Improving CG-CAHPS – the “secret” sauce
PX Advisor
WHERE STRONG LEADERS FIND INSPIRED THINKING
In this issue

Welcome to the first edition of PX Advisor, HealthStream’s new quarterly magazine dedicated to improving the patient experience. Each quarter, we will focus on a different topic important to the patient experience, examining it from various viewpoints and sharing our collective thought leadership. In this inaugural issue, we look at CG-CAHPS—what is being mandated by CMS, what we can expect from public transparency in this area, and how healthcare organizations should be thinking about and preparing for this important new government initiative. We hope this information is helpful to you as you make decisions in your own organization that set the stage for improved patient and business outcomes. Please send any comments or suggestions to PXAdvisor@healthstream.com.

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At HealthStream, we are excited to see many of our customers embracing a broader notion of the patient experience. These innovators see the patient experience as something that is owned by the entire organization, and they are coordinating activities across survey measurement, talent management, risk management, quality, safety, and clinical practice to deliver an excellent experience for their patients.
Our company is energized by this resurgence of effort on behalf of patients and wants to do all it can to support the improvement efforts of our clients. In PX Advisor, we will share the best practices from high performers in our HealthStream databases, and we will bring you the best thought leaders the industry has to offer. Additionally, we will keep you abreast of CMS’ various CAHPS programs, and provide recommendations on improving the patient experience. In this first issue, we are focusing on CG-CAHPS, its repercussions for PX improvement, and issues leading to the first voluntary public reporting of this data through the Physician Quality Reporting System (PQRS) in 2014.

Because of our breadth of solutions across not only survey measurement but also compliance, competency, simulation, risk management, clinical orientation, and staff training and education, we believe HealthStream is in a unique position to support healthcare organizations on their PX Journey. We are bringing the full competency of our company to bear in supporting your efforts to improve the patient experience of care. We hope the information in this publication is valuable to you and that together we will continue to improve the quality, outcome, and experience of care for all patients.
While there is still a bit of mystery surrounding national implementation of the CAHPS Clinician & Group (CG-CAHPS) survey, we finally have a road map of who will be required to participate and who will be able to participate voluntarily. Over the past several years, the CG-CAHPS survey has become increasingly recognized as the measure of patient experience for medical practices. Use of this standardized survey is expanding every year, with the list of survey sponsors quickly growing to include accountable care organizations (ACOs), patient-centered medical homes (PCMHs), state agencies, insurance plans, hospital systems, and health plans. In the proposed rule published in the Federal Register in July 2013, the Center for Medicare and Medicaid Services (CMS) submitted its official plan for the survey to be administered for selected practices. In this article, we will summarize the requirements as they are now known.

About the CAHPS CLINICIAN & GROUP SURVEY

- The CG-CAHPS survey is part of a larger family of CAHPS surveys that are designed to assess patients’ healthcare experiences in a variety of settings.
- There are currently two main versions of the CG-CAHPS survey: the 12-Month version and the Visit version, each of which includes an Adult and Child option.
- The CG-CAHPS survey asks patients to report on their experiences with providers and office staff.
Public Reporting Begins in 2014
CMS has already administered the CG-CAHPS survey for the following practices and will do so again for the 2013 performance year:
• Group practices with 100 or more eligible providers that reported data in 2013 under Physician Quality Reporting System (PQRS) Group Practice Reporting Option (GPRO)
• ACOs participating in the Medicare Shared Savings Program (MSSP)

CMS will post the first CG-CAHPS survey results to the Physician Compare website for these practices in early 2014. Results from the following survey domains will appear on the website:
1. Getting Timely Care, Appointments, and Information
2. How Well Your Doctors Communicate
3. Patients’ Ratings of Doctors
4. Access to Specialists
5. Health Promotion and Education
6. Shared Decision Making (ACO measure)

Status of CG-CAHPS by Practice Type
CMS proposes to expand use of the CG-CAHPS survey to practices with 25 or more clinicians in 2014. This is in addition to Medicare ACOs and practices with 100 or more eligible providers. Smaller primary care practices will be able to choose the CG-CAHPS survey as one of their quality reporting measures under PQRS. The following summarizes the status of CG-CAHPS for the various types of practices.

CG-CAHPS Required for These Practices

ACOs in the MSSP
CMS will collect and fund CG-CAHPS for ACOs participating in MSSP in 2013 and proposes that it will do so again for the 2014 performance year. Under the final rule for ACOs, the Patient/Caregiver Experience Domain is weighted equally with three other quality domains at 25% and consists of two measures, which are:
• A composite of six CG-CAHPS survey measures
• A Health Status/Functional Status measure

Medicare ACOs will transition to pay-for-performance starting in the second year of their agreement period.

Pioneer ACOs
CMS will collect and fund CG-CAHPS for Pioneer ACOs participating in 2013. Beginning in 2014, Pioneer ACOs must contract with a certified vendor, such as HealthStream, to conduct the CG-CAHPS survey on their behalf. The individual Pioneer ACOs will also be responsible for paying for the survey in 2014.

Primary Care Group Practices with 100+ Eligible Professionals in PQRS GRPO
CMS will collect and pay for CG-CAHPS for group practices with 100 or more eligible professionals participating under PQRS GRPO in 2013 and will do so again for the 2014 performance year.

Primary Care Group Practices with 25+ Eligible Professionals in PQRS
CMS proposes to make the CG-CAHPS survey an available quality measure for practices with 25 or more eligible providers participating in PQRS beginning in 2014. CMS will encourage these group practices to report CG-CAHPS by making the survey an approved measure under PQRS and for the Value-Based Payment Modifier. However, CMS will not fund the surveys for these groups. A group practice will need to indicate its intent to report CG-CAHPS data when it registers to participate in the PQRS via the GPRO. For the 2014 PQRS incentive, practices with 25 or more eligible providers who choose the survey as one of their reporting measures will need to report the CAHPS survey measures via a certified vendor (such as HealthStream), and to report at least six measures covering at least two of the National Quality Strategy domains.
**CG-CAHPS Optional for These Practices**

**Primary Care Group Practices with 2 to 24 Eligible Professionals in PQRS**
Beginning in 2014, CMS proposes to publicly report CG-CAHPS data for any primary care group practice, regardless of size, that voluntarily chooses to report CG-CAHPS. However, CMS will not fund the surveys for these groups.

**Individual Primary Care Physicians**
The CG-CAHPS survey remains voluntary for individual primary care providers, except as mandated by state or other program requirements with which a provider may be affiliated. For example, the survey may be a reporting option or requirement for a specific specialty under the American Board of Medical Specialties’ Maintenance of Certification (MOC).

**Non-Medicare ACOs**
The CG-CAHPS survey is optional for non-Medicare ACOs.

**Specialty Group Practices and Individual Specialists**
The CG-CAHPS survey remains voluntary for specialists, except as mandated by state or other program requirements with which a specialist/practice may be affiliated. For example, NCQA launched its Patient-Centered Specialty Practice (PCSP) recognition program in March 2013. It extends the principles of the patient-centered medical home to specialties besides primary care. Practices seeking PCSP Recognition are allowed to use the full 12-Month CG-CAHPS survey or any patient survey as long as it includes at least three of the following categories: Access; Communication; Coordination and/or Self-Management Support. The survey may also be required for the American Board of Medical Specialties’ MOC.

**CG-CAHPS Survey Versions**
There are currently two main versions of the CG-CAHPS survey—the 12-Month version and the Visit version. The 12-Month version asks patients to respond based on their experiences with their provider over the past 12 months. In contrast, the Visit version asks patients to comment on their most recent visit to the practice. Some view the Visit version to yield more actionable data because it ties questions to the most recent encounter at the practice. However, we are seeing increased adoption of the 12-Month version of the survey. Several national programs, some with public reporting components, are driving increased use of the 12-Month version of the survey. For example, the NCQA PCMH Recognition and Distinction programs, the CMS Shared Savings Program (ACO CAHPS), the Comprehensive Primary Care Initiative, and the Multi-Payer Advanced Primary Care Demonstration project have all adopted the 12-Month version. Nevertheless, CMS has yet to announce which version of the survey will be required, or if either version will be acceptable for public reporting.
With the launch of national reporting, CMS is in the process of creating a survey vendor certification program that will create a means for HealthStream and other vendors to administer and submit CG-CAHPS data to CMS for scoring and public reporting on Physician Compare. Practices that wish to publicly report data on Physician Compare will be required to use a CMS-approved vendor, such as HealthStream, to administer the CG-CAHPS survey.

### Vendor Certification

With the launch of national reporting, CMS is in the process of creating a survey vendor certification program that will create a means for HealthStream and other vendors to administer and submit CG-CAHPS data to CMS for scoring and public reporting on Physician Compare. Practices that wish to publicly report data on Physician Compare will be required to use a CMS-approved vendor, such as HealthStream, to administer the CG-CAHPS survey.

### Physician Compare Website

Full implementation of the Physician Compare website, as called for by the Affordable Care Act, is in preparation for transition to value-based purchasing for physicians and other providers (see the 2008 Medicare Improvements for Patients and Providers Act). CMS will publish data on physician quality and efficiency, as well as on the patient experience of care in support of value-based purchasing and consumer choice. CMS is required to report the following types of measures on Physician Compare:

- Measures collected under the PQRS
- An assessment of patient health outcomes and functional status of patients
- An assessment of the continuity and coordination of care and care transitions, including episodes of care and risk-adjusted resource use
- An assessment of efficiency
- An assessment of patient experience and patient, caregiver, and family engagement (CG-CAHPS)
- An assessment of the safety, effectiveness, and timeliness of care

Data presented on the Physician Compare website will reflect the care provided to all patients seen by physicians, under both Medicare and to the extent applicable to other payers.

