSA cycle. I'm going to drill down in each of them.

The two basic components are diagnosing the problems and developing an action plan to address those problems. Before we move on to that, however, Carla, do we have any questions from folks out there yet?

>> Donna, we do have a question for you. One of our participants notes that there are a lot of different types of QI methods like lean and rapid cycle improvement, six sigma. They would like to know which one is the best to use.

>> Donna Farley: That's a very good question. Almost any of them. I think that as I have indicated a few minutes ago, they all have very core elements in common. And any one of them has been shown to be effective. So I think the real source of the decision on that is to take a look at how a particular method fits with your organization, and the reactions of the people in your organization to them. Where the greatest comfort level; I would go with that one.

Any others?

>> Great, we have another one. What's the most important step of the PDSA cycle?

>> Donna Farley: Good question. I would say you can probably anticipate this given what I've already said. It's probably that "Do" step. That test it on a small scale. And of course that implies with it measuring the results and learning from that process, so that when you go live with the full implementation, with a full intervention, that you have a good solid set of confidence that it's going to work. So I would probably put my vote for that one.

Well, let's move on to the diagnosis step. And let me try that again. There we go. I suspect you all had a delay because I certainly did on my computer to get this up here.

The work sheet here is an example of a report presenting results from a CAHPS survey. It shows the four composites that were on the survey, and results for an individual health plan, which is labeled as your health plan, "your plan." As well as two benchmarks: the sponsor's plan and all plans. And this is the first step here, the benchmark Dale will talk a little bit further about when he talks about the CAHPS Database which can provide a very useful resource for these kinds of comparisons.

Taking a look at this, the first thing that you want to do is see how your plan is compared to the benchmark -- on which composites is it performing worse? Those are the ones that you're probably going to want to focus your implementation efforts on.

Now, as I look at this, I have identified the Getting Care Quickly composite as one that looks like it could be a priority for action. Why? Because your plan is farther below the score for the sponsor's plan for this composite than any other composite. Your plan, however, is performing similarly to all plans. So the focus here might very well be on the sponsor's plan as a composite.

Both the doctor communication and customer service scores, on the other hand, your plan is doing better than the benchmark.

The other one, which is also lower, is Getting Needed Care. Now, I identified that one second because it isn't as far below the sponsor's plan by comparison as the Getting Care Quickly is.

Now, this information then begs the question, what do we do with this information? Well, the very reasonable first next step is to drill down to the individual items on the CAHPS survey that are in each of these composites to see where -- which ones are performing well and which ones are not when you compare it to the average composite score. Which is what we have here on this slide for the Getting Needed Care. We have the percentage of usually or always, for each of getting to specialists appointments, or usually got the tests or care that you needed --the two items in the composite.

We also show correlations for each of those items, scores on those items, with the overall rating of care that the respondents to the survey gave to the health plan.

So if you take a look at these two, you see that the getting specialist appointments is scoring lower than the overall score, which means that that item is dragging down the score, as opposed to the getting tests and care you needed, which is performing somewhat higher.

Similarly, we have the score for Getting Care Quickly, which has care for the problem when needed, or appointment for routine care when needed. And those two also show a difference, where the appointment for routine care is lower than the overall composite score. So it's a natural place to begin your intervention.

The correlations in these cases give you an opportunity to see how much an item affects the overall rating, and therefore if you improve performance on that particular item, you have a chance of also improving the overall rating for whatever you're looking at.

Another correlation that can be used and is not shown here is one between the individual item score and the composite score in which it is located. This is called a driver analysis. In other words, what is driving the composite score. And we have found that also to be extremely useful.

Now, we will be moving on to developing an implementation strategy and action plan in the next few steps, but let me again stop for questions on the diagnosis step. This is one of the steps that many people seem to have the most questions on and this is a good time to stop on this particular item before we move forward. Any questions, Carla?

>> Donna, we've had several questions. If you could please clarify what the difference between your plan is and what is the sponsor's plan. From your previous slide.

>> Donna Farley: Absolutely. Sorry I wasn't clear on that. The "your plan" is your particular health plan, the one that you are working with and interested in doing quality improvement for.

The sponsor's plan, in this context, your plan is one of the ones in the group of a larger sponsor that has perhaps fielded the survey or expected the survey to be fielded in your plan as well as others, so that what you're doing there is comparing yourself to others in the group that are captured or included in the sponsor.

One example on the Medicaid side is that a state Medicaid program would be the sponsor, and all of the health plans that they contract with would be the group in the sponsor's plans and your plan would be one of those plans.

Any others?

>> Great. We have one more question. The approach that you were talking about was looking at your patient experience data specifically CAHPS. But how do you integrate that data with other types of quality data? One of the health plans that's participating is actually using CAHPS plus a customer satisfaction survey.

>> Donna Farley: That's an interesting question. I think that if you're using both CAHPS and a separate patient satisfaction survey, I think one of the first things you'd want to do is look at where the commonalities are between the two surveys, and where one survey may or may not sort of reinforce what the other one is saying.

My guess is that a separate survey is also covering other dimensions, which means that you're going to have to start to make decisions across a bigger set of performance dimensions.

Another example that I hear people talking about extensively is making tradeoffs between quality improvement for patient experience of care and the more clinical aspects of quality represented, for example, by the HEDIS measures.

