

Improving Patients' Experiences: How Primary Care and Specialty Practices Are Using the CAHPS Clinician & Group Survey

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Participants

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Lillian Martinez, Director of Operations at DMPG Clinical Practices

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Presentation

Operator

Greetings ladies and gentlemen and welcome to the Improving Patients' Experiences: How Primary Care and Specialty Practices are Using the CAHPS Clinician & Group Survey. At this time all participants are in a listen only mode. If anyone should require operator assistance during the call, press star zero on your telephone key pad. As a reminder, this conference is being recorded. It is now my pleasure to introduce your host, Ms. Donna Farley. Thank you, Ms. Farley, you may now begin.

Donna Farley

Thank you very much. Good afternoon everybody. Welcome to the Improving Patients' Experiences webcast sponsored by the Agency for Healthcare Research and Quality. This webcast will provide you with information on how primary care and specialty practices are using CAHPS Clinician & Group, which we also refer to as C & G, survey results. I'm Donna Farley, I'll be your moderator for the webcast. I'm the co-principal investigator for the RAND CAHPS team and I lead the RAND's quality improvement team as well.

You can listen to the webcast either through streaming audio, through your computer speakers or by telephone, and you would get the telephone connection by dialing 1(877) 445-9761. And enter the pass code 322108 with a pound sign after it. Please feel free to join us by phone at any time or if you experience any difficulties with the streaming video, streaming audio. You may experience a slight lag as the slides are advancing during our presentations. This is dependent on your own computer speed and the type of Internet connection that you have.

As you may already know, CAHPS represents a family of surveys that asks consumers and patients about their experiences with health care. The first CAHPS survey was the Health Plan Survey. These surveys were designed to evaluate

patients experience of care at the ambulatory and facility level. At the ambulatory level, this includes not only medical groups and practices but also other ambulatory settings, such as hospital outpatient clinics, public health clinics, for example. While we received a few questions in advance about our facility surveys, please note the focus of this webcast is on the ambulatory setting with the Clinician & Group Survey. We will be providing information for you on how to join our listserv later in the webcast so you can get notification about future events that focus on this as well as other surveys.

There are multiple versions of the CAHPS Clinician & Group Surveys just so you have this information and they meet the differing needs of different types of users. There are different versions of the surveys for adults and children as well as for primary and specialty care.

At this point I'm pleased to introduce what I think is a great lineup of speakers today for this program. Two speakers will present case examples of their quality improvement efforts for issues in patient experience of care in medical practice using CAHPS data. They are Lillian Martinez and David Finn, both of whom have led these quality improvement activities in their own medical practices. Lillian is the Director of Operations at the Department of Medicine and Professional Group (DMPG) Clinical Practices and she'll be talking about a project in a specialty practice office to improve office staff communications with patients. David is Associate Medical Director of Mass General Medical Group and is a primary care physician. He'll be talking about strategies for quality and service improvements in a primary care practice office.

Our third participant is Susan Edgman-Levitan who is Executive Director of the John D. Stoeckle Center for Primary Care Innovation and she is the co-PI of the Yale CAHPS team and the lead of the Yale's quality improvement group. She's also a co-author of the CAHPS Improvement Guide. Susan is responsible for managing the systemwide quality improvement efforts for Health Partners to improve CAHPS scores for physician communications in primary care practices and she'll be talking today in that capacity.

And as I've already identified and introduced myself, I'm serving as the moderator for today's webcast. In the webcast, we'll start with the presentations on the two medical practice quality improvement initiatives where Lillian and David will share their approaches and experiences with their work, one in specialty care, the other in primary care. These case examples are provided in response to requests from participants in our previous quality improvement webcast as well as from many others who seek to learn practical lessons from those who have already been through it. Following these presentations, we'll then have 10-15 minutes of audience participation questions, questions and answers with the audience. After which we will be moving into a panel discussion on a few key issues on quality improvement experiences. The three panelists will be the two speakers on their quality improvement examples as well as Susan Edgman-Levitan, who has had responsibility for system-level quality improvement efforts in a multipractice setting. And then finally, we'll have the remaining time opportunities for additional Q&A with the audience.

Before we get started I'd like to cover a few housekeeping items. We've learned from previous webcasts that you really learn from the "question and answer" session at the end of the presentations and we really do enjoy hearing from you. We encourage you to submit your questions throughout the presentations. As you can see on the slide, simply select questions from the navigation bar in the upper right portion of your screen. You'll then see a pop-up box and you should type your question into the text box and select send. You'll also have an option to send your question anonymously if you prefer to do it that way. Please feel free to send in your questions throughout the presentations. We'll address them during the Q&A questions. If you're unable to see the slides fully on your screen, in other words, you need to scroll to see the entire screen you can adjust your resolution to 1024 X 768 and that will fix the problem for you. Each operating system is different but you can typically do this by right clicking on your desktop and selecting display modes or display settings. Okay, one last item on here, anytime during the webcast you can access the slides, documents, and phone numbers by selecting the appropriate tab at the bottom of your screen as shown here. And if you have a need for help, things still aren't working for you, here's some of the information that you need for getting help from a variety of directions. You can select help in the upper right portion of the screen. If you're dialed in to the telephone to hear the audio you can also dial star zero. A common problem is not being able to hear the webcast through your speakers. Again, you can join us by phone at any time by dialing 1(877) 445-9761 and entering the pass code 322108 with the pound sign. Another common problem is having your computer freeze during the presentations. Hit your F5 button on your keyboard to refresh your screen. Remember that you may just be experiencing a lag in the advancement of the slides due to your connection speed. You can also try logging out and logging back in, if that's necessary. Finally, if you want to call for technical help directly, you can call 1(866) 490-5412.

And now let's head on to the program. Our first speaker, as I indicated, is Lillian Martinez. She'll be talking about improving communications with patients by office staff at a UCLA Medical Specialty Suites practice. This practice is part of the UCLA Faculty Practice Group (UCLA FPG), which has been working for several years now, on a group-wide initiative to improve patient experience of care in its member practices. To do this, the FPG has been using a multi-part strategy that includes BRITE training for office staff to improve their patient communication skills, a quality improvement collaborative with several of the member practices, and a variety of training programs for physicians. RAND has had the pleasure of working with the UCLA FPG as part of our CAHPS quality improvement demonstration work. The lessons we're learning from their experiences will be used to provide information and tools that others can use in their own QI activities and a good example of that is this webcast. OK, I'll now turn it over to Lillian to tell her quality improvement story. Lillian?