<table>
<thead>
<tr>
<th>Description</th>
<th>CG-CAHPS 12-Month Survey</th>
<th>CG-CAHPS Visit Survey</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description</td>
<td>Asks patients to report on their experiences with providers/office staff over the past 12 months.</td>
<td>Asks patients to report on their experiences with providers/office staff during the most recent visit.</td>
</tr>
<tr>
<td>Response Scales</td>
<td>4-point never-to-always scale.</td>
<td>3-point yes/No for “most recent visit” questions</td>
</tr>
<tr>
<td>Child Version</td>
<td>Available; includes additional items specific to pediatric care.</td>
<td>Available; includes additional items specific to pediatric care.</td>
</tr>
<tr>
<td>Variations</td>
<td>• PCMH; includes additional items specific to medical homes. • ACO (uses a 6-month reference period).</td>
<td>• 4-point never-to-always scale for Access questions.</td>
</tr>
</tbody>
</table>
Next Steps
So where do you go from here? First, you must determine if your practice’s participation is mandatory or optional. If the survey is still optional for your practice type, we encourage you to begin surveying now so that you have the foundation in place once it becomes mandatory. With public reporting on the horizon, as soon as 2014 for some providers, HealthStream has the experience and improvement tools to prepare your practice. HealthStream can help you:
• Choose the survey version that is best suited to your needs
• Choose the methodology that is best suited for your patients
• Onboard key stakeholders
• Focus improvement on the things that matter most to your patients

Whether you are considering the cost-effective eSurvey or the personal-touch telephone methodology, HealthStream will work with you to choose an approach that works best for your patients and your practice. In addition, HealthStream offers a full complement of tools and resources to help you improve.

ADDITIONAL INFORMATION
1. Accountable Care Organizations (ACOs): General Information; http://innovation.cms.gov/initiatives/aco/
3. American Board of Medical Specialties – Maintenance of Certification; http://www.abms.org/Maintenance_of_Certification/
4. CAHPS® Survey for Accountable Care Organizations Participating in Medicare Initiatives; http://acocaahps.cms.gov/
8. Physician Compare; http://www.medicare.gov/physiciancompare/
## Summary of Proposed CG-CAHPS Implementation by Practice Type

<table>
<thead>
<tr>
<th>Type of Practice</th>
<th>2013 Final Rule</th>
<th>2014 Proposed</th>
<th>2015 Proposed</th>
</tr>
</thead>
</table>
| Pioneer ACOs     | • Required; CMS conducts and funds CG-CAHPS survey.  
                    • Results posted to Physician Compare (survey data first appear in 2014). | • Required; Pioneer ACO contracts with and pays for a certified vendor to conduct CG-CAHPS survey.  
                    • Results posted to Physician Compare. | • Required; Pioneer ACO contracts with and pays for a certified vendor to conduct CG-CAHPS survey.  
                    • Results posted to Physician Compare. |
| ACOs participating in Medicare Shared Savings Program | • Required; CMS conducts and funds CG-CAHPS survey.  
                    • Results posted to Physician Compare (survey data will first appear in 2014). | • Required; CMS conducts and funds CG-CAHPS survey.  
                    • Results posted to Physician Compare. | • Required; ACOs contract with and pay for a certified vendor to conduct CG-CAHPS survey.  
                    • Results posted to Physician Compare. |
| Primary Care group practices with 100+ eligible practitioners | • Required; CMS conducts and funds CG-CAHPS survey.  
                    • Results posted to Physician Compare (survey data will first appear in 2014). | • Required; CMS conducts and funds CG-CAHPS survey.  
                    • Results posted to Physician Compare. | • Required; Practices contract with and pay for a certified vendor to conduct CG-CAHPS survey.  
                    • Results posted to Physician Compare. |
| Primary Care group practices with 25+ eligible practitioners | • Voluntary; Not an option under PQRS reporting.  
                    • No reporting on Physician Compare. | • Voluntary under PQRS reporting.  
                    • Results posted to Physician Compare. | • Voluntary under PQRS reporting.  
                    • Results posted to Physician Compare. |
| Primary Care group practices with 2-24 eligible practitioners | • Voluntary; Not an option under PQRS reporting.  
                    • No reporting on Physician Compare. | • Voluntary under PQRS reporting.  
                    • Results posted to Physician Compare. | • Voluntary under PQRS reporting.  
                    • Results posted to Physician Compare. |
| Individual primary care providers | • Voluntary except as mandated by state or other program requirements.  
                    • No public reporting on Physician Compare. | • Voluntary except as mandated by state or other program requirements.  
                    • To be determined if results will be posted to Physician Compare. | • Voluntary under PQRS reporting.  
                    • To be determined if results will be posted to Physician Compare. |
| Specialty practices and individual non-primary care providers | • Voluntary except as mandated by state or other program requirements. | • Voluntary except as mandated by state or other program requirements. | • Voluntary except as mandated by state or other program requirements. |

CG-CAHPS will become an eligible, but optional, quality measure for practices to select for PQRS reporting. If a practice wants CG-CAHPS data publicly reported, it must select the measure during the annual PQRS registration process and contract with a CMS-approved vendor to administer and submit data to CMS.
TAMING THE WILD WEST of the Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) surveys once seemed far off into the future. Today, however, real progress is being made around how, where, and when the survey and survey data will be used. Although CG-CAHPS still is not fully mandated for all practice types and sizes, the push to adopt these patient experience surveys has reached a crescendo, with significant forward momentum happening in 2012 and 2013. In the last year alone, the Centers for Medicare & Medicaid Services (CMS) has provided more clarity on the roll-out, publishing final CG-CAHPS rules for Medicare accountable care organizations (ACOs) and primary care group practices participating in the Physician Quality Reporting System (PQRS). CMS has also published timelines for public reporting, which will start in 2013 and 2014, and has indicated that pay-for-performance will begin for some groups in 2014.

As the government progresses with its plans, physician groups, national quality organizations, and states continue to voluntarily adopt the survey. States like Minnesota [see sidebar], for example, now require physician offices with adult patients to administer the patient experience survey. In 2013, Minnesota released patient experience scores from more than 230,000 patients. (Minnesota Department of Health, 2013) In the meantime, increasing numbers of physician offices are gaining real-world experience, using the survey to measure patient experience scores and develop improvement strategies. There is much to be learned from these early innovators who are gaining ground on important trends and preparing to compete against national benchmarks.

HealthStream has collected a large sample of CG-CAHPS survey results from physician offices over the last three years. The survey data identifies clear trends in how patients perceive the care they are receiving from their providers. Specifically, the data illustrates that how well a provider communicates in the exam room has ramifications on the patient’s overall impression of the practice. Because national CG-CAHPS scores are trending on a tight curve like HCAHPS, providers will need to receive high marks on surveys just to reach the average at the 50th percentile, nationally. It’s time for all providers to develop a patient experience strategy. The good news is that physician offices that have not yet participated in CG-CAHPS can learn from others and begin establishing their own best practices.
EARLY CG-CAHPS TRENDS: What the Data Tells Us

As increasing numbers of physician practices participate in CG-CAHPS, a large body of measurable patient experience data is being created and analyzed. Between 2010 and 2013, HealthStream collected 174,000 CG-CAHPS surveys (Visit and 12-Month surveys) from 3,200 physician practices. The data results illustrate the importance of exam-room dynamics. [See Tables 1 & 2]

Patient Satisfaction Highly Correlated to Provider Communication

Many factors can affect a patient’s perception of care. HealthStream’s CG-CAHPS survey results show that several questions fall within the Communication domain (“How often did this provider explain things in a way that was easy to understand?” “How often did this provider listen carefully to you?” “How often did this provider show respect for what you had to say?”) had the highest, positive correlation to a Provider’s Overall Rating.

The data also show a high, positive correlation between a patient’s willingness to recommend a particular physician office and how well the physician/provider explained care and treatment. Furthermore, the patient’s perception of the thoroughness and completeness of the patient exam and medical treatment was highly correlated to how well the physician/provider explained the patient’s care and treatment. When it came to listening skills, there were several high, positive correlations between the perception that doctors listened carefully to their patients, and the following: a doctor’s respect for what patients had to say; giving understandable health information; clearly communicating; and the amount of time the doctor spent with the patient.

Appointments/Office Staff Are Less Important to Overall Satisfaction

Interestingly, survey scores related to questions on the “Getting Timely Care, Appointments, and Information” (Access) domain were not strongly correlated to overall satisfaction. For instance, seeing the doctor within 15 minutes of the scheduled time had a low correlation to the overall rating of the provider and a willingness to recommend the facility. This suggests that patients may have long held expectations that they will have to wait for appointments. Similarly, survey scores on the helpfulness of office staff and how well office staff treated patients had a lower correlation to the Overall Rating of the provider, when compared to other areas such as communication.

Sidebar 1:

KEY LESSONS LEARNED: Minnesota Takes on CG-CAHPS:

In an effort to improve the quality of patient care and reduce healthcare costs, Minnesota began requiring physician clinics meeting a threshold number of adult visits to administer CG-CAHPS through the Minnesota Statewide Quality Reporting and Measurement System. Minnesota’s 2008 health reform law requires medical clinics to report their performance on a standard set of quality measures. The program was piloted in 2008 and mandated in 2012. In 2013, the state gathered results from more than 230,000 patient experience surveys from 651 clinics that were completed in 2012. (Minnesota Department of Health, 2013; Shaller, 2013)
The data demonstrates there is wide variation in patients’ perceptions of how well their providers perform. In other words, some providers have a lot of room for improvement in their patients’ eyes. For example, according to a press release from the Minnesota Department of Health, “60 percent of all survey respondents said they experience the top-level access of care at their clinics. In one clinic, however, only 33 percent of respondents reported top-level access; at another clinic, 83 percent of respondents reported top-level access.” Provider communication scores also saw wide swings of 66 percent to 98 percent. When CG-CAHPS becomes fully mandated, low scoring groups will be penalized financially as pay-for-performance programs kick in.

correlations are the relationship between items that change together. the use of correlations is useful as they indicate a predictive relationship. specifically, a positive correlation indicates that as one item increases, so does the other. the closer the correlation is to 1, the stronger the correlation, or relational influence, is between the two items.