In this case you can get your priorities on CAHPS, but then this really requires a higher level organizational decision making process -- which I would recommend actively involve the leaders of the organization to really decide where the issues are most severe, and probably where the greatest risks and performance are, as well as the greatest opportunity for benefit with improvement. There's no magical formula on this one, unfortunately.

But those kinds of tradeoffs have to be made by organizations all the time. And I highly recommend that this be done through, almost a strategic planning process.

Okay. Well, let's move on to the implementation strategy and action plan. I'm starting here with this slide on barriers, and those of you that have experience in implementing quality improvement, are no strangers to this issue. There will be barriers. That's why I'm starting here. People tend to overlook this issue, and often the best time to start thinking about barriers is you've identified an issue, you know where you want to work, you have an idea of who would be involved in that and what functions within your plan or the providers you're contracting with would be involved.

Start to anticipate where you could run into problems. These barriers are usually the ones that lead to those midcourse corrections, because you -- someone with an organization goes into an implementation process without having thought about some horrible problem that comes up from around the corner and hits them right in the face as they try to move forward.

The second bullet is particularly important here. Keep in mind that these barriers could come from the external environment, they could exist within your larger organization, or they literally can emerge in response to your very own quality improvement intervention that you're working with.

One of the best ways to deal with this is to attempt to identify those in advance through feedback from others and scanning those environments. And that not only helps you anticipate where the problems were, but you may even start early to alleviate barriers as you build collaborations with others in developing your action plan. This again helps them build ownership in their plan. In the plan that you're developing. So keep that in mind as you are moving ahead.

Now, this slide is step 4 in the process. The second one in the action plan development. And I've taken this from an action plan template that I've developed over the years, and used in a number of projects.

The first page that is here is the strategies and priorities. And you can see that we've just lifted the results of the analysis from the CAHPS data onto this form. The four performance dimensions are the CAHPS composites in the left-hand column. Their scores for the composite at the composite level are listed in the second column, and then the third and fourth columns identify action priority and the specific strategy focus to be undertaken.

Let's start down at the bottom with numbers 3 and 4. You can see because the scores, if you recall on the CAHPS survey, were higher for your plan than the benchmarks, we've specified those as low priority and no action. But they're there. They're there to remind us that these are also performance dimensions.

The ones that we are focusing on are number 2 with a high priority because it had the largest difference from the benchmark. And then the Getting Needed Care with a medium priority. And again, drawing on the items that you -- that were identified within the composite, the care quickly item is improving timely appointments for routine care, and Getting Needed Care is to improve access to specialty care.

Now, this again begs the question of okay, we've got a problem here with something in these access to care or timely care, but what is that problem? And this is where your additional diagnoses become extremely important to help inform that process.

So I encourage you as you go through this process, to dig a little bit deeper, depending upon what your issues might be.

Now, for the rest of the slides, I'm focusing on the improving timely appointments for routine care. So that we can show some of the next slides, the next components in the action plan.

As you go through the process of developing the specific actions, I think you can anticipate that it's at this point in the planning process that debates are going to start to rise. Simply because it's not easy to decide which problems to address first or how to address them.

And we're going to talk about some tools that are available depending upon what issues you're dealing with to help find some of those resources to work with.

Again, this is a good opportunity to bring together a range of people to engage in that decision making, to build the ownership so that the subsequent implementation process should be easier for you.

Now, once you have actions identified, and this is -- this is one of the tedious but I believe one of the important parts in the process of developing an action plan. Start to lay out the specific actions, the steps to be taken, and who is responsible for them, the resources you're going to use, and the time line that you're going to be on.

The completion of a work sheet like this will help ensure that you've organized it and you've clearly defined where you're going to go and who is responsible for it. This is often where an intervention can really get off to a poor start, because people get enthused about one particular activity and they head forth. Or there's not clear delineation and accountability for the process. This allows an implementation team to really oversee the work and track to see whether what you think you're doing, you're actually doing.

You see the CAHPS Improvement Guide listed here as one of the tools. Dale again will be talking about that. There are a lot of very good suggestions for specific interventions depending upon the nature of the problem that you're attempting to address here.

Now, the next one I'm not going to spend much time on, but I have often found it's very useful to translate that previous sheet into a time line chart so that you can check your schedules and be sure that you're not trying to do everything at once. Which often happens when you have a group working on something like this. This also gives you an opportunity to track progress as you're moving ahead.

Again, you might miss the schedule. It's important to strive to keep to it. But it might not stay on schedule and if that's the case, that's not necessarily bad. It's an opportunity to check and find

out what it is that's causing the delays and give you an opportunity to work on. Don't lock it in, don't use -- use this as a guide on the path, rather as something that really stifles your creativity and your flexibility.

Now, the last page, is, I think, the key. And it's the key assembly because so many people miss it. And this is the measures and monitoring. You see at the top of the slide, there's item 1, 2 and 3 in terms of what to measure.

I have found that this distinction is very, very important to keep in mind. First thing you want to be sure you know is have you actually pulled off making the changes that you had planned to make? The unfortunate part of many implementation processes is that a team or an organization has implemented something, has told someone we're going to use this new procedure and doesn't check to see whether it's really used.

I remember from one of the projects I worked on, they wanted to use a new asthma form to document the asthma stage in everybody's medical chart. And they distributed the forms and trained people on it. And then they went forth thinking that everything was fine. They did an audit of a sample of the charts, however, and found that only 10% of the charts were getting those forms in them, so they haven't implemented the change that they had intended to.

