IMPROVING CG-CAHPS– *the "secret" sauce*

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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.

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.

> "When leaders acknowledge that they are themselves representative of their organization's culture, the battle is half won."

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."

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.

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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, welcome to the Mass General. Is there something I can help you find today?"

We didn't reserve our words of welcome, our eye contact, or our smiles for people that appeared to be our patients or their families. We also said "good night" to the nurses as well as the housekeepers when they left at 7am to head home. We said "good morning" to our unit secretaries and physician colleagues as they arrived to see their patients. And we said "welcome back" to the families that we had gotten to know and who we knew didn't want to be there. We wanted them to know that we would do our best to take the very best care of them.

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?

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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.

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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.