Sidebar 2:
Minnesota Takes on CG-CAHPS:

**Survey Highlights**
- 60% of survey respondents said they experienced top-level access to care from their providers.
- 90% of respondents say their providers were top-level communicators.
- 92% of respondents gave office staff at their clinics high marks for being respectful and helpful.
- 78% of patients gave their provider a top rating of 9 or 10 on a 10-point scale.

**What the Data Means**
The data demonstrates there is wide variation in patients’ perceptions of how well their providers perform. In other words, some providers have a lot of room for improvement in their patients’ eyes. For example, according to a press release from the Minnesota Department of Health, “60 percent of all survey respondents said they experience the top-level access of care at their clinics. In one clinic, however, only 33 percent of respondents reported top-level access to care; at another clinic, 83 percent of respondents reported top-level access.” Provider communication scores also saw wide swings of 66 percent to 98 percent. When CG-CAHPS becomes fully mandated, low scoring groups will be penalized financially as pay-for-performance programs kick in.

*Follow up with test results to be reported at the individual question level, and not part of a domain.*
Translating CG-CAHPS Scores on the National Stage

Ultimately, the HealthStream CG-CAHPS data show that strong communication skills influence a patient’s overall opinion of a provider and whether or not they will recommend that practice to friends and family. It’s important to point out that when it comes to understanding CG-CAHPS trends, patients have a history of giving hospitals, and now providers, overall high scores on the CAHPS surveys. This doesn’t mean providers are in the clear. It actually means the opposite because the difference in Top Box scores (the percentage of respondents reporting the most positive response) between the highest performer and some of the lowest performers is rather small. Only a very few patients are giving lower scores of “sometimes” or “never.” Nearly all are choosing “usually” or “always” as a response. For most hospitals and physicians, the difference between a high performer and a low performer is the number of patients who say “usually” vs. “always.” For many items on the CG-CAHPS survey, physicians will have to receive a 90% Top Box score or higher to be considered a top performer. On a positive note, improving a Top Box score by only a few points may lead to a substantially greater improvement in an organization’s percentile ranking.

When comparing the HealthStream CG-CAHPS database to national Top Box scores, we find that physician offices must attain scores in the 80s on the communication domain of the survey to even be considered at or above average.

* Follow up with test results and Overall rating of provider items to be reported at the individual question level, and not part of a domain.
Start CG-CAHPS Best Practices Today

With more data becoming available, physician offices have new opportunities to analyze patient experience trends and prepare for CG-CAHPS becoming fully mandated and linked to pay-for-performance initiatives, such as Value-Based Purchasing.

Stories from early adopters point a clear line to provider involvement. If there is a single, sage lesson learned, it is to bring your providers into the CG-CAHPS conversation and don’t underestimate the time to get those providers on board.

Providers are dedicated to their patients, but they may not all immediately see the value of patient experience data. Educate your medical staff on the survey and the driving forces behind national adoption. Be prepared if there isn’t universal acceptance of CG-CAHPS. Providers typically ask more questions about the survey construction, the size of the database, the number of responses, etc. Use your HealthStream consultant for CG-CAHPS education and initial data sharing.

As physicians and advanced practice clinicians gain a better understanding of the survey and initial results for your organization, target an area most likely to enhance your patients’ experience. HealthStream’s CG-CAHPS survey data draws a clear line between patients’ overall satisfaction and the level of interpersonal communication between the provider and patient. A good first step for those physician offices starting down the road to CG-CAHPS is to focus on establishing a set of best practices around the communication domain. While there are many physician communication programs and tactics available, these four simple strategies will lay the groundwork for a detailed plan later on:

1. Make the First Three Minutes Count

Start the visit off with a good first impression. Providers can quickly set a tone of trust and rapport with their patients by doing the following: Take a minute to read the patient’s chart and health questionnaire; smile and establish eye contact; restate his or her understanding of the patient’s visit in their own words; pause and let the patient speak. In these simple actions, the patient witnesses that the provider cares, is fully engaged, and listens.

2. “Show” a Willingness to Be in the Moment

Providers must also give physical cues that he or she is tuned in to the patient and providing a thorough medical exam. One way is by sitting down with the patient. The importance of sitting cannot be overstated. Patients’ perception of time spent is greater when the provider takes a moment to sit down and have a conversation. Also, some provider behaviors may lead the patient to perceive that the provider does not have time for them, such as speaking very quickly, checking the time, and keeping a hand on the doorknob. These actions will affect the patient’s perception of the quality of communication, the quality of the provider, and the overall value of the office visit.
3. Commit to Becoming an Active Listener

Look and listen. These are the qualities of a strong active listener and will affect how patients rate a provider’s communication skills. When it comes to “looking,” establishing eye contact is the easiest way for a provider to demonstrate he or she is paying attention. The eyes reveal a great deal to the patient, such as depth of interest and concern. When it is time to shift attention away from the patient, for instance to enter information into the computer, the physician should politely say, “Excuse me.” Being a good listener also involves practicing the skill of “reflecting” what the patient has said. This helps clarify what the provider heard and tells the patient that the provider cares. Finally, the most important part of listening is allowing patients to speak without interruption.

4. Make the Last Three Minutes Count

Close communication loops in the last few minutes of the visit by practicing these two effective tactics:

- Offer and describe patient education materials –
  Give patients preprinted, written materials about their condition or treatment and brief them about the content. Encourage patients to make notes, using their own words to help remember key points.

- Discuss next steps – After determining that patients understand their course of treatment and have a clear protocol for patient follow-up, communicate to patients the day they can expect to receive results and ask them the best way to communicate these results. Understanding the patient’s preferences will lead to successful follow-up.

These steps provide an opportunity for the patient to be an active participant in his or her care, and help to close the communication chasm.

“The groundwork you lay today will pay large dividends in engaging providers. An engaged provider translates to a rich patient experience—take it from the CG-CAHPS pioneers.”

CONCLUSION

As the government becomes clearer about its intentions on how CG-CAHPS will unfold, it is safe to assume that the surveys will impact most physician offices in the next few years. Take the message from early adopters to heart and begin planning for provider education and training. Help them understand the survey, the process, and the value patient experience feedback has to the practice. Begin sharing data on clinic performance and set expectations for providing individual reporting. The groundwork you lay today will pay large dividends in engaging providers. An engaged provider translates to a rich patient experience—take it from the CG-CAHPS pioneers.

ABOUT THE AUTHORS

Cyndi Tierney, Consultant at HealthStream, has worked in the patient experience industry for the past five years, providing coaching and training to clients in medical practice, acute care, and home health settings. Previously, she was the Patient Experience Administrator for a regional healthcare system in Tennessee. Cyndi has also served as an examiner for Tennessee’s Performance Excellence (Malcolm Baldrige), was an adjunct professor at Vanderbilt University’s Human and Organizational Development Internship program, and has led local and statewide professional boards. Her Master of Education from Vanderbilt is in human resource development, augmented by a year-long coaching certificate from Villa Nova/Newfield Network.

Amanda Holland, Product Director at HealthStream, oversees research, development, and implementation strategies for new survey and assessment products, as well as enhancements to existing products and services. With more than 8 years of experience in healthcare research and strategy, Amanda’s experience includes a successful track record of new product launches and innovations, market research, brand management, strategic relationships, client management, as well as consulting and customer education. Previously, Amanda was Product Manager at Heraeus, a large dental manufacturer, and Brand Manager for a large survey and performance improvement organization. She received a Bachelor in Business Administration in management, marketing, and advertising from Indiana University.

References


For most of us, HCAHPS proved to be quite an education. Participating in the HCAHPS and Value-Based Purchasing programs over the past several years showed us new ways to interpret survey results and helped us know what to expect in a public reporting and pay-for-performance environment. Fortunately, many of the lessons we learned from HCAHPS can carry over into the CG-CAHPS setting and can be useful for practice managers and physicians as they too join the world of data transparency. In this article, we will look at five key lessons that will be helpful as we work with CG-CAHPS results.
When we first look at our CG-CAHPS survey results and see Top Box scores in the 70s or 80s, we automatically think we have scored well on the survey. We become complacent when we see that 75.5% of our patients are “always” able to schedule their appointment as soon as they want, and an additional 21.4% say they can “usually” book an appointment when they want. It is a shock to see that “always” scores in the 70s or 80s typically mean your performance is only average. One key lesson from HCAHPS is that hospitals as a whole score well on the CAHPS surveys; therefore, extremely high Top Box scores are necessary to be considered among the best performing hospitals in the country.

This phenomenon is even more evident with the CG-CAHPS survey, where patients on average are giving high marks to their physicians. For many items on the CG-CAHPS survey, physicians will have to receive a 90% Top Box score or higher to be considered a top performer. The following table shows the score each provider will need to achieve on each survey item to be considered as performing at the norm (roughly the 50th percentile) in the HealthStream database.