Then if you have a change, implement it successfully, you think you've got it in place, how are those changes affecting your care processes? Your service processes? And third, and the more distal measures, how are those changes ultimately affecting patient experience? And it's through the CAHPS data and other surveys like that that you can begin to measure that.

Now, this form, the example I've got here is pretty simplistic but I think it gives you an idea that one measure would be to be sure that you've gotten 100% of the staff trained. Second, that you have a new scheduling method fully in place, and the third being that patient wait time for appointment has decreased. You would specify the schedule on which you would be monitoring that.

So we're going to go on to the last section now, which is the key factors for success. And I think again before I actually get into talking through the rest of the slides, I'd really like to get a sense of the type of experiences that all of you have had in implementing quality improvement strategy and actions for performance -- for improving answers on patient experience of care. And you can see there are four responses here. If you could choose one of those and click the vote button and let's tabulate and see where people are in terms of actual implementation experiences.

We have two yeses -- yes, you've had experience and have used the CAHPS survey to do it. Secondly, you've had experience but you've used other sources rather than CAHPS.

And then two nos -- that no, but you have plans to do QI, in this area, or that you don't have plans to do so at this time.

So I think this would give, I think, some interesting perspective in terms of the range of experiences that people have at this point. And we're getting -- we have some counts in now. I don't think we're completely up at this point. It looks like at this point that there are quite a few people who are saying that you've worked with the CAHPS survey. And quite a few more that have done it with other surveys. Not CAHPS, but that you've had the experience.

We're going to wait just a few more minutes here, see if we can get as full a count as we possibly can. Very few are saying that you don't have plans to do. Which I find encouraging. Let me give it just a few more minutes. And I think we will share this information with you at this point.

You can see that a lot of people have -- you've already got experience. So a great deal of what I've talked about may be very familiar to you. Hopefully I provided a little structure that can help

you package the work as you move forward in the future. But 43% are -- have used CAHPS survey and another 33% have used other surveys. And we've got quite a few more that are planning to do some work. So kudos to all of you for the efforts that you have already put.

The rest of the slides are -- I'm going to go through fairly quickly, and they're simply to give you some thoughts on the things you need to think about as you're moving ahead. The things that can affect your work. And this particular slide, this chart, is a framework that the CAHPS QI team has developed to guide our evaluation work for the CAHPS quality improvement demonstrations that we have been doing. And very briefly, this is a set of three concentric boxes. The first one is the white box in the middle which is where the implementation is happening. And you have team leads and members and involved staff engaged and affected by those implementation activities, as well as the patients served.

The second box is the yellow one, with the organizational philosophy and capacity. So that intervention is happening within that organizational environment. And therefore that environment is going to affect what you're doing. And that includes not just the executive leadership, but the actions and the activities and the interactions with you of other units in the organization. And all of the people sitting in all of those units are other stake holders that are relevant to the process.

And finally, the external environment. Much of which you probably don't have much influence over but can certainly affect what you're doing.

Now, as we went through this framework, we fleshed out some of the items under each one of these components. And this is the -- these are some of the elements that we've identified in the implementation activities. All of which can have an influence on your success. Synergies, the experiences, effects on changes. We want to keep track of all of those. And a very dynamic process. You don't necessarily need to do it formally, but keeping your eye on this is really important.

If I had to choose one slide on the -- in the framework that is the most important, it's the stakeholders. We all think of stakeholders and we think of the team and the people you're working with in a particular department that you're doing it, but there are dozens of them that can have an effect and react and help. These are the team itself, higher level stakeholders and those that are directly involved. So keep -- and to the extent that you can keep them engaged in the process, it really helps to facilitate successful actions as you move forward.

The organizational philosophy, we've distinguished between that and the organizational capability. The philosophy is what's driving the organization, and you can see a number of factors here.

The capacity is what its capabilities and therefore constraints may be at the system position and individual level. And we believe that that's an important set of factors to keep in mind explicitly as you go through it.

The external environment includes policy, market influences and information. And some of those you might be able to change, but many of them are operating on you and you need to find a way to work within those successfully.

The factors for successful implementation that are listed on this slide come from work that we've done over the years, and I characterize them as necessary but not sufficient conditions for success. You need a number of aspects of organizational infrastructure in place, as well as aspects of the implementation process itself.

So I encourage you to keep those in mind as you're building your strategies and carrying it out.

Finally, engaging others in implementation. I've said it over and over again over the last half hour or so. But develop the consensus on the plan and the measures, involve them in the process, and you will be much more successful in making it happen, because you're building that buy-in.

Some summary guidance to wrap this up and turn it over to Dale. From the field.

The first one is building an effective strategy and action plan. Make it realistic, focus on an overall strategy, address training and actions. Clearly define who is in charge of the actions, and take advantage of that Improvement Guide as a resource.

Second, keeping the work going. Perseverance is the message here. Don't give up. Make those corrections, recognize that it's going to take time, and facilitate exchange between people and among people so that you can keep them engaged and active in the process. This is not going to happen overnight.

And finally, the ultimate goal is to institutionalize those practices as fast as you can. You want to get this done; you want to make a change because you have other priorities and other goals that are waiting to be addressed. And you want the momentum to carry you into a point where these practices are an inherent part of the way you do business.

Okay, Carla, I think we're done here.

>> Great, thanks so much, Donna, a lot of useful information.