Lillian Martinez

Hello, everyone, I would say good morning, but I know some of you are on the east coast. Again, I'd like to introduce myself, I'm Lillian Martinez, I'm Director of Operations for the Department of Medicine and Professional Group here at UCLA. And I'm very happy to talk about what it is that we're doing here at the Medical

Specialty Suites, which I should preference that by saying that I was in the Medical Specialty Suites for just over three years and the practice included 11 specialties in all and some of the specialties included cardiology, gastroenterology, endocrinology, rheumatology, nephrology, pulmonary. We had a few internal medicine physicians and also our pulmonary and nephrology clinics included transplant, which were very, very heavily populated clinics. We are in 200 UCLA Medical Plaza, which is right there on campus in Suite 365. We had over 76 physicians and at that time about 65 office staff and we saw about 75,000 patients annually. The way that the office was that it was all on the same floor.

Obviously, that many specialties in one location is a little bit difficult to do but we had five corridors where each of the specialties were housed. Not all physicians were there at the same time, thank goodness, but, so we used those corridors to have different specialties but there was normally one primary specialty in each corridor and then staff were assigned accordingly so it went like A, B1, B2, and then C2 so that each one had their own nurses that primarily worked there, the front office staff and then we had a different call center which included several different people that were answering phones for multiple specialties. So we can go to the next slide.

So when I came to the office I found that some of the staff had a sense of perhaps being entitled, that this is where I am, this is where I work, and what can UCLA do for me. That was somewhat of a problem because we wanted our patients to feel that we are there to serve them and not of, you know, why am I talking to somebody who is not having the welcoming feeling that I should be getting. So we really wanted to do something in order to fix that issue. In seeing that, I was also walking the space quite often and seeing what the interaction was between the staff and the patients, not just in person but over the telephone as well, and the problems that I identified were reflected in the CAHPS survey scores. So at that time, the clerk receptionists, the helpfulness score was 84% and the clerks receptionists was 90% in courtesy and respect. You might not think those are bad scores but we thought we could do better so we had set our goal to make that -- make that our priority to improve the scores.

So our director, Laurie Johnson, was working on an initiative to start a training program where we could have customer service be the focus of that. And that came, that came in the form of BRITE and BRITE stands for Begin Right with Instruction Through Education. Laurie had been working behind the scenes and she hired somebody to facilitate that. And that was Lisa Surgy who was just wonderful. She really had the same buy in that we all needed, identifying that this was an issue in several of our practices, not just Medical Specialty Suites, and took that and spoke with the managers, spoke with different people in the organization, directors, physicians, to see what it is that she felt we could do to improve this.

So the Faculty Practice Group established training for the staff and managers. And that class for customer service was connecting with the customers. They also initiated classes for our computer system, which was Registration 101 and Managed Care 101. And then the second class to connecting to the customers was Working with Difficult Patients which that's actually now changed to Dealing with Difficult Patient Situations. So how BRITE training was provided is that the initiative had to

be the -- excuse me, the managers had to take the class first. They needed to go in to see what the -- what the staff was going to be learning and what we needed to do to confirm that the information they received and to make sure that we were reinforcing the behavior once they came back to the job, which I thought was incredibly important. And then once the managers took the class, then, staff could go but the staff could not go unless the managers took that class first, so that's important to know.

Sending staff was a challenge, which we'll discuss later. But we only sent a few at a time because, as you know, if you're working in a practice, you need to make sure that everything is being covered, your phone lines, the front desk, the authorization staff, you need to make sure that there's people everywhere so, again, like I said, we'll talk about that in a little bit but that was a challenge. So from the very start, when I did see what the interactions were and looking at the survey results I was eager for the training, I definitely bought into it. I did participate in the first survey or excuse me, session, which was, I believe in February of 2007. Once I took it and I sent my supervisors to it, then I started to send the office staff. And this was a mandatory thing. People did not have a choice. They got paid for their regular hours so they needed to go to this class.

The approach was train the staff in the order that the patients encounter them. So we put ourselves in a position of what does the patient experience when they are -- when they're trying to make an appointment or trying to get in to us for the first time. So normally they're calling. So that would be the people on the phone. We took about two to three from each corridor and then they go to the front desk to check in once they've made their appointment, so some of those people as well. Then, if they go in for the appointment and they're given an authorization then they deal with authorization staff, so that was the next group that we sent and then the nursing staff. I have to just say on the nursing staff, that was -- that was tough because nursing staff is always somewhere where we feel we're short but we did end up sending everybody. So new staff were set up for BRITE training from the moment they get on. My process is when the staff member comes for their first day I set them up for everything at that time because classes are not every week. Next slide.

The office manager's role to reinforce training is, I think, crucial. The manager must be -- must actively reinforce the patient communication practices taught in BRITE. Monitoring -- so in doing that, that is where I was able to see the changes in the staff. I was, again, walking the floor constantly, looking at the interaction between the patients and the staff at the front desk and then also in the call center. Really, I started to see a change immediately. Even when they came back from the class the next day or the same day people had a better, a better idea of why they were there and I thought that was really important. So the message that we used to reinforce the training, I know it sounds a little bit elementary but we had gold stars. And we would, whenever we noticed there was positive interaction, we would give them the gold star and say we are recognizing that you are doing a great job. We also did that publicly so that they would know that this isn't something that is taken lightly, we want everyone to know that this is what the expectation is so hopefully that they would get the public recognition as well. Whenever we saw somebody that wasn't doing what was taught in BRITE we would take them aside and privately speak with

them to let them know we wanted to see more improvement, or where we could help them improve. Next slide.

Success from the training. Like I said, when the staff would come back from the training that day or next day, they would come to us and say, "I am so glad I went to that class. I remember things that when I first got here, that I had been excited about working in the medical field. I'm, you know, I'm eager to get on the phones and get one of those gold stars." That was heard by other staff. The other staff would come and say, "when am I going to go to training?" It was a very positive experience for people. I have to say that I feel that the people that trained in that class are instrumental in getting the staff that attend to be excited about what it is that they're doing. And it really was pretty quickly that we were able to see the difference in the interactions with the patients and with each other. We consider our customers, which is what they teach us in the class, to be anybody that we come in contact with. Our patients, our physicians, each other, other departments, so we did reach sustainability but we always need to reinforce the behavior and to make sure that everybody knows that once they leave the classroom, it's not something that that stops there. We just need to continue that as the manager.

We did experience some challenges. Scheduling the staff to go was a bit difficult, especially with the nurses, like I said. And at first, before we sent people, there was some resistance, saying, you know, why do I have to do this, I'm already so backed up in the things that I'm doing, but that did change once they started to go. And then cardiology was a bigger challenge for me because it was managed independently and they had a smaller group of people so coverage was much more difficult to obtain. But eventually we did get everybody on board. So the effects on the staff behavior, that was observed by the managers, so I was a manager, I also had a set of supervisors, three supervisors. And, again, almost immediately we saw a different demeanor. They had a pep in their step. They were smiling, and their conversations with the patients on the phone and at the front desk had improved tremendously. And then we could see that throughout the suites. It was from A-C as I mentioned before with the corridors the way we have them, they were working together better. It wasn't anymore this person isn't helping me, this person isn't doing that, or why can't this happen? It was more, thank you so much for helping me, or is there anything else I can do for you? Truly it was amazing. We have a mystery caller report that we -- that we receive from the Faculty Practice Group. I could see that the numbers on the scores for those reports were improving. Patients had additional things to say about how they appreciated how they were treated once they called. I did receive e-mails from physicians, instead of receiving e-mails saying so and so did not do this, they, you know, were rude to my patient or something like that, we started getting e-mails that I just want to let you know that so and so is doing a great job, that they have really, you know, gone above and beyond for this patient, I want you to know this is happening and please do something to reward that behavior. Then we also were doing reports for our new consults. We were calling them to see how their experience was. Again, positive feedback from that. And I think that's all a result from that BRITE training. Next slide.