**CG-CAHPS SURVEY NORMS**

<table>
<thead>
<tr>
<th>Item</th>
<th>Norm Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider saw you within 15 minutes</td>
<td>54.2</td>
</tr>
<tr>
<td>Gave answer after regular hours</td>
<td>60.3</td>
</tr>
<tr>
<td>Gave same-day answer during business hours</td>
<td>68.6</td>
</tr>
<tr>
<td>Helpful clerks/receptionists</td>
<td>74.3</td>
</tr>
<tr>
<td>Able to get appointment right away</td>
<td>75.5</td>
</tr>
<tr>
<td>Follow up with test results</td>
<td>75.6</td>
</tr>
<tr>
<td>Rate provider 0 to 10</td>
<td>77.8</td>
</tr>
<tr>
<td>Able to get routine appointment</td>
<td>78.0</td>
</tr>
<tr>
<td>Provider knew your history</td>
<td>78.1</td>
</tr>
<tr>
<td>Provider spent enough time</td>
<td>83.5</td>
</tr>
<tr>
<td>Provider gave easy instructions</td>
<td>86.8</td>
</tr>
<tr>
<td>Provider treated you with courtesy</td>
<td>87.6</td>
</tr>
<tr>
<td>Provider listened carefully</td>
<td>87.6</td>
</tr>
<tr>
<td>Provider explained things</td>
<td>87.6</td>
</tr>
<tr>
<td>Provider showed respect</td>
<td>89.5</td>
</tr>
</tbody>
</table>

*(Based on results from approximately 3,200 physician practices and 170,000 respondents)*
LESSON TWO: The Gap between High and Low Performers Is Small

With both the HCAHPS and CG-CAHPS surveys, the difference in Top Box scores between the highest performer and some of the lowest performers is rather small. Another way of saying this is that almost all hospitals and providers are scoring relatively well on their respective CAHPS surveys. Only a very few patients are giving replies of “sometimes” or “never.” Rather, almost everyone is giving a response of “usually” or “always.” For most hospitals and physicians, the difference between a high performer and a low performer is the number of patients who say “usually” rather than “always.” The key to success for most CAHPS participants is to improve the patient experience in your organization to the extent that patients who now give you a response of “usually” are convinced to move up a notch and give a response of “always.”

The following table shows Top Box scores that must be achieved to reach the bottom 10th percentile, the 50th percentile, and the top 90th percentile. As you can see, the difference between the top and bottom performers is often only 10-30 points. One implication is that the improvement of your Top Box score by only a few points may lead to a substantially greater improvement in your percentile ranking compared to other hospitals in the database. For example, looking at the first question in Table 2 below, you can move from the 10th to the 50th percentile by improving your Top Box score from 81.3% to 89.5%, and you can improve from the 50th to the 90th percentile just by moving your Top Box score from 89.5% to 95.4%.

### DISTRIBUTION OF CG-CAHPS SURVEY ITEMS

<table>
<thead>
<tr>
<th>CG-CAHPS SURVEY ITEM</th>
<th>HealthStream Database Top Box Score Representing the 10th Percentile</th>
<th>HealthStream Database Top Box Score Representing the 50th Percentile</th>
<th>HealthStream Database Top Box Score Representing the 90th Percentile</th>
</tr>
</thead>
<tbody>
<tr>
<td>How often did this provider show respect for what you had to say?</td>
<td>81.3%</td>
<td>89.5%</td>
<td>95.4%</td>
</tr>
<tr>
<td>How often did this provider explain things in a way that was easy to understand?</td>
<td>79.3%</td>
<td>87.6%</td>
<td>93.4%</td>
</tr>
<tr>
<td>How often did this provider listen carefully to you?</td>
<td>79.2%</td>
<td>87.6%</td>
<td>94.0%</td>
</tr>
<tr>
<td>How often did clerks and receptionists at this provider’s office treat you with courtesy and respect?</td>
<td>78.9%</td>
<td>87.6%</td>
<td>94.0%</td>
</tr>
<tr>
<td>How often did this provider give you easy to understand instructions about taking care of these health problems or concerns?</td>
<td>77.7%</td>
<td>86.8%</td>
<td>92.5%</td>
</tr>
<tr>
<td>How often did this provider spend enough time with you?</td>
<td>74.1%</td>
<td>83.5%</td>
<td>92.0%</td>
</tr>
<tr>
<td>How often did this provider seem to know the important information about your medical history?</td>
<td>67.7%</td>
<td>78.1%</td>
<td>86.6%</td>
</tr>
<tr>
<td>FOR ROUTINE CARE: How often did you get an appointment as soon as you thought you needed?</td>
<td>67.1%</td>
<td>78.0%</td>
<td>88.8%</td>
</tr>
<tr>
<td>Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider? (% 9-10)</td>
<td>65.2%</td>
<td>77.8%</td>
<td>87.0%</td>
</tr>
<tr>
<td>When this provider ordered a blood test, x-ray or other test for you, how often did someone from this office follow up to give you those results?</td>
<td>62.6%</td>
<td>75.6%</td>
<td>83.6%</td>
</tr>
<tr>
<td>FOR CARE RIGHT AWAY: How often did you get an appointment as soon as you thought you needed?</td>
<td>62.2%</td>
<td>75.5%</td>
<td>89.0%</td>
</tr>
<tr>
<td>How often were clerks and receptionists at this provider’s office as helpful as you thought they should be?</td>
<td>61.5%</td>
<td>74.3%</td>
<td>84.0%</td>
</tr>
<tr>
<td>REGULAR BUSINESS HOURS: How often did you get an answer to your medical question that same day?</td>
<td>55.9%</td>
<td>68.6%</td>
<td>80.8%</td>
</tr>
<tr>
<td>AFTER REGULAR HOURS: How often did you get an answer to your medical question as soon as you needed?</td>
<td>47.7%</td>
<td>60.3%</td>
<td>72.7%</td>
</tr>
<tr>
<td>How often did you see this provider within 15 minutes of your appointment time?</td>
<td>35.6%</td>
<td>54.2%</td>
<td>74.2%</td>
</tr>
</tbody>
</table>

*(Based on results from approximately 3,200 physician practices and 170,000 respondents)*
When HCAHPS piloting began for most hospitals in 2006-2007, there was controversy about the entire CAHPS program and the notion of Value-Based Purchasing. Would it be much government ado about nothing or would it really be a program that would drive improvement in the patient experience of care? Today, we can actually document the impact of the HCAHPS program from the patient’s point of view.

First, we have seen a steady increase in hospital participation in the HCAHPS program since 2008. Some 2,500 hospitals were represented in the public release of HCAHPS results during the 1st Quarter of 2008. By the 1st Quarter of 2013, that number had climbed to nearly 4,000 hospitals. Since 2008, we have also seen a steady, year-over-year improvement in HCAHPS scores nationally. The aggregate Top Box score in 2008 was 67% compared to 72% today. We can definitely say the patient experience of care has improved, and HCAHPS is achieving its initial objective.

One implication of this steady improvement is that hospitals can ill-afford to remain complacent in their efforts to improve the patient experience. Hospitals that are not improving are actually seeing their percentile scores decline as the rest of the hospitals in the U.S. are pushing ahead without them.

It is reasonable that we might expect the same “rising boat” phenomenon to occur with the CG-CAHPS data. The voluntary, public display of CG-CAHPS data on the CMS Physician Compare that will begin in 2014 is likely to stimulate improvement efforts among physician practices so that we see a trend similar to that noted in Table 3 for HCAHPS.

### NATIONAL HCAHPS SCORES 2008 - 2013

<table>
<thead>
<tr>
<th>Year</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st Quarter 2008</td>
<td>67%</td>
</tr>
<tr>
<td>1st Quarter 2009</td>
<td>68%</td>
</tr>
<tr>
<td>1st Quarter 2010</td>
<td>69%</td>
</tr>
<tr>
<td>1st Quarter 2011</td>
<td>70%</td>
</tr>
<tr>
<td>1st Quarter 2012</td>
<td>71%</td>
</tr>
<tr>
<td>1st Quarter 2013</td>
<td>72%</td>
</tr>
</tbody>
</table>

(Based on CMS public reporting on the www.hospitalcompare.hhs.gov website)
LESSON FOUR: We Have a Lot of Explaining to Do

There has been a steep learning curve for most of us over the past decade as we have attempted to understand the complexities of the HCAHPS and Value-Based Purchasing programs. We had to absorb the meaning of such things as the use of the “always” to “never” frequency scales, mode and patient mix adjustments, public transparency, and scoring for Value-Based Purchasing. With CG-CAHPS, there will be a need to transfer our CAHPS learning to a different audience—practice managers and non-hospital-based physicians. These new audiences will need to understand topics such as:

• The purpose of CG-CAHPS in improving the patient experience of care
• The rules of the CG-CAHPS program as dictated by CMS (including additional rules for physicians who are participating in either patient-centered medical homes or accountable care organizations)
• Their organization’s sampling plan and the resultant reliability of the data they are viewing
• The definition of Top Box and the implications of CMS only considering this top response
• The importance of the Percentile Score as the true metric of performance
• The relationship between the items in the CG-CAHPS survey and behaviors that occur in the practice
• How to set priorities for improvement based on CG-CAHPS survey results
• How to set accountability for improvement within the practice
• How to respond to various stakeholders who ask about publicly reported CG-CAHPS results
• The possibility that CG-CAHPS data may be used in the future to impact reimbursement from CMS

HealthStream encourages organizations to begin the education process now. An early start will allow staff time to be prepared to process CG-CAHPS results appropriately and begin making early improvements, so that they are not behind the curve as these results begin to be reported widely and publicly.

LESSON FIVE: Physicians Will Need to Become Even More Customer-Focused

As physicians review their CG-CAHPS results for the first time, many will be motivated to try to improve the patient experience in their clinics. While we have already noted that most physicians are meeting patient expectations relatively well today, the bar is about to move much higher, putting pressure on physicians to consistently receive an “always” response from their clientele. At the same time, this is an area of performance in which most physicians have had little to no training.