At this time I want to turn it over to Dale Shaller who is the managing director of the national CAHPS Database who is going to go over our new online reporting tools and resources that are available. Dale?

Using CAHPS® Benchmarking Data for Health Plan Quality Improvement, Dale Shaller, CAHPS Database

>> Dale Shaller: Okay, thanks, Carla. I want to build on Donna's excellent overview of quality improvement methods by describing a few specific tools available through the CAHPS Consortium that can help health plans and other provider organizations assess their CAHPS scores and then direct them to strategies and resources that can support their quality improvement efforts.

My segment is going to include a brief overview of the national CAHPS Database. A preview of our new online reporting system that will be released later this spring. designed to allow easy access to comparative CAHPS Health Plan Survey data. A snapshot of an online resource called the CAHPS Improvement Guide, which Donna has already referred to and which is already available on CAHPS site to provide quality improvement guidance to health plans and medical groups. And then a few additional quality improvement resources that are also available on the CAHPS site to help you implement many of the steps that Donna has outlined.

I know that many of you are familiar with the CAHPS Database, but we also know from the webcast registration survey that some of you are not. So very briefly, the CAHPS Database is the national repository of data contributed on a voluntary basis by users of the various CAHPS surveys.

The Database is funded by AHRQ as part of the CAHPS User Network administered by Westat. We have a national advisory group that provides oversight and direction for our work, and that's composed of public and private sector users of CAHPS surveys, as well as members of the CAHPS Consortium.

The Database is designed for two major applications. The first is to support benchmarking, with national comparative data that will help users assess their performance, and to identify opportunities for improvement. And then the second major application is to support research by making research data files available through authorized use that can support research on patient assessment, their care experiences, and also to support improvements in survey design and implementation.

The Database consists of three major components. The Health Plan Survey Database is the oldest and largest of the three components. It's been underway since 1998. We have over 11 years of data currently and millions of survey respondent records for plan enrollees in the commercial Medicaid and Medicare sectors.

The health -- or excuse me, the Hospital Survey Database, or H-CAHPS Survey Database has three years of data. And our newest component which is the national database for the CAHPS Clinician & Group Surveys, which we're organizing now as a major focus of our efforts as the surveys which were endorsed by the National Quality Forum in July of 2007, are adopted and as data become available to create a national database.

So for each component the CAHPS Database develops a series of products and those include an annual chartbook which presents summary level results by sector or geographic location or organizational characteristics, of interest to users so they can compare their results to organizations like them. And I want to emphasize that identities of individual health plans or hospitals or medical groups or clinicians are never released through our public reports. For health plan sponsors that contribute data to the CAHPS Database, we also produce custom sponsor reports that compare their individual results to selected benchmarks.

In recent years we've limited this service to Medicaid and S-Chip sponsors only. But as you'll see in a minute, our new online reporting system will extend this feature to all sponsors that contribute data directly to us. We also maintain research files of deidentified data available to researchers that submit an application that's approved and who agree to protect the confidentiality of the data they receive. And we also support our use of CAHPS measure in its national health care quality and disparities reports. And we provide special analyses and reports on an as-needed basis as resources allow.

So to illustrate how these comparative data will be available for users through our new online reporting system, I'm going to walk through a series of screen shots from the Westat development site, this is not currently available but it will be going public in late April on the CAHPS web site.

The online reporting system will eventually be made available for all of the CAHPS surveys that we support, and will eventually replace all of the benchmark tables and charts we've published for years as PDF or Word documents.

So when we launch in April, this online system will contain only the Health Plan Survey data but our aim is to quickly add data for the Clinician & Group Survey, and also H-CAHPS's data we will obtain through CMS to allow us to continue production of our H-CAHPS's Chartbook.

So as you can see from this first screen shot, the system will be accessible --

>> Excuse me, Dale, I'm sorry to interrupt. I just wanted to let the participants know that if they are having trouble hearing it over the stream, they should press F5 to refresh their connection. Thanks.

>> Dale Shaller: Okay.

I'm going to just pick up, then, where I left off to describe the first screen shot that you see. So this shows the CAHPS comparative data section, where it's located as part of the overall CAHPS web site. And you can see that there will be a new section on the left, menu, called comparative data. And the welcome page of the comparative data section is going to provide a brief summary of its capabilities, which we're going to walk through quickly here. So the drop-down menu on left will give you a choice of viewing data for the health plan, Clinician & Group Survey data as well as eventually H-CAHPS's data, and other resources.

So since we're focused today on the CAHPS Health Plan Survey and since that's what the online reporting system will initially include, this example shows the selection of data for health plans on the left, which takes you to an overview page for the health plan data.

And here there's a description of the available data sets and a couple of windows that allows you to select the year and the specific survey of interest.

So shown on this page I've selected 2008 data for the Medicaid 4.0 plan survey, other options that have been available to me are commercial or Medicare data for either 2007 or 2008.

Our plan is to always have loaded the current year and the prior year of data for comparison. And archives of earlier years will be available through our research files as well as the historical chartbooks posted on the CAHPS web site.

So with my selection of the 2008 adult Medicaid data, I can now begin to look at various data views. The first shown here is my selection of a two-way frequency for one of the two questions that compose the Getting Needed Care composite. That's question 27. That relates to getting necessary care, tests or treatments through the health plan.

So you can see I've checked question 27, and then I could go on to either choose a one-way frequency which would basically let me see results for this question item displayed as a table of responses. Or to select two-way frequency which is circled here that allows me to compare the responses to this question, against some other question results.