Here's where you can see that our CAHPS surveys improved. This is the helpful office staff survey. You can see the red line is for our Medical Specialty Suites and

the blue line is the for the UCLA Faculty Practice Group which encompasses all ambulatory clinics. You can see when we started it was lower than the mean for the Faculty Practice Group. And once we started BRITE training, it significantly went up and we're very, very proud of that. Next slide.

What I can tell you about our lessons from our experience is definitely the managers and supervisors should keep an open mind and physicians as well as their -- if they are working with the supervisors. Keep an open mind. Look at the training as a quality improvement/performance improvement project. Accept that training is not always going to change some of the staff but that the majority will respond. You need to have effective, enthusiastic trainers. And we absolutely have that within our own BRITE training program. They were absolutely key. People would come back and not only speak about how much they learned from the class but how great it was that they had a trainer that was very enthusiastic about what -- the material that they were teaching. And, again, the first thing you need to do is go to the class yourself. See what it is that your staff are learning and possibly make suggestions for other things that you feel could be in there or take out and try and mold it to what it is that you yourself are identifying a need for improvement within your clinic. Another thing is to meet with the staff regularly to share the information, the feedback that we receive from the physicians, from the patients, so that they know that they are making a difference and that their efforts are being recognized. And then after staff, once they return, you know, how did you feel the training went, is there anything you feel you didn't get on there, is there something that you suggest that we add to that, so they know you're very interested in their portion of what they're getting from that training. And, again, reinforce that, the positive action that they're having with all of their customers, with public praise. What we did is we had regular staff meetings and we would publicly say we just want to let you know so and so has received three gold stars because of their interactions with our patients. And they received letters from Dr. Smith and Dr. Jones thanking them and thanking us for being able to improve the experience that our patients are having. So that truly is -- and I'm so proud to speak about this initiative for our BRITE training because it really has made such a huge difference for us and we were excited to continue sending staff to it. It's just been a very, very positive experience for us. Thank you.

Donna Farley

I will be turning it over now to Susan Edgman-Levitan to give a little background on what is happening at Mass General and to introduce David Finn. So we can move on to that. Susan.

Susan Edgman-Levitan

Yes, thank you, Donna. Can we move on to the next slide? One quick thing I just want to mention. Donna introduced me as being from Health Partners, and I would be honored to be from Health Partners but I'm actually from Partners Healthcare.

And what I'm going to be describing very quickly, so that we can get on to hear David talk about what he and others in his practice have accomplished is an initiative that's been underway for about three years as part of the Partners Community Health Inc.'s Pay for Performance Initiative around improving the patients' experience of care. Let's go to the next slide.

This initiative was started and this was a pay for performance arrangements with Blue Cross/Blue Shield of Massachusetts for several reasons and I'm sure many of them will be familiar to people on the call. We knew the environment was changing with respect to transparency, that performance measures were going to be publicly reported and in fact, here in Massachusetts, patient experience of care measures at the practice level had been publicly reported for several years and we also knew that at some point, cost-shifting was going to move more to patients and they were going to be looking very hard at patients experience of care data, other quality measures to make sure they really wanted to pay a higher copay to see a specific physician in a specific practice and finally patient centeredness is one of the six IOM aims. Let's go to the next slide.

From the perspective of the overall system we also were very committed to this because we know that improving the patient's experience improves clinical outcomes, it improves patient adherence, it improves patient safety issues, we know it reduces malpractice risk. We've done some internal analyses with our malpractice insurer and have found that if a physician or someone on his or her office staff receives a complaint to our patient advocacy office, if they receive more than three complaints in a year that they are four times as likely to be sued and we also know that patients are really the only ones who can judge many aspects of quality. Next slide.

And then the final reason and I think this is the one that from my perspective is very important to emphasize when you're working with clinicians and practice managers and front line staff, and that is there is absolutely no way that we can improve the patients' experience of care unless we pay very, very careful attention to what it's like to be a physician in the practice, a nurse in the practice, a front desk person in the practice and we do everything we can to make sure that their quality of life is as good as it can be. It's very difficult to do things for patients when you're working in dysfunctional systems or you actually don't even know exactly what your job is or you have to work with physicians who all have a different practice pattern and don't really realize it. So this is a little bit about the rationale for why we decided to do this. Let's move to the next slide.

And I just wanted to give a very brief overview of the way that this contract was set up. The first year we had to do a physician oversample of our primary care physicians and we did this in all of our practices. We have 15 large groups, some of which are large academic medical centers such as Mass General or Brigham and Womens' Hospital. We have several community hospitals, Falkner (ph) Hospital, Newton Wellesley and North Shore Medical Center, and then we have many community-based practices that are spread all over eastern Massachusetts, so all of the physicians, the majority of the physicians in these practices received an individual report about their patients' experiences with them. We couldn't do this in a practice where they were not seeing enough commercially insured patients to qualify for the oversample. Then in 2008, for every practice that had a composite on the survey that was statistically significantly below the state-wide mean, they had to create a performance improvement plan that we then submitted to Blue Cross and we helped them with the standardized format, we actually populated a lot of the

documents for people because we know how busy people are and they had to customize it to the specific things they were planning to do and who would be the leaders in the practice. And now we're at the point that is perhaps most critical. MHQP is back in the field surveying now and our goal is to achieve an 80% improvement in the practices that submitted the performance improvement plans, I'm sorry I want to correct that. That could be confusing. Each of the practices that submitted an improvement plan has to either reach the state-wide mean in their 2009 scores or they have to have a 5% improvement in their overall score. And so we will know how we do in early 2010 but many of our practices collect ongoing patient feedback using the clinician group CAHP survey so we've had an opportunity to check in many places to see how we're doing and so far I'm not staying awake at night every night, so I'm optimistic.

Let's go to the next slide: Just so people know we had about \$5 million riding on this particular pay for performance initiative, so I mentioned several of these things on this slide. We met the contractual obligations for 2007, 2008, and I wanted to give a quick overview of the kinds of support that we've been providing to our practices. We have a variety of courses that focus on everything from improving patient adherence to medications to doctor-patient communication. We have a program for our office staff that is very, very similar to the BRITE program. And then we also offered a program for our medical directors, associate medical directors and practice administrators that was a workshop run by the Studer Group that was extremely well attended, quite popular and I think has really motivated many of these practices to take on other initiatives that are helping improve the leadership, the capacity for process improvement and other things. Let's go to the next slide.