At HealthStream, we are seeing a number of hospital executives and practice managers taking a variety of steps to support physicians in their improvement efforts. Some of these steps include…

Awareness: Most clients by now have begun to acclimate their physicians to the CG-CAHPS program. They are collecting and reporting data at both the practice and individual physician levels so that physicians have a good idea of their percentile ranking relative to a large national database. The fact that half of all physicians participating in the CG-CAHPS program will, by definition, score below the 50th percentile creates a demand among physicians for support services to help improve the patient experience.
Importance: Organizations are realizing the strong relationship between the physician-patient interaction and medical malpractice claims. Richard Corder, AVP of Business Development at CRICO/RMF, the medical malpractice arm of Massachusetts General, attests to the impact that even one negative verbatim comment in a survey can have on physician risk, indicating that the risk of a medical malpractice claim skyrockets for any provider who receives a negative comment from a patient. There is also the looming possibility that CMS will mandate the public reporting of CG-CAHPS results and will ultimately tie survey scores to physician reimbursement.

Preparation: As healthcare employees join an organization for the first time, we are seeing topics such as customer service and service recovery being taught as part of new employee (and physician) orientation programs. Hospitals are setting standards for service that are being taught in orientation, measured through CAHPS surveys, and reviewed in employee performance reviews. Employees of all types (physicians, nurses, non-clinical, etc.) who work or practice on units that receive low CAHPS scores are being asked to repeat their employee orientation program.

Coaching: At one health system we have encountered, lay people from the hospital’s Patient Advocacy Group are trained as coaches on the patient experience and are dispatched to “shadow” physicians who voluntarily ask for help in improving the patient experience they provide. After a full day of shadowing, the coach prepares a thorough report for the physician, telling what they observed and providing recommendations on how the physician can improve.

Intervention: The CG-CAHPS program will force organizations to confront physicians who have a consistent pattern of acting-out in the workplace. For years, organizations have tolerated the highly competent physician who exhibits inappropriate workplace behavior. In the new world of CG-CAHPS, physicians will be expected to show top clinical skills while also providing a highly favorable patient experience. Dr. Gerald Hixson, Senior Vice President at Vanderbilt University’s Center for Patient and Professional Advocacy (CPPA), is tackling the issue of the problem physician head-on. He heads the CPPA, where the relationship between patient safety and outcomes is clearly linked to the patient experience. The CPPA offers educational programs for physicians, programs to address physician misconduct, and tools to scour survey verbatim comments to identify at-risk physicians.

Beginning in 2014, CMS will allow physicians to publicly report CG-CAHPS survey results as one component of the Physician Quality Reporting System (PQRS). Whether CMS will ultimately mandate the public reporting of CG-CAHPS data is unknown at this time, but voluntary participation in and of itself will create momentum for improvement and push high performers to make their scores known on the Physician Compare website. If we have learned anything from HCAHPS, it is that you don’t want to be known as an entity that performs below the 50th percentile. The time is now to understand how you score, initiate improvement efforts, and take advantage of the fact that public reporting is not yet required.

“The CG-CAHPS program will force organizations to confront physicians who have a consistent pattern of acting-out in the workplace.”
In my experience, **THE BEST WAY TO IMPROVE CLINICIAN AND GROUP - CONSUMER ASSESSMENT OF HEALTHCARE PROVIDERS AND SYSTEMS (CG-CAHPS) SCORES IS TO STOP TALKING ABOUT CG-CAHPS SCORES.**
Seriously. Stop focusing on this acronym, these scores, whether they are robust or “significant,” and how big the “n” is. Stop this now. Instead, start focusing on what matters. What really matters is whether we are fostering and leading cultures which create safe environments for caregivers to do their best work and ultimately, whether their patients receive the best care.

During my career at both community and academic medical centers, I have learned that responding to this required going back to some of the basic tenets of leadership: systems improvement and culture.

Ah, speaking of culture. We are all too familiar with the elusive, and yet frequently referenced, “it’s the way we do things around here.” It remains the holy grail of management consultants. But what is culture? How do we change it?

When leaders acknowledge that they are themselves representative of their organization’s culture, the battle is half won. Another way of thinking about this is, “an organization cannot be what its leader is not.” Hospitals that boast a “just culture” are led by “just” leaders who have been clear with their expectations about speaking up and speaking out. They model behavior that is congruent with a healthy, non-punitive, accountable culture. They “walk the walk.”

Taking this concept one step further: it is therefore reasonable to state that as leaders we are our cultures. In fact, culture doesn’t exist without us; there is no culture without people. If no-one shows up at your hospital tomorrow, is there a culture?

First and foremost this starts with me, you, and us. We are personally accountable for our results and for the results of our organizations. We need to remind ourselves that to be successful and fulfilled is to remember that we are 100% accountable for what happens to us. At the very least, remember that 100% is available to you, and how much you own is a choice.

“A Look in the Mirror”

If you are clear about what you want as a leader, and clear about the expectations of your role and those that report to you, you will be leading with clarity and conviction, and honesty and transparency. In the words of Chuck Lauer, former publisher of Modern Healthcare, “you will bring inspiration and determination to everything you do.”

Personally accountable leaders hold themselves and those around them to clearly articulated agreements, they understand the need to treat different performers differently, and they create a contagious enthusiasm that permeates their organizations.

Personally accountable leaders are employing different definitions of accountability, responsibility and empowerment:

• Responsibility – a before the fact mindset of personal ownership and commitment to a result
• Self-Empowerment – taking personal action and risk to ensure an agreed upon result
• Personal Accountability – a willingness, after the fact, to answer for the outcomes produced
It is important to note that empowerment cannot be “given” to anyone. You can give or assign someone the authority to act in a certain role, but their personal action to lean in, to step up and take the risks necessary to achieving results, is a personal choice.

As a leader, ask yourself whether you have created a safe and rewarding environment in which your teams and colleagues can act in the best interests of their patients.

So the questions become:
Are you committed to doing what it takes to put the patient and family at the center of your work? Are you making it easy, convenient, and rewarding for your colleagues to practice?
How do you know?

Listen
Truly listen to people, nurses, techs, doctors, housekeepers, patients, and family members. Listen to everyone.

Look at the data, read the comments, and discover what it’s all telling you.

At CRICO (the group of companies owned by and serving the Harvard medical community) one of the many ways we listen is by clinically coding and analyzing medical malpractice data. We then share this analyzed patient and provider safety data (with robust peer comparisons) with leaders at all levels of the organization.

Leaders then have a choice.
The choice is to decide to act differently (or not) based upon what we are “hearing.” The data is telling a story about performance, safety, mistakes, and best practices. As leaders, we must ask ourselves, do we like the story so far and what do we want the next chapter to look like?

We “listen” at CRICO when we convene our chiefs and leaders. We use data as the catalyst for conversation and are repeatedly reminded that we are experiencing some of the same system challenges across a wide variety of services and organizations. We are in a position to use this convening as a means to share best practices too. From that data, we can see where an organization may have approached an issue like improving communication between surgical residents and their attendings, while others can replicate the approach and avoid the costly and timely work of starting from zero.

The same is true when my colleagues and I would examine our H- and CG-CAHPS data.

When sharing department and service level CAHPS data with colleagues, the conversation cannot be one that seeks to learn what’s right or what’s wrong per se. The conversation is one of, “lets understand what we are seeing and hearing, and then let’s make a decision driven by whether the story fits with what we want our experience to look and feel like.”

Use data as a listening point, sit with it, discuss it, and ask the tough questions. Use data as a conversation starter and then have face-to-face conversations and listen to people.

Really listen. Don’t interrupt, don’t jump to solutions, and don’t appear to be thinking, “if only they’d just start doing discharge phone calls…” or “why don’t they just start using AIDET?”

Hear their pain points. Remember that the majority of your colleagues entered the field of healthcare (and stayed in it) to improve the lives of others and make a difference.

Once you have a clearer sense of what you’re “hearing,” ask yourself, “Is this what we want to be known for? Are we proud of what the data is telling us?”

Get Clarity
If we know what is happening, if we are open to hearing about the good, the bad, and the ugly, we then need to get clarity about what we want.

What does the ideal experience look like to those we serve? Work to get clarity around expectations and then communicate those expectations widely.

Document expectations, and get clear about what the experience is that you are trying to create for those you serve: employees, patients, families, providers, suppliers, community, and other parts of the continuum of care. Map the experience.
Make Friends
Early in my healthcare career, I picked up the phone and called Don Berwick, then CEO of the Institute for Healthcare Improvement. I had never met Don although I had always been impressed with his clear thinking and commitment to improving systems to make care safer and better for those we serve. Given this, I thought he might be able to advise me and offer a sage perspective.

I was put through to his office and what ensued was a robust coaching call centered on the role I had recently accepted to “improve the patient and family experience” at a large academic medical center in Boston.

Don’s take away advice was “find your friends.” I asked him to expound on this and he explained to me that there will always be people ready to disagree, argue the data, and straight up work to derail your efforts. They are entrenched and have been rewarded for their behavior for many years. Don’t focus on collaborating and working with these folks; they will either come along later or they’ll retire.

He advised me to find leaders (physician and non-physician) who shared my belief that the experience we were currently creating could be improved upon and that it was worthwhile, mission-driven work. He encouraged me to seek them out and find ways to collaborate, co-present, co-chair, and otherwise engage. This approach is a lot easier and a lot more fun than the alternative.

Don’t Over Complicate
Sometimes answers are quite simple and right in front of us.

At Massachusetts General Hospital (MGH), we made a “clear commitment” to creating a welcoming environment. So, to evaluate that commitment I spent some time observing our main entrance and lobby. MGH is a 1,000 bed academic medical center whose lobby is cavernous, busy, and a somewhat confusing place to navigate. You only needed to stand there and watch to realize that this was not a very friendly or welcoming space.

My observations of this area revealed several things. I saw the human interactions, the “feel,” the smell, the fact that trash wasn’t getting picked up by employees, people waiting in lines at the reception desk, the apprehensive, scared and bewildered faces of people walking through our doors. These were our patients, their family members, and the public.