And so what I'm doing here, then, is showing a comparison of question 27 results on getting necessary care, tests and treatment. With another question on the plan survey related to respondents, self-reported health status.

So what is shown here, then, are sort of the distribution of results, with a number of respondents. And each category. And percentage for each category.

So other things I could have cut this question by include other respondent characteristics like age or gender or education or race, ethnicity. Or even other kind of question items. If I was looking at doctor communication, for example, I could take a look at that by overall doctor rating. And see, you know, what the comparison of results would show me.

So then by selecting benchmarks from the menu bar at the top of the page, I can also look at both composite and question item results in these familiar three-part bar charts which are kind of a CAHPS reporting convention. And shown here is the Getting Needed Care composite which combines the two questions, question 23 and question 27 for the national regional and product type distributions. And as you can see there are arrows either up or down or not at all, and those arrows indicate whether the mean values for the question scores, and these composites are above or below the national distribution.

Now, for just kind of for future use, we're looking at Health Plan Survey results here. When we look at H-CAHPS data, the bar charts would be organized with comparisons by other characteristics relevant to hospital CAHPS data like region, bed size or teaching status and ownership and control and when we get into the CAHPS Clinician & Group Survey, we've

determined that benchmarks will be report by location, by physician specialty, by the size of the group or the practice and by ownership and affiliation characteristics.

So everything I've shown you so far, and a lot more is related to the summary level data, things like looking at frequencies, bar charts, trend charts, ability to build your own reports, based on the views that you've selected, that is all going to be available to anyone who comes on the site.

But there's a very important second dimension to this whole system that will be available only to those sponsors who contribute data to us. And that's a password-protected area of the system where sponsors who can view their own results compare to selected benchmarks.

Now, this screen shot shows that I've logged in as Janice Ricketts who happens to be the CAHPS Database manager at Westat and the person who has led the development of the online system, and who will be doing a live demonstration of the system in April as part of a national webcast I'll tell you about in a moment.

For now I want to give a brief view of the capability to pique your interest. I'm logged in to my password and you can see what's on the public site as well as how my own data compared to selected benchmarks.

So for example, this is my own sponsor view and a question was asked earlier by what do we mean by sponsor? We use that term to mean like a cluster or group of health plans. In this case, the sponsor is the Westat group, meaning I'm in an employer and I offer a number of plans to my employees, and I'm looking then at my sponsor results for the Getting Needed Care composite. And I see not only the national and regional and product type distributions, but also the results of each of the plans in my own group, the Westat group, and how they compare to each other.

So the list of plans is actually a lot longer than you can see if we could scroll down all the way. You can see a list of plans A-F for 2008, and their results for this composite. And the chart also shows whether the mean score for each plan is above or below the national distribution for all the plans. And I should mention, too, that all of the results that we show at the plan specific level are case mix adjusted for age, education, and self-reported health status.

So another feature for both the public and sponsor-only dimensions of the system is the ability to look at two-year results, side by side by looking selecting the trending function from the me yew bar at the top of the screen.

This page shows that question 27 again but this time with 2008 and 2007 results together. And again scrolling down would show the plan specific results for the two years, for each of the plans in my group for in this case question 27. And so let's pretend that I'm online and I am scrolling down you can and see that my group's plan scores here are actually pretty good. Comparative to national distribution. But I've circled what I've noticed in plan B, which is that plan B. scores have fallen a bit from 2007 to 2008, from 54% of respondents saying always to 48% of respondents saying always. I want -- I might want to pay close attention to those results even though they're statistically the same as the average national distribution.

One last feature I'm going to quickly point out is the ability to save everything that I've looked at, as I go, through this report builder function, and this is something that allows me to save and then download a report at the end of my session, which would be constructed as a specific views, I've selected along the way which I can then import into Word or Excel files when I'm no longer online and logged in.

So I've only scratched the surface of the online reporting system capabilities, but there's going to be an opportunity for you to learn more and to see a live online demonstration, not screen shots but an active demonstration on either April 22nd or April 23rd, or both dates if you want to come, from 2:00-3:30 p.m. This is a free web site. You can register immediately after this by going to

the CAHPS web site at www.cahps.ahrq.gov, and selecting registration on the home page, and you can contact CAHPS for further information through the toll-free number or e-mail information listed here.

Now, I'm going to briefly turn to the CAHPS Improvement Guide, which is a resource for health plans and medical groups seeking to improve their performance. You can do this measurement, select data. And the question is how. We developed this Improvement Guide as part of the Harvard CAHPS team back in 2003, with support from CMS and we've distributed by CMS and hard copy and PDF format to all of the Medicare plans that CMS contracted with.

But now this Improvement Guide is online and it is also located within the CAHPS web site, accessible from the menu bar on the left. And once you go there, you can select from several different sections, such as background or organizational issues, that would affect your readiness to implement quality improvement related to patient experience. Guidance on how to analyze your CAHPS results, along the lines we've just been talking about. There's an overview of the quality improvement process and steps similar to what Donna has reviewed earlier. And then the main content of the Guide consists of specific interventions for improving the patient experience, organized by both problem area and by survey topic.

So for example given our focus in reviewing the CAHPS online database, on Getting Needed Care, let's say I want to explore strategies for improving access. So I would go and select access from the performance problem menu. And now I can choose from what you see here are five specific interventions that are documented in the Guide. And so if I select Internet access for health plan information and advice, it would take me to a section that would present an overview of the problem, the nature of the intervention, and then specific resources and examples related to how the intervention actually gets implemented.

