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CAHPS & SOPS Users Meeting
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UCLA Experience with using CAHPS data for Ambulatory QI Initiatives
UCLA Faculty Practice Group (FPG)

- 1.8 million encounters/year (68% ambulatory, 30% primary care)
- 1261 faculty with 603 Clinical FTE of activity
- 65+ ambulatory locations (20% primary care)
- 18 Clinical Departments
- Provides Central services for the Departmental practice plans of the David Geffen School of Medicine at UCLA
UCLA Health System

- UCLA Hospital System
  - Total Average Daily Census 711
  - Ronald Reagan UCLA Medical Center
  - Santa Monica UCLA Medical Center & Orthopedic Hospital
  - Mattel’s Child Hospital at UCLA
  - Resnick Neuropsychiatric Hospital at UCLA
Launching MD-Level Survey

■ **Senior Leaders Prioritize Service & Quality (2005-2006)**
  - Patient feedback is important data
  - Greater emphasis on ambulatory and service metrics

■ **Adult Specialist Patient Experience Survey (2006-current)**
  - Build upon experience with primary care surveys (pre-2006)

■ **Strategic & Operational Support for Improvement Efforts (2006- current)**
  - Physician Leadership Group identified
  - Ambulatory Services resources increased for support, reporting and interventions
  - Some Departments experiment with incentives
  - Health System rolls out recognition, reward & service recovery program (2008)
Expanded Ambulatory Services Support

- Scorecard (2006)
- Standards & Guidelines (2007)
- Staff training / BRITE (2007)
  - Scheduling and registration
  - Customer service (e.g. “Connecting with the Customer”)
- Performance & Quality Measurement & Reporting & Improvement (2007)
  - UCLA Medical Group HMO only focus (pre-2006)
- Consultative Services (2007)
- Clinical (e.g. staff competencies) (2007)
- Ambulatory Services Director (pre-2005)
- Operations Oversight (pre-2005)

BRITE=Begin Right with Instruction & Thorough Education
### Survey Evolution for MD level Reporting

<table>
<thead>
<tr>
<th>Survey Focus</th>
<th>2005 and earlier</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
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</thead>
<tbody>
<tr>
<td>Adult PCP</td>
<td>CAHPS-like PAS</td>
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<td>CAHPS-like PAS</td>
<td>CG-CAHPS PES</td>
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<tr>
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CG-CAHPS= Clinician & Group CAHPS (Consumer Assessment of Healthcare Providers and Systems)
CAHPS-like= Modified/Testing versions of CAHPS or precursor works
PAS= Patient Assessment Survey Sponsored by PBGH/CCHRI used in California P4P program
PES= UCLA Patient Experience Survey
Light Brown Shading= limited to HMO primary care population; Mustard & Green Shading=All Payors
Early Issues

- “Federalist” governance and diversity of settings and practice realities limit standardized approach
- Do we know what to do?
  - Strategy appropriately lagged behind learning
- Improvement priorities vary across Departments/Units
- Thin evidence base for QI improvement strategies
- Specialists challenge relevance of some CAHPS survey items
- Lack of appropriate benchmarks
Our Strategy - I

- Ambulatory Service Improvement Efforts (regardless of CAHPS performance):
  - CAHPS data as component of Ambulatory Scorecard metrics (with Standards support)
  - Use CAHPS data in discussions with Departmental & Practice Leadership
  - Staff Training
    - Customer Service
    - Systems
  - Add “Point of Service” surveys
  - Enterprise-wide Standards & Guidelines Work Group
Identify Target Practices

- Used CAHPS data to focus on the lowest third performing practices by creating a summary score across the major domains.

- Metric used: Averaged score derived from the major CAHPS domains.

- Simple rank order (highest to lowest).

- In retrospective analysis, low current performers tended to have low scores in the prior times periods (more recent data to the right).

![Graph showing data over time periods with arrows indicating trends towards improvement.](image-url)
Our Strategy - II

- Ambulatory Service Improvement Efforts (for targeted lower performing practices)
  - Practice Consultation
    - Operational assessments, reports, recommendations
  - Patient Experience QI Collaborative
    - Experimental data-driven diagnostic approach
      - Leadership and opinion makers
      - Identify goals & Key changes to target
      - Small cycle change
      - Spread
Initial Engagement

- Distributed MD level & practice reports
- Shared methods, data, information with administrative and physician leaders in various meetings
- One-on-one tutorials with Department leadership
- Group and individual tutorials with physicians
- Grand Rounds presentations
- Presentation to different levels of management and leadership of PES results.
- Accepted feedback on evolution of reporting templates
Exploratory Dialogue with Providers - I

- Concepts behind CAHPS
  - What patients report is important
  - Only one component of total health care received
- How we chose the MDs to survey
- Specific items and composites
  - Structure of CAHPS
Exploratory Dialogue with Providers - II

- Variation of MDs within “average sites”
- Interpretation of Reports
  - Response distributions
  - Comparison to mean
  - Trend from prior
  - Response histograms
Outcomes from Dialogue

- Operational and structural issues affect CAHPS data
- General agreement on face validity
- Some disagreement, e.g. over relevance of some items
- More data more quickly
- Desire for explicit tools and strategies to improve performance…”what do I do?”
- Stakeholder groups tend to focus on what they can personally control
- Need for team-work (MDs, CAO's, Managers, staff) to achieve most improvements
Our Strategy - Qualified

• Reporting in itself has many challenges that we must still address.

• Building engagement & learning became priorities for our work.

• Need to balance core FPG improvement needs and diverse needs & priorities of practices.
Interventions Linked to CAHPS

- BRITE Training (Helpful Office Staff)
- Physician communication training pilots (MD-Patient Interaction)
- Patient Experience Quality-Improvement Collaborative (Multiple domains)
- Standards & Guidelines re: communication of diagnostic test results (Coordination of Care)
Other Interventions

- Ambulatory Scorecard
- Rapid-Cycle “Point of Service” Feedback
- Systematic review of complaint database
- Education & Information: For physicians and staff
- Departmental alignment and incentives:
  - Community Practice Network (stronger)
  - UCLA Medical Group (weaker)
Not a linear path

Start

Something that didn’t work

Something that works
Lessons Learned

- Faculty willing to accept CAHPS when there is face validity
- Diffuse authority
  - Difficult to get engagement
- More rapid feedback of survey results better
- Practice-Level Reporting Challenges
  - Variable MD clinical effort
  - Sampling methods
  - Relevance to practice
- Culture change takes time
- Support for direct incentives & recognition needs to be more fully explored in our environment
Our Improvement Team

- Laurie Johnson, Director, Ambulatory Services
- Anne Staunton, PhD, MPH - Quality Improvement
- Lisa Sergy – BRITE Training
- Brandie Guenther, RN, MSN – Clinical Quality
- Jamie Gallus – Consultative Services