So how do we change this without spending large sums of money or a great deal of time getting buy-in and approval? What else could we do to make a difference?

We committed to “greet” in the lobby, which consisted of volunteer hosts standing in the middle of this large lobby saying “Hello,” “Good morning,” and “Good afternoon...”
We didn’t stop at greeting. We committed to escorting people to their destinations, learning more about them on the way, and trying to alleviate their fears a little by making them feel welcome. More often than not we would be asked whether this was really a part of our job, why were we doing this, and did everyone get such special treatment? Special treatment? The fact that being greeted and escorted to where you needed to go was too often considered special treatment was sobering.

When the escorts arrived at their destinations, they would be able to introduce the patient to a fellow employee behind a desk or at a reception area and explain what this patient was here for and any other relevant information that they had learned during their walk (or ride). They could also look at the patient and family and, with confidence, say, “this is Mary. You are in great hands, and she is going to take the best possible care of you today.”

Eventually we were approached by our colleagues and asked what we were doing and if they too could be included. “It looked like fun,” they said, and more and more folks signed up. The vice-chief of Pediatrics, the SVP of Human Resources, the CEO, all greeting for an hour at a time—perhaps only once a month—were all making a difference for our patients, their families, and visitors, and by example, for their fellow employees.

A simple, inexpensive, grass roots effort that reminded us that creating a welcoming, caring, patient-focused environment was much more fulfilling than focusing on our H- or CG-CAHPS scores. This is not intended as an exhaustive list of tactics or approaches but rather a small handful of reminders that when we focus on the right things in healthcare, and use data to guide our actions, we create cultures that are safe and rewarding for caregivers to do their best work for their patients and families who are now receiving the best, safest and most efficient care.

This really came to life for me during my time at MGH. As a part of a larger strategic initiative to improve the experience of patients and their families, my colleagues and I were invited to create a strategy to “move the needle” on our MD Communication scores.

Our initial approach was to do as we were told. Craft a program and strategize a way to roll it out and then determine strategies to drive attendance—the theory being that if we could teach what people didn’t know we would improve the scores.

Arrogance and naiveté at its best.

Who were we, correction, who was I to think that I could change others’ behavior, let alone try to accomplish it in a ninety minute classroom session with a tepid, at best, atmosphere?

“We spent many full days standing as observers in the operating rooms of some of the most talented clinicians I have ever met.”

So we looked in the mirror and found that for this to be genuine we needed to walk the walk and change the experience of those that would be experiencing this material and this effort.

We listened. We examined our CG-CAHPS scores, presented them to as many physician leadership groups, nurse leaders, and support staff focus-groups as possible, crafted dashboards and even did 1:1 education for leaders who had never seen this data before.

We also “listened” by observing the practice and lives of our physician, nurse, and other caregiver colleagues.

We spent many full days standing as observers in the operating rooms of some of the most talented clinicians I have ever met. We witnessed life hang in the balance, and we watched the change of shift during a 14-hour procedure. We were graciously welcomed to shadow a “day in the life” of a busy spine surgeon and an equally busy family practitioner, just to name two. We saw all that they bring to their efforts to heal; we saw flawed, hard-working, and tired colleagues who wanted to make a difference. We heard from their nurses, techs, front desk clerks, colleagues, bosses, and subordinates. I’m sure we didn’t get the “full” picture, but what we heard changed our perceptions and opinions.
We achieved greater clarity by working to develop an approach that was reasonable and supported by all levels of leadership. Setting a goal for improving H- and CG-CAHPS scores certainly does not come without some gnashing of teeth and difference of opinions. We set clear numeric goals for both attendance and achievement, and with finite time constraints.

We found our friends.

We found influential physician and non-physician leaders that could partner with us to get things done. We found physicians that had spent their professional lives researching and advancing the art and science of certain areas of this field.

“We took the approach that we were not teaching anyone anything that they didn’t already know.”

We found Dr. Helen Riess, an Associate Clinical Professor of Psychiatry at Harvard Medical School and Director of the Empathy and Relational Science Program in the Department of Psychiatry at Massachusetts General Hospital. Helen conducts translational research utilizing the neuroscience of emotions in educational curricula to improve empathy and relational skills in physicians and other health care providers. She can actually show you the science behind empathy and teach you how to be more empathetic.

Helen proved to be a gracious creative lead, colleague, and busy faculty for one of four programs that we ultimately made available to 1,500 physicians at MGH as a part of this improvement effort.

We found the compassionate and committed Vicki Jackson MD, MPH, the Chief of the Palliative Care Program at Massachusetts General Hospital. Vicki, like Helen, had committed her career to leading not just her research but also the gentle, creative education of others. For Vicki and her team of specialists, their focus is on helping patients and their families maintain a high quality of life when facing life-threatening illness.

In this relatively young field of medicine, Vicki trains clinicians in this evolving practice, offers supportive services to clinicians working with seriously ill patients, and promotes the benefits of palliative care. She was the perfect friend to facilitate an offering that would ultimately also make up a robust piece of our curriculum.

And we kept it simple.

We took the approach that we were not teaching anyone anything that they didn’t already know. What we were providing was an environment, 90-minutes away from the daily grind, to hear about and be exposed to the work of colleagues that have dedicated their lives to improving elements of communication. We crafted the time together to be more driven by the sharing of best practice than the discussion of poor scores.

Helen used real pictures of human expression to generate discourse and explained the neuroscience behind our emotions. Vicki used a patient actor to simulate an interaction escalating out of control. Both gave their colleagues a personal insight into aspects of communication that they had otherwise not been exposed to.

92% of eligible physicians participated in at least one of the four sessions we offered and some attended all four.

Feedback from the course evaluations was 4 and 5’s on a five point scale.

And we improved our CAHPS MD Communication scores.

So, try not to focus on improving CG-CAHPS. Focus on looking in the mirror, listening, getting clear, making friends, and keeping it simple—this is what your patients and their families need and expect.

And finally, it also creates an environment where caregivers are treated with dignity and respect, have what they need to do their work, and are recognized for the results they achieve. They are personally accountable and self empowered.
HealthStream’s Acquisition of BLG: What It Means for Everyone Involved
What does it mean for BLG and its customers to become part of the HealthStream family?

BLG and HealthStream share the same values; at a base level, BLG has always been focused on creating patient-centered excellence. Much like HealthStream, we are devoted to helping our clients achieve outcomes driven by developing new patient-centered skills, establishing accountabilities and driving culture transformation. HealthStream’s strong grounding in patient-centered excellence allows us to create a wonderful union of BLG’s expertise, proven approach, and coaching with the powerful learning technology and research consulting expertise of HealthStream. Our combination means that BLG experts and coaches will have greater impact on creating patient-centered excellence in America’s hospitals, health systems, and physician practices.

What are the benefits of acquisition for BLG customers?

BLG is already a nationally recognized leader in patient experience consulting and cultural transformation in healthcare. BLG has been innovating the patient experience through our living lab at Baptist Health Care for the past two decades. We are known for walking the journey with our clients. By engaging senior leaders, leaders, staff, and physicians with our proven approach, our clients experience service and operational improvements as a result of our work. We help healthcare organizations create a journey unique to their own strengths and opportunities to transform the patient experience. That will never change.

Our acquisition by HealthStream will have a profound, beneficial effect on BLG, as it allows us to accelerate our investments in technology and cutting edge learning techniques. This elevates our coaching efforts and will create a demonstrable impact to a far greater reach of American healthcare. Our customers will now have access to the HealthStream community of improvement, which will provide more opportunities for best practice sharing and innovation.
What should HealthStream customers know about BLG?

BLG is widely known for coaching healthcare leaders, staff, and physicians to elevate and develop their focus on patient experience despite an unprecedented level of competing priorities. We are an incredible asset for helping healthcare executives who are eager to improve patient and business outcomes and transform patient experience at their organizations. BLG’s coaches will be a new team of experts available to HealthStream customers for establishing accountabilities, improving skills, and changing behaviors. This is a team of people skilled at overcoming the three primary challenges to creating the best possible patient experience: accountability, consistency, and staff buy-in.

What are the top BLG products and services?

BLG is nationally recognized for the efficacy and success of our consulting and tools. Organizations all over the country choose BLG to help them assess the state of the patient experience and coach them to develop and transfer crucial skills.

In our Patient Centered Excellence Assessment Process, we measure the strength of the organization’s culture and performance outcomes through on-site observation. We also perform a Patient Centered Excellence Survey, using the results to create a Customer Road Map to Improvement.

What improved outcomes have customers achieved by using them?

The results of an engagement with BLG have been significant for many of our customers. Achievements include improvements in CAHPS survey scores, clinical quality, physician and employee engagement, and financial and operational metrics. If an organization is focused on patient-centered excellence, executing patient-centered behaviors consistently, and using their patient experience survey feedback to guide actions, they are poised for breakthrough and sustainable improvement. For example, one of our partners began with us when their physician communication scores on HCAHPS were below the 10th percentile and after 18 months are now reaching the 80th percentile.

What big healthcare problems will BLG help HealthStream customers solve?

HealthStream’s vision is to improve healthcare by assessing and developing the people who deliver care. BLG will further propel this core purpose by continuing to develop and inspire thousands of healthcare leaders each and every year. Uniting the operational bandwidth of HealthStream’s technology and organizational platform with BLG’s expertise will transform HealthStream’s patient experience focus. It will create a valuable solution for healthcare cultural transformation that no one else can match. The combination of learning, coaching, and performance management will allow us to have an exponential impact in healthcare. We’ll help healthcare leaders focus closely on their most pressing challenges, develop prescriptive solutions to those problems, and offer the tools and resources to help them make patient experience a core competency.
Flexibility in Survey Design
HealthStream offers versions of the CG-CAHPS survey to meet CMS, NCQA, and individual state and other program requirements. Whether your facility is a medical home, seeking NCQA PCMH Recognition or Distinction, is part of an accountable care organization (ACO), or is seeking to fulfill PQRS quality reporting requirements, there’s a solution to meet your needs.