And this same basic format of kind of problem description, what's the intervention and resources and examples available would apply to the nearly 30 specific interventions profiled in the Guide. So I can also view as shown in the right-hand menu, additional information related to the surveys and selected resources and tools that will be spotlighted from time to time as we continue to update the Guide.

Now, in addition to the specific interventions, cataloged and described in the Guide, there's a detailed review of quality improvement process and specific steps as Donna laid out earlier.

So finally I want to mention several additional resources designed to support quality improvement activities related to CAHPS and these include a series of case studies of selected quality improvement initiatives. Some are currently posted on the CAHPS site, and others will be made available based on current work of the RAND and Yale teams as part of their CAHPS 3 demonstration work.

There's a list of supplemental survey questions specifically designed for quality improvement. There are archived webcasts and presentations from previous CAHPS user group meetings all related to quality improvement. And then there are a number of links to various related resources and all of this is on the improving quality page of the CAHPS web site, again, at www.cahps.ahrq.gov.

That's a quick cycle through a number of tools the comparative database, the online Improvement Guide and the number of other resources on the CAHPS web site and I'm going to turn it now back to Carla for the question and answer portion of the webcast.

Question and Answer

>> Great, thanks, Dale. I just wanted to remind everyone that to ask a question, all you need to do is select questions from the upper right portion of your screen. And then select new from the

pop-up window that will appear. For you and we're going to get the questions in just a minute. I know several of you asked questions about getting the slides. I know some people have some audio difficulties during the presentation, and so you will be able to access an audio recording of this webcast. The slides have already been posted to the CAHPS web site and there will also be a written transcript that we will post out there as well.

If you have any questions or comments, please feel free, Dale had already given you the line specific for the CAHPS Database, but we also have one specific for CAHPS, it's cahps1@ahrq.gov, and the toll-free phone number 1-800-492-9261. And again our web site is www.cahps.ahrq.gov. If you're interested in receiving e-mail updates about CAHPS, you can visit the CAHPS web site and select e-mail updates from the top navigation bar. You'll be able to sign up for CAHPS specific updates, that will take you generally to all AHRQ programs but if you select CAHPS you will get all of the CAHPS updates as well.

Again, we will be having another webcast focused on quality improvement using the Clinician & Group Survey as the focus and that will be in the fall.

So I want to go ahead and get -- we've had a lot of great questions and I want to make sure we have as much time to go through them as possible.

I also want to ask you to stay online when we're finished because we will have a short evaluation survey. As I mentioned, the topic for this webcast came from your request for what types of information you would like to see the CAHPS User Network disseminate to you so we look at all of your responses and take that information seriously as we do our fight planning.

Donna, this question is for you. A user wanted -- or one of our participants wanted to know the benchmarks that you were citing, were those averages or were they specific percentiles like the 90th percentile?

>> Donna Farley: Those were the percentages of respondents that responded either always or usually to the questions on the CAHPS survey where the response options were those two options as well as two others that were lower ranking.

So that particular way of measuring the response was the percentage that gave the most positive responses for each of those items, and then the composites the items were in.

>> Great. Thank you.

A question for Dale about the web site and the database. Will the web site online tool have a demographic breakdown of for health plans that are represented in the database, for example will you be able to look at just a Medicaid-specific benchmark? That would help the plans determine how well that benchmark applies to them.

>> Dale Shaller: Yes, because the view would allow to you select among the three sectors that we receive data, from Medicaid, commercial and Medicare. And so by selecting one of those data sets, then you're comparing to plans similar to you at least by sector. So that breakdown would be available.

>> Great. And similarly, Dale, are Medicaid CAHPS survey data included in the database?

>> Dale Shaller: Medicare or Medicaid?

>> Sorry, Medicare.

>> Dale Shaller: Yes, at the summary level. We get data from Medicare that are collected annually for the Medicare Advantage plans. And we don't have plans specific scores. We may in

the future. We don't now. So what's available for the Medicare are those summary level results that I was showing in terms of, you know, overall distribution of scores by composite and by question item. That's also going to be true for the hospital CAHPS data.

>> Great. Donna, a question for you. One of our participants noted that problems are often prioritized based upon the difference between the benchmarks, but what if that difference is not statistically significant? Is it better to look at more than just the percentages?

>> Donna Farley: Is it better to look at more than the percentages?

>> Right.

>> Donna Farley: If the difference is not significant -- different from the benchmark is not significant, then there's -- there are a couple of other dimensions that you can take a look at. And I think Dale identified one of them in his comments, where you can look at trends over time. How are you, your organization, doing, now compared to how you were doing before? And also within your own scores, which of the dimensions, which of the composites are you scoring best at and which are you scoring less satisfactorily compared to some of the other ones? So that you can compare yourself to yourself as well as to others. And this often is true for organizations that are performing well, relative to the benchmarks. They're already doing well. But that doesn't mean they don't want to continue improving.

So then they really have to take a look inside and decide which ones, which areas they want to focus on to strengthen because they are relative to other things they're doing, they're somewhat weaker.

>> Great, thanks. Another question for Donna. Plans seem to struggle with pinpointing from where in their network their problems are emanating. Using your example of timeliness for appointment, what steps would a multicounty plan take to determine what specific practices are driving the low rating?