And we also had staff at the Stoeckle Center who actually went into the practices, if they were interested, to do consulting and work directly with the staff of the practice. And so I think overall this has been a -- it's been a very robust effort. It has been very labor-intensive because of the scope of the practices that we're working with. But I have to say that we are very, very heartened by the results we're seeing and partly what I mean by that is the way that physicians and practice managers are responding to these kind of data. Initially, when we did this in 2005, people were very resistant to the data, they didn't really trust it, and I think that's totally turned around and, if anything, now they want more and they really want more ideas about what they can do to improve. I think that's my last slide and now I want to turn this over to David Finn who is the Associate Medical Director of the Mass General Medical Group. And David and his practice have done some very interesting work in this area that I think will be very interesting for you all to hear about. Thank you.

David Finn

Thank you, Susan, and thank you for having me. I hope that the experience that we've had in our practice at Mass General is something that will be -- resonate with people and will be something that can be applied whether it's a primary care practice, a specialty practice, and we can certainly learn from where we've been and where we hope to go and learn from each other. Mass General Medical Group was established in 1994. We are eight primary care physicians, three managers, seven residents, we have five part-time nurse practitioners, three nurses, four secretaries, four medical assistants, as well as several additional front desk staff, a radiology

technician, a pharmacist has been in the practice at times and on average the staff has been employed in the practice for about five years, so we have a relatively low turnover. The management structure in the practice includes a medical director, the associate medical director, which is my position, we have a clinical nurse manager, an operations manager, a business manager, as well as on our management team we rotate every year either a nurse or a nurse practitioner with another physician in the practice.

About two years ago we decided as a management team, as a practice, to structure the practice along care teams. And we did that because we thought there would be a lot of pros for continuity for patients, continuity within communication for them, it would allow us to also do more internal or piloting of projects within the practice and so we aligned two physicians with a specific medical assistant, a nurse or a nurse practitioner and a secretary. The cons of that system and what we found some of the challenges are of course sorts of cross-coverage between the teams, the mentality of being, you know, on a team, in a silo versus a part of a larger practice and when someone on the team is not there, what do you do next? So we're sort of moving along on our team structure and thinking about all of the different projects and initiatives and directives that we have to do as a practice and I think this will resonate with a lot of the people on this call because as a management team we would have a retreat once a year to sort of prioritize where we're going as a practice, what we want to do and we decided to use our retreat in the summer of 2008 to kind of prioritize all of the different projects, initiatives, directives that are either internally derived, things we wanted to work on as a practice, externally placed upon the practice, be it a pay for performance initiatives, other directives, and we tried to -- trying to prioritize what we wanted to accomplish, you know, in the next year. As we were doing this, we as a group, all the people on the management team thought we really needed to take a step back and look at what are we really trying to accomplish and how will these projects align with our practice, goals, ideals and vision as opposed to making the practice fit into the project and how do we provide the highest quality of sort of care and service to patients and to ourselves in the practice. And this was really the kickoff of our overall, you know, quality and service initiative.

So what we decided to do as a management team was we actually surveyed our entire practice. We surveyed everybody from the front desk person, all the doctors, the management people and we asked them to define what does quality care mean to you, what does quality service mean to you, what do you need to do your job better and what are the obstacles to this? And the responses were overwhelming, pages and pages of responses, from everybody in the practice, 100% participation in the survey without any reminders or prodding which is fairly rare for surveys. So people had a lot to say and wanted to share how they wanted to take care of patients.

I'm not going to go through all the responses and all of the different things that people said because that'll take, you know, a lot of time but I wanted to share a few things in terms of quality care that were both provider and staff responses and you can sort of read through these and see them. There's sort of unanimity in wanting to really give exceptional care above and beyond the way people would want to be cared for themselves or for their families, some of the responses in terms of quality

and service that providers and staff sent back to us. And then more challenging, of course, now was the question of what are the obstacles to giving this kind of care and service and how do we make it so that that can be delivered. We took all of the responses and they really broke down into about five categories that focused on communication, access, resources, and environments, or the physical environment, the patient experience and, of course, teamwork. The overwhelming majority of responses all really focused, in the end, on teamwork. And so we viewed these different obstacles or these areas, sort of care teams as opportunities. How do we take the obstacles and make them into an opportunity to see what we can do to provide that highest level of care and service. The obstacles that people talked about, both providers and staff, as you hopefully can see, had to do with lack of communication, lack of coordination, lack of support for each other. I suspect this will again resonate in a lot of offices and staff in and around the country. I don't think this is unique, unfortunately, to our office. So what we realized as a practice was that what we were really talking about was a core value and a core culture in the practice that we needed to change. That we needed to enhance professionalism, recognize and reward accountability in investment in the practice, initiative in the practice, move from a culture that is good enough to the best we can be for everybody, to have a much clearer vision and goals and to get out of neutral, to get out of being stuck in doing the things we had always been doing because it had worked OK, and people had been generally pleased, both staff and patients overall, but it wasn't good enough and it wasn't going to get us to where clearly not just the providers in the office wanted to be but everybody in the office wanted to be at based on the responses we got from the surveys. And we felt that if we do these things, if we really work on kind of culture change then that will allow us to provide that highest level of quality of care and service to patients, to families and to our practice.

So in the end we came at it from a slightly different perspective in terms of starting with really changing the culture, which we can then respond to a survey, whether it's this particular survey, the CAHPS scores, pay for performance issue, whether it's some other directive that comes down the line. My strong feeling and where we are at as a practice is that we can adjust ourselves to address one of those issues at any one given time and we can focus energy and effort on improving a particular score or achieving a particular pay for performance goal but if we don't fix the underlying culture to do what the practice wants and people really seem to crave and respond to, then we won't -- that benefit will be transient. We'll score well at one point and then it won't be sustainable. What we really realized is we have to do something that will be sustainable for the long-term to address whatever comes down the line because the only thing we know will change is the questions will change, the pay for performance initiatives at some point will change, the way medicine is delivered will change, we have to have a culture that's adaptable and able to change with it.

So how do we actualize our goal? How do we then move forward in this quality of care and service initiative? The first thing we did realize is that you need full practice involvement. From the person at the front desk who checks in patients has as much to say and just as much to improve the practice as the medical director. We did do a lot of training and utilization of resources that were available through the hospital,

the LEAP program which is an efficiency in technology and electronic record program which involved a lot of teamwork and piloting projects. We have a Front and Center program here which sounds similar to the training described earlier in terms of staff training and service training that Lillian described and that, we sent everybody to as well, physicians, providers, front desk, everybody. We have a Medical System Professional Development series and other ongoing staff of continuing education support. We did management training. We did attend Studer Group conferences, the GPIN conference, leadership academies here, as well as sending some of our managers to the Disney Institute to get a sense of how people do things around the country and what are some people already doing and what can we learn from others.