The standard Visit and 12-Month surveys measure the patient experience across a common set of survey themes, or categories, but differ in both the reference period and the scales used. The Visit survey asks patients about care during their most recent visit, and the 12-Month survey asks about experiences with care over the past year. The Visit survey primarily uses a 3-point yes/no scale; while the 12-Month survey primarily uses a 4-point never-to-always scale.

In addition to the 12-Month and Visit versions of the survey, the Agency for Healthcare Research and Quality (AHRQ) has introduced versions of the CG-CAHPS survey to assess patients’ experiences with ACOs and patient-centered medical homes.

While the standard surveys are comprehensive, there may be times when you need to add supplemental questions to address topics unique to your practice or as required by other programs. HealthStream will work with you to develop questions that meet your unique needs, or you can choose questions from our extensive question catalog.

Survey Methodologies that Complement Your Patients and Your Practice
Whether you are considering the cost-effective eSurvey or the personal-touch telephone methodology, HealthStream will work with you to choose an approach that works best for your patients and your practice. HealthStream used guidelines provided by AHRQ, which created and maintains the CG-CAHPS survey, to design a variety of methodologies for administering the survey, including:

- Telephone
- eSurvey (email link to web survey)
- Mail
- Mixed Modes (e.g., a combination of phone and email)
Sampling Protocols that Promote Accountability

While the CG-CAHPS survey is designed to report data at the practice level, you can go one step further by setting a targeted number of completes at the individual provider level. Provider-level sampling promotes accountability and ensures each clinician in your practice has a sufficient number of completed surveys to have confidence in the results. Statistically-reliable results at the provider level are key to improvement.

Premium Reporting and Service
National Benchmarks

In addition to national and regional comparisons, you may also consider segmenting the data at the specialty level:

- Cardiology
- Family Practice
- Internal Medicine
- Medical
- Neurology
- Neurosurgery
- OB/GYN
- Orthopedics
- Pediatrics
- Rehabilitation/Physical Therapy
- Surgical
- Urgent Care
- Urology

Insights Online Reporting Platform

With Insights Online, you have everything you need to receive actionable insight into what your patients are saying about their providers and your practice.

- Compare yourself nationally: Benchmarks are available at the clinic and provider level, allowing you to see how you compare to other practices across the country.
- Save time by scheduling reports to be delivered via email. Insights Online allows users to schedule reports to be delivered automatically.
- Customized reports: With our advanced query and filtering tools, you will be able to generate reports that meet your specific needs.
- Stay informed with dashboards: Our dashboards are a quick and easy way to get the latest information on key performance indicators, trends, and current results.
- Prioritize improvement: Using the simultaneous analysis of importance, performance, and trending, HealthStream’s proprietary Priority Analysis report allows you to identify which survey items are most critical to your practice’s success.
- Multi-level reporting: Reporting options are available at multiple levels, such as at the overall organization level, practice level, and at the individual provider level. Insights Online allows you to roll-up results for selected practices or providers, as well as the ability to look at each segment independently.

Improvement Solutions

CG-CAHPS-specific improvement tools have been designed with a focus on the unique needs of the practice environment:

- Evidence-based Best Practices
- Educational Webinars
- HealthStream Competency Center
- HealthStream Community
- White Papers, Discoveries and Success Stories

Nearly 80% of hospitals that switched to HealthStream have improved their HCAHPS scores. Start improving your CG-CAHPS scores before they’re publicly reported.
EXCELLENCE THROUGH INSIGHT AWARDS®
These awards recognize hospitals that excel in their ability to gain insight about their patients, employees, physicians, and community through research and use that information to build excellence within their organization.*

Woodward Regional Hospital
2012 Overall Physician Satisfaction

Altavista Regional Hospital
2012 Overall Physician Satisfaction

Homestead Hospital
2012 Overall Physician Satisfaction

North Cypress Medical Center
2012 Overall Physician Satisfaction

Doctors Hospital
2012 Overall Physician Satisfaction

Heritage Medical Center
2012 Physician Satisfaction
Most Improved

Heartland Regional Medical Center
2012 Physician Satisfaction
Most Improved

Portneuf Medical Center
2012 Employee Satisfaction
Most Improved

Minden Medical Center
2012 Highest Perception of Quality

Baptist Hospital East
2012 Highest Perception of Quality

Wythe County Community Hospital
2012 Perception of Quality
Most Improved

Andalusia Regional Hospital
2012 Perception of Quality
Most Improved

New Hanover Regional Medical Center
2012 Perception of Quality
Most Improved

Civista Medical Center
2012 Perception of Quality
Most Improved

Nor-Lea Hospital District
2012 Overall Employee Satisfaction

Dyersburg Regional Medical Center
2012 Overall Employee Satisfaction

Sarah Bush Lincoln Health System
2012 Overall Employee Satisfaction

Laredo Medical Center
2012 Overall Employee Satisfaction

Parkway Regional Hospital
2012 Employee Satisfaction
Most Improved

Heartland Regional Medical Center
2012 Employee Satisfaction
Most Improved

Portneuf Medical Center
2012 Employee Satisfaction
Most Improved

Minden Medical Center
2012 Highest Perception of Quality

Baptist Hospital East
2012 Highest Perception of Quality

Wythe County Community Hospital
2012 Perception of Quality
Most Improved

Andalusia Regional Hospital
2012 Perception of Quality
Most Improved

New Hanover Regional Medical Center
2012 Perception of Quality
Most Improved

Civista Medical Center
2012 Perception of Quality
Most Improved

Williamsburg Regional Hospital
2012 Inpatient (HCAHPS) Satisfaction
Most Improved

Midwestern Regional Medical Center
2012 Overall Inpatient (HCAHPS) Satisfaction

DEBORAH Heart and Lung Center
2012 Overall Inpatient (HCAHPS) Satisfaction

St. Francis Hospital – The Heart Center
2012 Overall Inpatient (HCAHPS) Satisfaction

Hazel Hawkins Memorial Hospital
2012 Emergency Department Satisfaction
Most Improved

DeKalb Community Hospital
2012 Emergency Department Satisfaction
Most Improved

Platte Health Center Avera
2012 Overall Emergency Department Satisfaction

Hendricks Regional Health
2012 Overall Emergency Department Satisfaction

Elmhurst Memorial Healthcare
2012 Overall Emergency Department Satisfaction

St. Anthony Hospital
2012 Outpatient Satisfaction
Most Improved

St. Joseph Medical Center
2012 Outpatient Satisfaction
Most Improved

*Award winners are recognized based on data collected from the 2012 calendar year.

The HealthStream Awards of Excellence® acknowledge exceptional performance achieved by healthcare organizations with the use of our solutions. This annual customer awards program spotlights innovative programs and leadership that support organizational excellence, workforce development, patient satisfaction, physician alignment, employee engagement, and positive community perception. We are pleased to recognize our customers as they innovate new methods and processes that lead to quality improvements and, in turn, improved patient outcomes.
Memorial Community Hospital
2012 Overall Outpatient Satisfaction

Legacy Salmon Creek Medical Center
2012 Overall Outpatient Satisfaction

Memorial Hospital
2012 Overall Outpatient Satisfaction

Regional Health Physicians
2012 Overall Clinic Satisfaction

Elk Regional System
2012 Overall Clinic Satisfaction

Pikeville Medical Center
2012 Overall Clinic Satisfaction

Elmhurst Memorial Healthcare – Affiliated Physician Groups
2012 Overall Clinic Satisfaction

Sarah Bush Lincoln Health System
2012 Overall Clinic Satisfaction

Methodist Germantown Hospital
2012 Overall Satisfaction
Inpatient – Maternity

Vidant Edgecombe Hospital
2012 Overall Satisfaction
Inpatient – Maternity

Watsonville Community Hospital
2012 Overall Satisfaction
Inpatient – OB/GYN

Rehabilitation Hospital
2012 Overall Satisfaction
Inpatient – Rehabilitation

Baptist Medical Center East
2012 Overall Satisfaction
Inpatient – Pediatric

DEBORAH Heart and Lung Center
2012 Overall Satisfaction
Inpatient – Cardiology

Avista Adventist Hospital
2012 Overall Satisfaction
Inpatient – Orthopedics

Women & Children’s Hospital
2012 Overall Satisfaction
Inpatient – Med-Surg

Hendricks Regional Health
2012 Overall Satisfaction
Inpatient – Medical

Redlands Community Hospital
2012 Overall Satisfaction
Inpatient – Surgical

Trinity Medical Center
2012 Overall Satisfaction
Inpatient – Intensive Care

Mercy Medical Center
2012 Overall Satisfaction
Inpatient – Telemetry

Memorial Hospital
2012 Overall Satisfaction
Inpatient – Oncology

Methodist Germantown Hospital
2012 Overall Satisfaction
Inpatient – Step-Down

Johnston Medical Center – Clayton
2012 Overall Satisfaction
Outpatient – Same Day Surgery

Vidant Bertie Hospital
2012 Overall Satisfaction
Outpatient –Same Day Surgery

East Alabama Medical Center
2012 Overall Satisfaction
Outpatient – Rehabilitation

Johnston Medical Center – Clayton
2012 Overall Satisfaction
Outpatient – Lab

Rapid City Regional Hospital
2012 Overall Satisfaction
Outpatient – Radiology/Imaging

Littleton Adventist Hospital
2012 Overall Satisfaction
Outpatient – Radiology/Imaging

DEBORAH Heart and Lung Center
2012 Overall Satisfaction
Outpatient – Cardiology

Salina Regional Health
2012 Overall Satisfaction
Outpatient – Endoscopy

TriHealth – Good Samaritan Hospital
2012 Overall Satisfaction
Outpatient – Oncology