>> Donna Farley: That is a great example of the kind of drill-down work that you'd have to do to figure out where your problem is. And I think this is -- this raises an interesting bigger issue for health plans. Because when you're dealing with an aspect of patient experience of care that's being driven pretty strongly by your network providers, rather than something that you have direct control over, your implementation strategies are quite different. One strategy that you might take in identifying where the appointment problems are happening, is a geographic one. Find out where the problems might be in terms of particular physician offices. You might even do some focus groups in different locations of members who live in different components, different parts of your service area, to see if you can begin to narrow that down.

This is a particularly difficult one to target, but at the same time you might be able to develop some overall interventions that reach out across all of the physician offices that might help them in the efficiency of their appointment scheduling so that you would be less in need of having the geographic specific data or the practice-specific data.

This actually begs the question of the value of the Clinician & Group CAHPS because that can begin to allow you to get to the information whereas the overall health CAHPS isn't that specific.

>> Great. Dale, can you talk about plans for the CAHPS Database for other types of data like Home Health data in.

>> Dale Shaller: Well, what our kind of strategic planning process determined this last year was to focus most of our resources on the CAHPS Clinician & Group Survey. And that is, you know, in addition to the plan survey, and ongoing maintenance of the H-CAHPS data through an

agreement with CMS, to basically post the chartbook level data consistent with what's reported by CMS on Hospital Compare.

Our major focus is going to be on organizing and presenting the Clinician & Group Survey. It's not to rule out the ability at some point down the line to add additional instruments like Home Health. But because of resource limitations, we have to sort of pick our priorities in that -- those three components will continue to be our priority with a special emphasis on the Clinician & Group Surveys.

>> Dale, while you have your hat on of looking forward, we've had several questions about whether there are any plans to be able to kind of cut the health plan data a little more finely, like for example by plan size or by county or geographically. Will there be more flexibility in being able to kind of slice and dice the health plan data?

>> Dale Shaller: There certainly could be. We have the capability of doing all of that dependent upon what data we get from those who, you know, submit their data. So size of plan is not a characteristic that we have routinely collected in the past. But the geographic location of the plan is something that we know and we could do. I mean, I think if we decided that there was enough interest in being able to look at results by those variables, we could make it a point to request that information when plans submit their data and therefore be able to present it that way.

>> Great. Donna, when you answered the question about the types of benchmarks or the fact that you were looking at the percent usually or percent always, we have a question whether there's any value in looking at kind of the more negative responses. Whether it's zero to 4 ratings, or percent never or percent sometimes.

>> Donna Farley: I think there is some value in that, and in fact many organizations do do that. They use what they call the problem score. It's a way of -- it's another way of dicing your data. If you're trying to make decisions with respect to which aspect of consumer experience you want to establish as your priority.

I would suggest, perhaps, that you might take a look at both the top and the bottom if there isn't a clear answer in looking at the most positive responses. Because sometimes people will answer in the middle and if you suddenly find that you've got a very high percentage of people that are giving you very negative responses, that's a signal that you really need to do something about it.

>> Great. Dale, are there any plans to update the CAHPS Improvement Guide?

>> Dale Shaller: We have had that in our sights for some time. The online version of the Guide that I just briefly described is basically the same content that was originally developed back in 2003 and 2004. We do have some material that's in the works that will add some case study kind of profiles to various strategies that are described in the CAHPS Improvement Guide. And so yes, we would love to be able to do that. And we are planning to do it. I can't give you a time frame for doing it, but we know it needs to be done.

>> Great. Donna, a question from a plan that they currently have an improvement intervention in place addressing claims, customer service, and Getting Needed Care, which have a direct correlation to the rating of the health plan. It appears that the survey results are showing improvements in all the targeted areas except rating of the health plan. Any ideas on what their next steps should be?

>> Donna Farley: I'm going to reveal one of my biases, I think. I think that the stronger strategy is to focus on the composites, on the actual reported experience with care. And I think that taking a look at which of those composites, which of those domains, if you will, influences the overall rating is helpful in making your selection. But we don't have perfect correlation between the ratings and the individual composites. The reported experience. So there are many other

factors, we suspect, that are affecting the rating of care which are probably not measured on the CAHPS survey.

If they're really interested in pursuing that, this could be an opportunity to pull together some focus groups of members of the plan. And actually ask them directly, have them talk through their experience with care and then ask them specifically what is it that I think about when you're deciding how to rate us in terms of the overall performance of the plan or the overall delivery of care or whichever of the overall ratings you might be talking about.

And there's nothing like getting it right from the sources to help you interpret what's going into that rating and therefore what features you might need to operate on to push the rating up.

>> Donna, similarly in terms of getting feedback from focus groups or direct interviews, how important would you say are the open-ended comments that they get from surveys?

>> Donna Farley: They can be extremely helpful. One of the things that several plans that we've worked with have worked with actually, are customer complaints. Because when someone is complaining, they have a very specific issue on their mind that's driving them crazy, or they wouldn't have gone to the effort of picking up the phone and making the complaint. And that's an actionable item. And to the extent that it looks like it's probably influencing how the members might be scoring the plan when they're responding to the survey, it can be extremely helpful.

I've also heard many people say that the same kind of actionable information is in those open-ended comments to the survey. So they can be extremely useful QI tools, and the kind of things that you could add to either to the end of a CAHPS survey if you have space, or on a separate survey, just to dig further into what's on the minds of those that are responding to the surveys.