We then had an all-practice retreat where we actually closed our entire practice for a full half of a day and had an offsite retreat with everybody where we broke the practice up into these care work groups we called them, a group of communication, access, resources and environment, with an underlying theme of teamwork in each group. And we charged the work groups to come up with solutions to the obstacles that they had identified earlier in the survey of the practice. And communication, it focused much more on internal than external communication, how we communicate with each other, access, in terms of phones and patient e-mail, resources for ongoing education, both patient and staff, technology, and, of course, environmental resources and working on the patient experience here. And we charged each of those work groups to then come up with proposals and plans to bring back to the practice in the future.

How do we keep up the momentum, sustain enthusiasm because there was very widespread enthusiasm as this has been going on now for about a year and a half. We did start a reward and recognition program called an "I notice" program started by our clinical manager, Linda Johnson, who designed this where people can come into the practice and all around the practice and every exam room there are cards that people can fill out that recognize and notice service or care that sort of goes above and beyond what is expected. Those are put into anonymous boxes, they're reviewed, they're shown publicly, the top ones are and anyone who gets a card gets a gift card bonus. At the end of the year we have a committee that's going to vote on the top one that really exemplifies what we're trying to do as a practice and that person will get a significant bonus. We have bi-annual all practice retreats and team building exercises scheduled. As I mentioned, we have staff involved in all of our work groups. We are developing ongoing action plans from the staff and patient surveys in conjunction with this initiative and this is we're trying to as I was saying earlier put the surveys into the culture and not in allowing us to move forward in a way that's more seamless. And then, of course, trying to find resources to support all of these efforts.

What have been the challenges? I'd like to quote the medical director of our group, Steve Levinson who often likens these things to changing the tires while you're traveling 60 miles per hour down the highway. That's really what we're trying to do. Because at the end of the day we still have to care for the patients. It's still a very complex world in medicine and primary care especially as more things are kind of put on the shoulders of the primary care teams and the primary care staff and the

primary care physicians. So how do you do try to do these things, how do you try to change the culture at the same time and what are the obstacles in the road while you're traveling? One of them we found early on was fiscal. We started this in 2008 and then the bottom of the economy started to fall out. And so even doing things like closing the practice for half of a day has a financial impact. Support for some of these initiatives, for some of the ongoing training, some of the conferences and things like that are more difficult to find now.

And so it is a challenge. We realize that setting the bar alone and doing some of these training programs, while fantastic, is just not enough. And one of the messages from my experience that I really want to share is that you need to have ongoing coaching and training, you know, as I said the one-time seminars are great, but if they're not constantly reinforced and constantly coached and the people who are doing the coaching are not constantly being retrained as to how to do that coaching, then the effects can be transient and we've seen that with some of the people. And finally if someone's not on the bus in terms of wanting to get involved, wanting to participate in this, how do you do that, how do you either raise them up and give them the opportunity to do so or if they just can't, how do you, then, figure out ways to actually replace those people, how do you integrate all of this change into the daily practice life. So those are some of the main challenges that we found.

As far as some of our numbers, we were starting at a much lower place than Lillian's group. I would have loved to have seen those numbers back in 2007. Clearly we had a lot of work to do and we've made some improvement although not nearly the numbers that we ultimately want to see. I mean, our aim is to be, you know, the best practice, the best rated practice across the board and for it to be reflected in this and I hope and expect that with our ongoing efforts it will be. And finally, I think this last slide sort of captures the essence of what we're trying to accomplish. Many of you may have seen this quote before, but President Lyndon Johnson was touring Cape Canaveral during the space race to the moon and during his visit he came across a man mopping the floor and he said to him, "What is your position here?" And the man looked up from his pail and proudly replied "I'm sending a man to the moon." I think it was mentioned earlier and certainly worth repeating, I think everybody who works in healthcare chooses to do so ultimately because they want to help people. Secretaries could probably make more money and work in a different area. Front desk people as well. Physicians, nurses, management, whoever it is, I think everybody ultimately wants to help people, wants to feel like at the end of the day, that they did something to help other people and to be a part of a team that does that and this is the mantra that we're looking for and this is the essence of the culture that we're hoping to accomplish here and I'm confident that we will and that although it will be a long process, we will get there. So thank you very much. And that's everything I have to share.

Donna Farley

Thank you very much, David. That was very helpful, very informative. Shows a lot of group dynamics which we all know is important in this process. We're now going to have a brief time for questions and answers from the -- from those of you who are attending the webcast right now. We're a little bit behind schedule so we're going to just have a few and then we'll have time later. A reminder, you can send the

questions by clicking the word questions at the top right of your screen, click on new and type the question into the box and select send. You can ask anonymously if you want to. We do have some interesting questions and we'll turn to them. I'm going to go with one question for each of Lillian and David right now and then we'll pick up some other ones later. First of all, for Lillian's presentation we have a number of requests for additional information on the BRITE training and we'll work with Lillian and others at UCLA Practice Group to see what information we can provide and hopefully get posted on the CAHPS website as resources. Lillian, a specific question that came in was with regard to how the physicians were involved in the work related to the BRITE training, what their reactions were to it. How did the docs in your practice support or impede the project and what kind of involvement did they have in it?

Lillian Martinez

Well, great question. We did speak with the physicians who -- the ones who their staff were being affected by this because we wanted to let them know, you know, this person is going to be away from the office for a bit, so please be patient with us while we get this training implemented. And, of course, because it seems that every office is always short-staffed we did hear the, you know, "you can't let them go, we need them here in the office, what we really need is to cover the front desk, we need to have our phones answered, I need to get my messages," and we did explain that we were hoping that with the training that the staff would receive that it would even help them be more efficient in their duties in the office. It was a little tough, I'll be honest. But we told them that it was mandatory and that our ambulatory scorecards would start to reflect the numbers of the staff that had been trained and so, you know, we went ahead and did that. Sometimes the supervisors would have to jump in and cover the staff, cover the staff position in order to make sure that everything was being taken care of so I would say that that was definitely a challenge at the beginning but, again, as I said, when the results of the surveys were showing up on our scorecards and the staff was coming back with a different kind of attitude I might say that they were enthusiastic. They would come to me and say, "when is so and so going, when is this person going, when are we going to get all of our staff trained and the other departments going to start their staff as well?" Because of the challenges that we have with dealing with different divisions throughout the university. So I would say that at first it was difficult but we did want to let them know what we were doing so that they weren't feeling like they're not involved in the process. So that's what I could tell you. But at the end it really worked out well.

