<table>
<thead>
<tr>
<th>Track:</th>
<th>Improving Patients' Experience With Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Session:</td>
<td>Improving Care Using the CAHPS Clinician &amp; Group Survey</td>
</tr>
<tr>
<td>Date &amp; Time:</td>
<td>April 21, 2010, 9:30 am</td>
</tr>
<tr>
<td>Track Number:</td>
<td>T2-S5-2</td>
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</table>

UCLA Faculty Practice Group
Lessons From the UCLA Faculty Practice Group:
CG-CAHPS & Ambulatory QI Initiatives

CAHPS & SOPS Users Meeting
April 2010

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Executive Medical Director
UCLA Faculty Practice Group & Medical Group
Professor of Medicine
David Geffen School of Medicine at UCLA
UCLA Faculty Practice Group (FPG)

- 18 Clinical Departments
- 65+ ambulatory locations (20% primary care)
- 1260 faculty with 600 Clinical FTE of activity
- 1.8 million encounters/year (68% ambulatory, 30% primary care)
UCLA Hospital System

- **Average Daily Census ~711**
- **Acute medical/surgical care facilities**
  - Ronald Reagan UCLA Medical Center
  - Santa Monica UCLA Medical Center & Orthopedic Hospital
  - Mattel’s Child Hospital at UCLA
- **Acute psychiatric care**
  - Resnick Neuropsychiatric Hospital at UCLA
## Our 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>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult PCP</td>
<td>CAHPS-like PAS</td>
<td>CAHPS-like PAS</td>
<td>CAHPS-like PAS</td>
<td>CG-CAHPS PES</td>
<td>CG-CAHPS PES</td>
</tr>
<tr>
<td>Child PCP</td>
<td>CAHPS-like PAS</td>
<td>CAHPS-like PAS</td>
<td>CAHPS-like PAS</td>
<td>CG-CAHPS PES</td>
<td>CG-CAHPS PES</td>
</tr>
<tr>
<td>Adult Specialist</td>
<td>CAHPS-like PES</td>
<td>CAHPS-like PES</td>
<td>CG-CAHPS PES</td>
<td>CG-CAHPS PES</td>
<td></td>
</tr>
<tr>
<td>Child Specialist</td>
<td>CG-CAHPS PES</td>
<td>CG-CAHPS PES</td>
<td>CG-CAHPS PES</td>
<td>CG-CAHPS PES</td>
<td></td>
</tr>
</tbody>
</table>

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 CCHRI in California
PES = UCLA Patient Experience Survey
Grey Shading = limited to internal HMO population; Mustard & Green Shading = All Payors
## Our Experience with MD Level Surveys

<table>
<thead>
<tr>
<th>Years</th>
<th>Types of MDs surveyed</th>
<th>Mean Doctors Surveyed per Administration*</th>
<th>Mean Surveys Sent per Administration</th>
<th>Response Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006-2009</td>
<td>Adult Specialist &amp; Primary Care; Child Specialist &amp; Primary Care</td>
<td>480</td>
<td>50,372</td>
<td>36.3%</td>
</tr>
</tbody>
</table>

*Faculty physicians surveyed are the ones most active in ambulatory care*
Initial Improvement Activities...

- Senior leadership and support for “quality and service” initiative
- Staff training / BRITE (2006)
  - Scheduling, registration, & business integrity
  - Service integrity
- CG-CAHPS data for individual MDs (2006)
  - “Tips to Improve Our Patients’ Experience” derived from CG-CAHPS results (2008)
- Ambulatory Scorecard: Practice Site and Department (2006)
- Practice Standards & Guidelines to support Scorecard (2006)
- Consultative Services for Operations (2006)
- Clinical Competencies for Staff and Patient Safety (2006)
- Measurement and (mostly) management feedback (2006)
  - CG-CAHPS data for Practice & Department & MD (2006)
    - CG-CAHPS data transparent at Department and Site levels
  - Mystery callers
  - Scorecards
  - Operations rounds
  - Point of Service Practice Surveys (CG-CAHPS like)