>> Great. I'm going to continue to move forward with a question and answer, but I did want to go ahead and put up the survey for those who aren't able to stay with us the last few minutes. Again, we value your feedback.

A question for Donna, kind of similarly. What about low response rates? If survey sponsors are not getting high response rates, are those results really representative?

>> Donna Farley: I may be the wrong person to ask that question. The quickest answer is that the lower your response rate, the greater the risk of introducing response bias into the results. So ideally you would want to get as good a response rate as you can.

That's why we actually encourage organizations when they're working with their vendors, to pay attention to the response rate more than end in terms of the number of people that have responded to the survey. Because the response rate really is important.

If the response rate gets too low, then you're going to have to look at those results with increasing questions in your mind. But from a quality improvement perspective, there may still be significant opportunities to identify where you can make improvements.

One of the interesting things about quality improvement is that it is an incremental process, and even if you're somewhat nervous with the potential of bias in your data, if you look across the dimensions and see that you're maybe doing better on one and not so well on the other, it might still offer you some opportunities for action.

>> Great. Melissa, do we have any questions from our audio?

>> Ladies and gentlemen, if you would like to ask a question, please press star-1 on your telephone keypad.

>> Okay. Donna, is there a need discriminate between desired and realistic? You used an example of a benchmark of having 100% of your staff trained. But at any given moment there's always new staff, they're not trained properly, or facilities that lack the ability to have two people in one position at the same time to cross train.

>> Donna Farley: What was the first sentence? Desired and --

>> And realistic.

>> Donna Farley: And realistic. Okay. I think that -- this is a wonderful debate. It's gotten almost philosophical in the quality improvement world. Whether it makes any sense to set a goal of 100% performance on something.

I've always taken the approach that an ambitious goal is very appropriate because it pushes you. It encourages you to move forward. However, in the implementation process, the key is taking steps and making progress toward that end. Let's say you've got a goal of 100 people trained on a survey. That may not be immediately. But in some cases, getting very close to 100% of getting people trained on a particular practice or intervention is critical. One example that I had in a recent project that I worked on was the implementation of team work practices in labor and delivery units. And if those units that did not train a substantial fraction of their staff on those practices and the philosophy of teamwork and the whole principle behind it, only trained a portion of their staff, didn't get very far in the implementation.

So the training is important. How important it is probably depends upon the intervention, the practice you're trying to put into place. So I think again, this is almost an "it depends" answer. It really has to be answered on a case by case basis.

>> Great. Dale, we've had several participants that were hoping to see actual case studies and presentations of specific interventions. Could you take just a few minutes and summarize again all of the resources that are available, as well as where they can go if they have more -- or have more questions about those specific interventions?

>> Dale Shaller: Well, currently on the improving quality page on the CAHPS site, there is -- there's one case study I know actually it was Donna's team at RAND that put this together for a plan. And Donna, I can't remember what the specific issue was. Do you recall?

>> Donna Farley: The issue was customer service, and the plan worked on it for a good two or three years, until they really got it to the point where they got good improvement on the CAHPS scores. And that whole story is in that case study.

>> Dale Shaller: There are other really good case studies presentations that are archived in the various user group meeting presentations. I remember a number of them over the past few years. From individual plans. One in California, there's one from a plan in New York. And so those are all available, you kind of -- I would say that if anybody has any trouble locating them, they should contact someone on the CAHPS team by e-mail, or, you know, that toll-free line, because we can actually sort of find them easier for you if you are having difficulty finding them.

There are others -- there are tons of case studies out there. Not all related to health plans, but some academic medical centers and primary care practices, and so there are links on the CAHPS site to some of those other web sites of various studies that have profiled these various journeys that plans and organizations have taken to improve their patient experience.

>> Donna Farley: Carla, if I can interject here, too. When you start to read through those case studies, it brings home the point that I made right at the beginning of my talk of how diverse the implementation strategies and actions are, because they're all determined, each one is determined by the unique characteristics of each organization. And for that reason, you know, I

was really during this particular talk was emphasizing some of the basic principles. The next step is to really get into some of those case studies to get some very concrete ideas, and figure out which might apply to you and which might not.

>> Dale, the interventions in the Improvement Guide were based on best practices. Correct? That or many of them were?

>> Dale Shaller: Well, we kind of culled the literature for interventions that were shown to have worked. In the quality improvement world, the evidence base for how you know individual strategies actually work is a kind of classic experimental design, we have a control and an intervention. We don't have a lot of that really hard evidence. A lot of it is anecdotal. But when we put the CAHPS Improvement Guide together, we did the best we could to find documented evidence that these particular interventions actually yielded success. And indeed they had for the specific organizations doing them. Whether they're transferable to other plans or provider systems, I think, you know, is a question.

But at least they're there as interventions that can be tried with resources to help you do the implementation.

>> Great. I just want to -- I know we're at the end of our time. If we did not have time to answer your question, and you sent your question in and you identified yourself, we will follow up with you with an answer to your question. You can -- if you think of questions afterwards, you can send them in through cahps1@ahrq.gov or call the technical assistance line and we will get you answers to your questions. If you could complete the survey evaluation you see on your screen and provide us feedback that will be helpful to us as we plan future events.

Melissa?

>> This concludes today's teleconference. You may disconnect your lines at this time. Thank you for your participation.

(End of conference.)