Donna Farley

Thanks, Lillian. David, we have a question here on the importance and issue of changing culture. Could you comment on the role of leadership in improving patient experience based on the work that you did with your strategy development?

David Finn

Yeah, I mean, I think it's critical. I think it has to be leadership from the top, I mean, I think if the medical directors, if the physicians, if the hospital, whatever is the leadership in your particular area isn't actively involved in doing the culture change, so to speak, themselves and allowing themselves to be trained and coached and involved then it's doomed, I think, to fail. I think that you have to have involvement of

everybody in your practice. And I think that, you know, it especially includes the physicians. If their behaviors and activities that the physicians are not doing well with, it has to be pointed out and coached and expectations have to be high for everybody so I think you can't just focus on, you know, phones, on the secretaries, on this or that, if we're trying to have an overall culture and if the culture change involves turnover it doesn't often only necessarily mean staff. It may mean management, it may mean other physicians as well.

Donna Farley

OK, thank you, David. Now we're going to move into the panel discussion section of the program and hopefully, and -- and I -- I encourage all of the speakers, as you respond to the questions and issues in here to keep your responses quick and succinct, if possible so we can get through as much as possible and buy a little time at the end for more questions and answers with the audience. We've asked our panelists to consider these four topics during the panel discussion. And we're also going to be asking for some contributions from you, the audience, as we consider each of these, through questions that we'll be asking you.

And we'll move on to the very first one which is priorities for actions and this is an opportunity to put your own vote in in terms of some of your experiences with your own organizations in establishing priorities. How does your organization balance the quality improvement priorities for patient experience of care in other dimensions and you'll -- I'll ask you to collect -- select one answer. Either that it has an importance in its own right, that you have balanced experience in other quality dimensions, that patient experience has lower priority or it's not viewed as quality. This will set the stage for some of the questions that the panelists will be talking to. And we all know that the priority setting is not only the first step in the process, but it's both an important and a difficult one to do. I know this is one of the things that we hear from many organizations as we work with them, the challenge of actually making that decision on where do you start, you have limited resources and you've only got so much that you can work with. So we've got a few votes in here at this point, looking for a few more but I'm going to go on and publish the results at this stage of the game and we can see that quite a few of you actually characterize patient experience as important in its own right and many of the rest of you balance it with other quality dimensions so that sets a nice frame for the discussion that we will be having with our panel members.

The question for the three panelists, Lillian, David and Susan in this topic are what trade-offs did you consider as you selected issues for your priorities and what types of data did you use and were most useful for you to do this? David, let's start with you, if you would.

David Finn

Sure, no, I think as Susan pointed out earlier, the patient experience and their perception of the care given to them is critically important and there's plenty of evidence to show that the patients that are more satisfied, that feel that they are getting better service from their physician and from the office in general, will do better, they'll have better health outcomes, they will be more compliant with medications, all of the things that we want to otherwise do. So from my philosophy

and the philosophy of our group the patient experience, from everything from the phones to the wait times to the times with their physicians is really the top of the quality because quality and service are so intricately linked. And I think if we can just the idea of the culture change, if we make that patient experience great, then I think a lot of the other quality improvement initiatives will follow along that line. You're more likely to make sure they come in and get their hemoglobin A-1-Cs checked and all the other things we need to do that fall under quality initiatives, so I think it's at the top of the list for us.

Donna Farley

Super. Thank you, Susan any thoughts from you -- from your experiences?

Susan Edgman-Levitan

I think one of the things that I would emphasize from our experience is the incredible value of physician level data. The physician level data that we collected was shared with all of the physicians in the practices, however, each doctor's data was blinded so they could see how they did compared to their peers in the practices, their peers across the healthcare system and then their peers in the state but the reason why it was invaluable to us is that you could very quickly look at a practice and determine whether you needed to go in and do some very targeted improvement work with a few people and sometimes it was just sort of helping them manage the way they were handling their panel of patients better or their scheduling better versus having an entire practice go through a quality improvement initiative when maybe that was not at all necessary.

Donna Farley

Okay, that's great, thanks so much. That comparison and targeting is, I think, a really important point. OK, on to the next question. And this is stakeholder involvement. It's a topic that I think we've all struggled with at one point or another and I'd like to ask those of you in the audience that if you think of a recent quality improvement project that you've done which of the following stakeholders in this list here were the most difficult to engage or commit to your initiative? This is one where you can select all the answers you think apply. Do that and click the vote button and we will see what kind of mix we get here. OK. The -- we've got some coming in. The experience that I've had as we've gone through some of this work is that many teams, when they're starting to implement something, forget that there are as many different groups of people that are either involved or affected by this and that the stakeholder issue is one that people have -- even very experienced people tend to trip over as they go. And I'm going to publish this now so that you can take a look at some of the results that we've got here. And we've got a big chunk of votes for the executives, leaders of organizations, and physicians as challenging groups to bring on, on board. So let's turn this issue over to our panelists and ask them this question. Again, on the same issue. How did buy in from key stakeholders or lack of it affect your QI progress in the work that you've just described and what would you advise others to do to build that buy in? Lillian, how about you?

Lillian Martinez

Sure. So we did, when this initiative was set, we did let the staff and the physicians and the supervisors know that this is something that we were trying to improve,

again, that we wanted it to be our number one priority. Obviously, aside from patient care. And that we felt that it would ultimately truly change the experience that our patients were having, that our physicians were having with working with the staff. So it really was something that we went to them with and said this is what we're going to do. Like I said previously, some of the physicians were a little bit resistant because they felt that it was going to take their staff away when they truly needed them. But in the end, again, it worked out. I would probably tell other people to do the same thing, to just keep everybody in the loop as to what's going on, as to what your expectation of the office is overall so that everybody feels like they're not being left out, everybody knows what the expectation is, they know that this is an important thing to you and that they should also be kind of mirroring that to let people know, OK, you're going to go to this class, I'm excited that you're going and let me know how you did after you get back so, again just communication I feel is key.

Donna Farley

Good. Thanks, much. David, what about your experience here?

David Finn

Yes, I think it mirrors the response there. In terms of buy in, physician buy in has been difficult and has been a challenge. A lot of that isn't because physicians in the group don't want to do these things. A lot of it comes down to time where a group that does see patients both in the office and we see our own people when they're admitted to the hospital as well so we round in the hospital and with all the paperwork and everything else, to really take the time either away from the practice and close to do retreats and engagements or to participate in some of these care teams and work on some of the areas in the communication access resource environment area, you have to show them that there's going to be some tangible results. So I think doing things that are targeted as the individual groups come up with their own solutions to the problems that they identified, doing them as a group and making sure everyone is involved but having that involvement be to their liking and what we did is we had, we told everyone in the practice, physicians included, they had to be on one of these groups but they could choose which area they wanted to work on, whether it was communication access, resources or environment, and they could have a role in actually affecting the outcome of that initiative, whatever it was. So I think having full involvement, having small projects that you can clearly show a benefit to and to some degree trying to find protected time for it, and all the meetings and things that we do have for the staff, they're all during the daytime so they don't really lose any of their income or salary but to ask the physicians to not see patients that does directly affect them. So I think to try to find some ways to protect that will help get buy in from the physicians which I think is just absolutely critical to sustaining any progress in the practice.