BRITE=Begin Right with Instruction & Thorough Education
Data emphasized compared to peers. Benchmark data is limited. Department, Sites, & Individual MD reports.
...then (2008) a practice Collaborative effort

- We sought out lower performing practices (all had high and low MD performers internally) that we thought were motivated to change.
- Data-driven performance improvement approach, based upon CG-CAHPS & Scorecard metrics.
- External content experts brought in as part of MD practice leadership engagement.
- Allowed practices to choose areas to work on
- Attendees were MD and staff leadership
- The goal was improvement in CG-CAHPS scores.
Lessons Learned (or confirmed)

- Physicians need to be assured by a respected source that CG-CAHPS data is valid and reliable.
  - Origins and purpose of survey.
  - Relevance of questions to specialty & surgical practice.
  - Sampling & adjustment methods.
  - Explanation of reports and how that might guide change.
  - Acknowledging interaction of “systems” and individual MD issues.

- Regular and frequent feedback of performance is needed.
  - But sending reports alone is not enough.
  - Explanation, discussion, counseling, & observation are important.

- Difficult if authority is diffuse.
- Suspected that we did not have enough direct incentives for specialists.
- Limited resources restricted us more than anticipated.
Lessons Learned (or confirmed)

- Our solutions were often “technical”*.
  - Specific methods to improve performance or outcome
- We did raise organizational concern regarding need to improve service quality.
- Set the stage for more extensive organizational change
  - Creating an imperative for change
  - A focus on behaviors
  - Creating an “safe” environment to foster participatory change

*See Heifetz & Linsky, Harvard Business Review June 2002
We continue with all these Activities...

- Senior leadership and support for “quality and service” initiative
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BRITE=Begin Right with Instruction & Thorough Education
More Recently (2009-2010)...

UCLA Faculty Practice Group

UCLA Hospital System

Sufficient time and exposure to accept change

UCLA System

A single “purpose”: articulated mission, vision, and patient centered values

Focus on standardized behaviors

Standardized measurement and feedback
In collaboration with the Hospital System

Establish the best evidence-based behaviors

- Hiring the best people (standardized screening)
- Agreeing and training to standard behaviors
- Measurement of behaviors
- Feedback & Observations based upon expected behaviors
- Standardization of dress
- Rewards and recognition
- Service recovery tools
In collaboration with the FPG practices

Used CG-CAHPS data to define a FPG-wide* performance improvement project

- Dialog on the issues
  - Data Transparency
  - MD Survey on status quo
  - Describing the FPG internal “best practices”
  - Being clear that all practices would work on the same project.
  - Being clear that patients should have a consistent experience
  - Laying out a framework for action.

- FPG support as needed (e.g. performance improvement coaches)

<table>
<thead>
<tr>
<th>Composite or Question</th>
<th>Adj. FPG Mean</th>
<th>Practice Site 90th Percentile</th>
<th>Gap (90th - mean)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Access to Care Composite Score</td>
<td>75.0</td>
<td>85.1</td>
<td>10.1</td>
</tr>
<tr>
<td>Same day response to phone question</td>
<td>74.9</td>
<td>87.3</td>
<td>12.4</td>
</tr>
<tr>
<td>Got advice after regular office hours</td>
<td>81.6</td>
<td>90.6</td>
<td>9.0</td>
</tr>
<tr>
<td>Coordination of Care Composite Score</td>
<td>78.6</td>
<td>88.2</td>
<td>9.6</td>
</tr>
<tr>
<td>Follow-up on test results provided</td>
<td>76.9</td>
<td>88.6</td>
<td>11.7</td>
</tr>
</tbody>
</table>

The quality gap “large” for these individual questions

Adj. scores based upon UCLA specific adjustment model

* all practices, PCP and Specialists (including surgeons)
2006-2010: We have moved from exploratory...

...to more proven performance improvement strategies and tactics involving both staff and physicians.
End

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