Saint Dominic—
Jackson Memorial Hospital
2012 Overall Satisfaction
Outpatient – Oncology

Miami Children’s Hospital
2012 Overall Satisfaction
Outpatient – Pediatrics

Saint Joseph East
2012 Overall Satisfaction
Outpatient – Women’s Health

Saint Luke’s Northland Hospital
2012 Overall Satisfaction
Outpatient – Women’s Health

St. Joseph Regional Health Center
2012 Overall Satisfaction
Home Health

Trinity Health System
2012 Overall Satisfaction
Home Health

Labette Health
2012 Overall Satisfaction
Home Health

Weld County Medical Center
2012 Overall Satisfaction
Clinic – General

McKee Medical Center
2012 Overall Satisfaction
Clinic – Cardiology

AZ Medical Center
2012 Overall Satisfaction
Clinic – Neurology

Lead—Deadwood Regional Medical Clinic
2012 Overall Satisfaction
Clinic – Family Practice
Sarah Bush Lincoln Health Center
2012 Overall Satisfaction
Clinic – Internal Medicine

Baptist Medical Group
2012 Overall Satisfaction
Clinic – Internal Medicine

Baltimore Washington Medical Center
2012 Overall Satisfaction
Clinic – Medical

Hartford Hospital
2012 Overall Satisfaction
Clinic – Pediatrics

Western Hills Professional Building
2012 Overall Satisfaction
Clinic – Surgical

Decatur Memorial Hospital
2012 Overall Satisfaction
Clinic – Neurosurgery

Alegent Creighton Clinic
2012 Overall Satisfaction
Clinic – OB/GYN

Weld County Medical
Clin-C/P-Women’s Clinic of Greely
2012 Overall Satisfaction
Clinic – OB/GYN

Regional Orthopedics
2012 Overall Satisfaction
Clinic – Orthopedic

Urologic Specialists of Oklahoma, Inc.
2012 Overall Satisfaction
Clinic – Urology

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EXCELLENCE THROUGH INNOVATION AWARDS

These awards recognize our customers that have executed initiatives within their respective hospitals that have led to improved outcomes, including, but not limited to process or quality improvements.

Pullman Regional Medical Center
Excellence through Innovation
Resuscitation Category

Bon Secours Virginia Health System
Excellence through Innovation
Healthcare Trends Category

Baptist Health
Excellence through Innovation
Healthcare Trends Category

Kettering Health Network
Excellence through Innovation
Talent Management Category

McLaren Health Care
Excellence through Innovation
Onboarding Category

St. Anthony’s Medical Center
Excellence through Innovation
Authoring & Instructional Design Category

SpecialtyCare
Excellence through Innovation
Compliance Category

THE PATRICIA E. LANE AWARD

Excellence through Individual Innovation

HealthStream created the Patricia E. Lane Award in 2009. Patricia was a HealthStream System Administrator, leader of the Virginia HealthStream User Group since its inception, and a 29-year employee of Rockingham Memorial Hospital in Harrisburg, Virginia. Sadly, Patricia lost her life in a tragic car accident in December 2009. She touched the lives of her co-workers and many healthcare organizations from across the state of Virginia who benefited from her expertise, sage advice, and leadership.

Recipients of the Patricia E. Lane Award are passionately dedicated to leadership and innovation in healthcare education.

Annette Dailey, Kettering Health Network
The Patricia E. Lane Award
Excellence through Individual Innovation
Elmhurst Memorial Affiliated Physician Practices serve families throughout Chicago’s western suburbs. With more than 110 physicians across 26 locations, they provide compassionate, quality care and a friendly, humanized approach in everything they do, for every patient they care for:

- Elmhurst Clinic
- Elmhurst Medical Associates
- Elmhurst Memorial Hematology/Oncology Services
- Elmhurst Memorial Primary Care Associates

“Every physician and staff member from the Elmhurst Clinic, Elmhurst Primary Care Associates, Elmhurst Medical Associates, and Elmhurst Hematology and Oncology are dedicated to providing exceptional service to every patient and their families.”

– Mary Stull, Vice President, Physician Practice Division

**CG-CAHPS Survey Results**
January - December 2012

“Using any number from 0 to 10, where 0 is the worst doctor possible and 10 is the best doctor possible, what number would you use to rate this doctor?”

HealthStream Database Percentile Ranking
72nd Percentile
Regional Health Physicians is comprised of more than 70 physicians who work with the largest physician network of primary and specialty clinics in western South Dakota. Their 17 locations include:

- Belle Fourche Regional Medical Clinic
- Buffalo Regional Medical Clinic
- Foothills Regional Medical Clinic
- Lead-Deadwood Regional Medical Clinic
- Massa Berry Regional Medical Clinic
- Newcastle Regional Medical Clinic
- Newell Regional Medical Clinic
- Pine Ridge Regional Medical Clinic
- Queen City Regional Medical Clinic
- Regional Orthopedics
- Regional Medical Clinic - Aspen Centre
- Regional Medical Clinic - Western Hills
- Regional Urgent Care
- Spearfish Regional Medical Clinic
- Spearfish Regional Medical Clinic - Derm.
- Spearfish Regional Surgery Center
- Upton Regional Medical Clinic

“To the culture of servant leadership is paramount to our success. We continually serve and empower employees to fulfill our motto, ‘patient centered, physician led, and performance driven care.’ This has a direct trickledown effect by empowering employees to meet the patients’ needs.”

— John. Y. Pierce, FACHE, CEO of Regional Health Physicians
"If I had to write up my dream job this would be it."
I am responsible for monitoring initiatives at the federal level that impact HealthStream and our customers. I primarily support HealthStream’s Research products around all of the various Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient surveys—HCAHPS, Home Health CAHPS, CG-CAHPS, In-Center Hemodialysis CAHPS, etc. I am also involved in tracking state and other national program requirements, such as the National Committee for Quality Assurance (NCQA) and the American Board of Medical Specialties, that require surveys as part of their certification processes. I work very closely with our product managers to ensure our products are current and compliant.

With the passage of the Affordable Care Act in 2010, we have seen tremendous growth in the number of CAHPS surveys that hospitals and providers are required or encouraged to conduct among their patients as part of their quality measures, public reporting, and Value-Based Purchasing. Just this summer, we have seen announcements on the national implementation of CG-CAHPS, In-Center Hemodialysis CAHPS, and Hospice CAHPS. All of the CAHPS programs have tremendous impact on our customers. We felt that the time was right to line up oversight of these programs under one person who could be dedicated to staying on top of developments. So, you could say that the government is responsible for creating this new position at HealthStream!

I’ve been in the healthcare market research field since the 1980s. Back then, there were no government-mandated surveys, so each survey was customized for each client. I distinctly remember our first patient satisfaction project—a customer wanted to survey its patients on an ongoing basis. This was a revolutionary idea that transformed our business. Prior to my new role, I managed our very talented Research Client Services team for 10 years.
What industry changes have you noticed over the years?

Perhaps the biggest change is the transition from measuring patients’ satisfaction with their care to measuring patients’ experience of their care. The CAHPS program has expanded from inpatient HCAHPS to include surveys that measure patients’ experiences across the continuum of care. These national surveys allow hospitals and healthcare providers to compare themselves to true national benchmarks and to focus on the issues that matter most to patients. Clients are no longer limited to their survey vendors’ client databases and unique set of questions.

Prospects should know how seriously we take our responsibility as their partner. As part of our vision, we continually look to develop products and solutions that improve the quality of healthcare. Everyone at HealthStream, from Bobby Frist and the board of directors, to our management team, to the operations and service teams and our professional interviewers, are committed to doing our very best. It’s a commitment that we strive to live up to every day.

What would surprise customers about HealthStream?

I think our customers would be surprised to know how much empathy we have for them. We are staggered just responding to the government mandates that impact the products we offer, and we know that we are just encountering the tip of the iceberg in terms of what hospitals are required to report on.

Something I’m very proud of is being involved in HealthStream’s decision to implement a CAHPS-aligned approach for all of our patient surveys. In 2007, well before the passage of the Affordable Care Act, HealthStream adopted the official CAHPS survey when available and created a CAHPS-aligned survey when there wasn’t an official survey in the public domain. Further, we centered all of our reporting and consulting services around the CAHPS products. That decision has helped our client hospitals stay ahead of the CAHPS tidal wave and to focus improvement across all care settings.
What makes HealthStream a great place to work?

For me, it's HealthStream's commitment to developing products that solve the big problems that our clients face. For example, the rapid escalation of CAHPS initiatives has required that HealthStream commit resources and our best people to creating products that stand up to the government's scrutiny, and that are also highly useful and cost effective for our clients. Even though we at HealthStream may never see a patient first hand, we all take our role in helping our clients improve the patient experience very seriously. We are passionate about what we do!

What do you like most about your new position?

If I had to write up my dream job this would be it. It allows me to research, write, solve problems, interact with clients, contribute to product decisions, and learn every day—all of which I love doing. I feel a bit like an investigative journalist, which is apropos since my undergraduate degree was journalism. It's worthwhile work that makes me feel like I'm making a difference for our clients.

Karin Sowser
Are You Improving?

76% of hospitals that switched to HealthStream have improved their HCAHPS scores

76% of hospitals see HCAHPS improvements after switching to HealthStream

National Percentile Rankings for HCAHPS

- Before HealthStream: 39
- With HealthStream: 64

Of the 204 hospitals that have switched to HealthStream, 154 (76%) have improved their HCAHPS scores.

Our Patient Insights HCAHPS research provides a complete solution for measuring and improving your patients’ perception of their hospital care. Our unique approach to assessing and improving patient experience is getting results.

To learn more about our HCAHPS Solution visit www.healthstream.com/HCAHPS