Donna Farley

Great. Thanks, David. Now on to the next one which is important factors in the implementation process and this list, in fact, is the same list that we're going to be laying in front of the panelists. But, again, in your Q -- in your QI work, those of you in the audience, which of the following factors have you found to be most important to carry out successfully? And, again, this is another one where you can select all answers that apply to you so that you can look at, you can identify more than one of

them. We found quite a diversity among organizations that we've worked with over the years in terms of which ones of them tend to be most important to what they're working on and sometimes it looks like they may even be specific to what topic you're dealing with. But I think this will help set a nice informational background for the discussion by our panelists as we go through this. OK, I'm going to get this out on the screen here. These are results from some -- a good number of you who have voted on it and this one is quite interesting, it's quite different from some of the other distributions where there seems to be a fairly even distribution in terms of which of these components are most important, which indicates to me that perhaps all of them at one point or another need to be addressed. So let's turn this question, now, over to our panelists, and ask what are your views about the importance of each of these factors and how would you advise others to handle them? Lillian, let's give the first shot to you here.

Lillian Martinez

OK. So what I could say is that when -- when I looked at the question for when I was looking at it from a standpoint of when we started this, the scheduling of the training was probably our biggest obstacle at first but then when I was looking at the responses, doing the midpoint changes and trying to make sure that we have a process after the training is completed, so I think that that's where the managers and the supervisors absolutely need to come in to make sure that they're consistently reinforcing the behavior and acting on counseling when the curriculum's not being followed. Also following that with a performance evaluation. Performance evaluations are always so difficult to keep up with. We always think that's the one thing we can put off but they're incredibly important because we need to let the staff know that we are looking at their behavior and their efforts in the office. And showing that on a performance evaluation, showing it during -- throughout the year, throughout the process, that that's where the implementation of the -- or excuse me, the aftereffect of the training really goes into effect.

Donna Farley

Okay, thanks Lillian. Susan, what are your thoughts?

Susan Edgman-Levitan

My thoughts. I think, in our experience, that there are two things that we found to be very important. And all of these are important at some point, as you said, but I think conveying to people the importance of starting with small-scale pilots, you know, when you're rolling out a new initiative and you're trying to look at a new way of delivering care, I don't think it's wise to approach it the way we often approach a new joint commission policy where on Monday everybody's going to do it this way and that's that, because I think here you have to get buy in, you have to do something that's relatively low risk and you have to design the pilot so that, if possible, they address all of the areas that people are worried about or your people that really need to be convinced that you'll actually have some data that you can share with them. I also think that providing training and ongoing coaching is critical. We find that very, very few people in our practices have ever had any kind of ongoing formal quality improvement training. Certainly when we started this work I think that's changed a lot over the last three years. There's been a big focus on this. But, again, I think that's -- that is one of the areas that I hear the most about when I'm talking to people

both in our system and outside of our system as an issue that we really have to pay attention to.

Donna Farley

OK, great, thanks, Susan. Now we've got one last question for the panel to -- and I'm going to turn to each one of you, in turn, on this because the issue of sustainability is a killer. I think it's something that all of us have struggled with at one point or another. You can make a change but how do you make it to the point where you can actually achieve sustainability of those new practices so they become a way of life and David, I'll turn to you first, what advice would you have in terms of this issue?

David Finn

I think it gets back a little bit to the prior question in terms of having projects and pilots that you can continual -- continuously do that will show success and show movement towards your goal and that those are in the context of the bigger culture change for our practice so having people ongoing and actively engaged and showing some results. But I do think the bigger problem that we've found in sustainability and keeping up that momentum is that idea of ongoing coaching and training and feedback and having people who can, within the practice, constantly reassess how we're doing, where we're at, where we want to go to and sustain that momentum and doing that as I said while we're all trying to take care of patients. We're at the point where we're actually looking at bringing in outside consultants in teamwork and building and coaching to show us how to do it better because it's not something any of us are really trained in here. So the sustainability is absolutely, the hardest piece of it I think. I think you have to show results that are tangible for people on small scales that play into a bigger picture and then have constant sort of ongoing coaching and feedback.

Donna Farley

OK, great, David. Thank you. Lillian, what about you?

Lillian Martinez

I think I jumped the gun a bit because I think I was kind of answering this question in my last answer. [LAUGHTER]. So I feel that sharing the score results, showing the staff that there have been this huge improvement after they have gone to the class. That, for me, was a big one. Going into the staff meetings, giving everybody a copy of the results, you know, prior to going to BRITE training and afterwards. I mean, you could really hear people in those meetings talking when previously it was just very quiet. They were looking at it, they were talking to each other. That, on a monthly basis, I think was very important and has been very important throughout all of our practices and then if there are some dips, you know, again, it reminds them of what they were taught. So, but what I also have to say that there's another course after BRITE training, like I said, Dealing with Difficult Patient Situations, that will then, again, remind them of what they learned in the Connecting with the Customers course. And then it teaches them even more things that they need to learn and also in the encounter registration and the appointment scheduling classes, they also remind them of what they learned in Connecting with the Customer. So, and then, again, just making sure that you are giving that feedback when you're noticing that

they do something or if a physician gives a comment. Just making sure that that gets back to the staff members, then it helps them retain that information.

Donna Farley

OK, thanks, Lillian. And Susan, any final thoughts on this? Susan?

Susan Edgman-Levitan

Yeah, I think -- I think David and Lillian have covered this quite well.

Donna Farley

Nothing else to add, huh?

Susan Edgman-Levitan

Nothing else to add right now. We have time for questions.

Donna Farley

Great, thanks a lot. Let's move back to the open question-and-answer part of the program. We have about -- we have up to 10 minutes left for the allotted time that we have. And we do have a number of questions that people have submitted. Just as a reminder, before we do that, the -- we have the other additional sources that you can go to. You can access both the audio recording and the written transcript of the webcast and the presenter slides will be available and you can contact through e-mail at CAHPS1@ahrq.gov for any additional information or comments that you would like to make. In addition, I want to advise you of a CAHPS User Group meeting that's coming up next spring if you're interested in learning more about the surveys and how they're used, be sure to join us there. We've got the next one scheduled for April 19-21, 2010, in Baltimore. And it will be in conjunction with the AHRQ surveys on patient safety culture. So both CAHPS and the Patient Safety Culture topics will be covered in that meeting. Finally, we've got some additional free resources from AHRQ's CAHPS user network that are available to all of you, these include the CAHPS improvement guide as well as a number of reports and case studies that are available and supplemental items. These are available at the website that we've identified here. When you go to the CAHPS site at CAHPS.ahrq.gov just click on the link labeled improving quality and it will get you there. You can also download the list of resources from the bottom of the webcast materials tab at the bottom of your screen right now. Finally, if you're interested in receiving e-mail updates about CAHPS including announcements about future events visit the CAHPS website and select e-mail updates from the top navigation bar. You'll be able to sign up for the CAHPS-specific updates. Again, the CAHPS website is CAHPS.ahrq.gov. Now let's go back to some final time of some questions from those of you in the audience for our speakers.

Lillian, I have one for you here on the BRITE training about resources. What resources were needed to support the BRITE training and what were available in your system and any FTE implications that you might be able to share with the audience?

Lillian Martinez

Sure. Obviously within the FPT where the BRITE class was initiated it was picking the right person in order to develop the training and I have to say that I think that we picked, not we, but our director, Laurie Johnson, had identified the perfect person because she had a lot of training background and was excited about the changes that could happen within our system after she was -- explained, you know, what it is that we were trying to do. I think that -- so sorry. I got a little distracted, I apologize. It's also, excuse me, I'm so sorry, I got something in my throat.

Donna Farley

Do you want us to move on to someone else?

Lillian Martinez

I'm sorry, could you come back to me for just a minute. I need to take a drink of water.

Donna Farley

Not a problem. Not a problem. Susan, there's a question for you on the sources of information for the statement that you made in your introduction about improving patient outcomes and also about the physicians being four times more likely to be sued. These are asked in the context, the person who asked this says we're very interested in the research that shows these important connections and can actually document them. Can you help anybody with that?

Susan Edgman-Levitan

Yes. I can just respond very quickly. There are probably hundreds of articles that document the relationship between doctor-patient communication, which is one of the things measured on the clinician group CAHPS survey and the quality of doctor-patient communication and the impact it has on adherence and quality outcomes. So there are many, many references there that we could put up on the, perhaps on the website, but there are also, several of them are included in the CAHPS Improvement Guide in the section on doctor-patient communication. And I would, you know, the work of Richard Frankle, Debra Roder, Wendy Levinson, there are many wonderful people that have researched this extensively. In terms of the risk management study that I quoted, that was actually a study that was done with Harvard Risk Management which is the Harvard malpractice insurer for all of the Harvard-affiliated institutions that we did at Mass General. I can send you, I have a slide that summarizes the data that I could share, if people want to contact me directly.

Donna Farley

OK, super, thanks, Susan. And a question for David. Could you, in your retreat and subsequent work, did you use a facilitator for the retreat and was this person internal or external? How did you work with getting those discussions to happen?

David Finn

So we didn't do a facilitator per say, as of yet, although we're looking to bring in some outside people to help us move the overall process forward. When we had the practice-wide retreat, the first thing we did was we showed everybody their

responses, we were very open about what people had said in their surveys. We did bring in an outside speaker, someone -- a professional, actually, a businessman in the community here that everybody recognizes and knows from television, is a very funny speaker, to come and talk about how he and his company built a culture of service excellence as a former owner of one of the furniture stores here and was a fantastic speaker and has done a lot of work in quality of service. And so we did have that which was very well received and humorous and at the same time though it really hit home the message about service and about getting involved with the practice. And then as far as facilitating each of the different groups that we broke up into, the actual facilitators were all members of the management team to start and to lead the discussion and help facilitate discussions around communication access, resources, environment. And then moving forward, the goal is that those facilitators on the management team will just be members of those groups as other people on those individual work groups step up to kind of lead individual projects.

Donna Farley

Okay, great, thanks, David. It could be an interesting point here that you actually have those leaders involved in the facilitation process, which is symbolic, as well as the process vehicle. A point before we wrap up because we're running very close to the end of time. At some point very soon an evaluation form is going to appear on your screen. When it does, we, please, encourage you to complete that form before you sign off from the webcast because we really value your feedback. It helps us in our work as we design subsequent webcasts to help make them more useful for those of you that we're providing them for, so we encourage you to do that. I have a fascinating question here for the panel and that is how have you involved the patient in your improvement efforts beyond the survey results? Have any of you engaged the patient directly in your processes? Lillian, any thoughts on that?

Lillian Martinez

Yes, I apologize for choking, I had to mute myself, I didn't think you wanted to hear all of that, I apologize.

Donna Farley

Not a problem.

Lillian Martinez

Actually, yes. What I would do when I was doing my walk-throughs, I would actually go and speak with a patient that was sitting down just to ask them, you know, how was their experience or go to them in the exam room, how was everything today. So in that type of setting, I was also able to get direct patient feedback, so not just a number on a score, on a survey result or something like that but an actual person telling me what their experience was and I thought that was wonderful. And that's something so tangible that you can take back to a meeting or take back to a staff member or take back to a physician and say this was this particular patient's experience. So that's -- that is certainly how I went about it. Just doing those walk-throughs, talking with the staff, talking with the patient, speaking with the patient over the phone.

Donna Farley

Great. David, what about what you've been doing so far?

David Finn

We try to involve them, obviously, and the patient is ultimately what we're trying to improve in terms of care and service so we've involved them on different levels, we've done some surveys of patients in terms of their experience in the wait room, experience in getting back to the exam rooms, wait times, things like that, sort of formal surveys. The reward or recognition or the "I notice" program is an attempt to get patients involved in recognizing staff or providers who have given outstanding care so a positive way. And then the next thing that we're working on right now is actually creating a patient advisory council or board specifically for our practice made of patients in our practice to actually advise us on how to move the practice forward in the most patient, you know, responsive way.

Donna Farley

That's super, that's super. Susan, any thoughts from the breadth of work you've done?

Susan Edgman-Levitan

Yes, I think one of the things that we have done is to the greatest extent possible we've tried to get practices use techniques like the walk-through, which is something, a process where you go through your own clinic as if you were a patient. And that's also in the CAHPS Improvement Guide. We've asked people to get feedback from patients about many aspects of their improvement. We've also found that for a lot of our primary care practices, especially smaller practices, creating formal patient-family advisory councils can be a challenge just in terms of the staff time and the cost of it, so we tried to get people to think about don't do any new process improvement without trying it out on patients. And in some respects much like what Lillian described where you talk with people in the waiting rooms, you may have certain patients that you see a lot so you can talk to them. But I think it's critical to do that.

Donna Farley

Great. Great. Thank you very much. We've just run out of time. So I think we'll close up the webcast at this point. Again, if you haven't already done so, please fill out the evaluation form that now is on the screen. And we appreciate your participation in the webcast. We thank you very much for joining you and look forward to further interactions with you in the future.

Operator

Ladies and gentlemen this does conclude today's teleconference. You may disconnect your lines at this time and we thank you all for your participation. Have a wonderful day.