The CG CAHPS Handbook

A Guide to Improve Patient Experience and Clinical Outcomes

By

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About the Authors
All three of us are patients. We go to a care provider for annual check-ups, make appointments for minor illnesses, follow up after medical tests. We take our children and our elderly parents to the doctor. We accompany friends who need support. Because we’ve “been there” we know: The experience we have at the provider’s office makes a difference. It makes a difference in how we feel about the provider, our confidence level in being a partner in our own care, and, yes, in our clinical outcomes.

Because we are patients, we are advocates for patients. And because we are healthcare professionals too, we know that the well-being of patients is intertwined with the well-being of the physicians, nurse practitioners, physician assistants, nurses, and staff who care for them. That’s why we wrote this book: to better serve those who serve the patient. Our mission is to make healthcare better for care providers to practice medicine and for patients to receive the care they deserve—the same care you
want to receive when you visit your provider and the care you most certainly want your family members to receive.

Look at the cover of *The CG CAHPS Handbook* and you’ll see it’s coauthored by Jeff Morris, Barbara Hotko, and Matthew Bates. While it is true that the three of us put the book together (along with several more contributors, editors, and other helpful souls), many talented and hardworking people deserve to share the credit.

We are only the distillers and reporters of the content in this book. The hard work—the *real* work—was done by the following two groups who have our eternal gratitude:

a. the organizations we’ve worked with over the years, along with the 100,000-plus providers who work with these organizations, that provided the fertile field for these tactics to take root and grow

b. the Studer Group® Physician Services Team, who discovered, harvested, and collaborated to share the tactics described in this book

The men and women collectively known as Studer Group have spent years doing intensive research in our national Learning Lab of 1,000-plus healthcare organizations. They are masters at discovering what the people inside these organizations are doing right—mapping it out and taking that message to others in the field to be able to produce quality results.

The knowledge that our coaches refine and share has evolved over time. The tactics in this book will continue to evolve as changes in healthcare and the external
environment place ever-increasing demands on organizations.

We believe the organizations we coach are comprised of many of the finest healthcare professionals in the world. It is their dedication, their passion for helping others, and their generosity of spirit that made this book possible. Every day, they work tirelessly to provide better and better care to the patients they serve.

To both these groups we offer our deepest appreciation. This relationship is truly a partnership where both parties are enriched by the work of the other—and the real beneficiaries are the patients, their families, and the communities they serve. May we continue to care for them for many years to come.

Jeff, Barbara, and Matthew
Introduction

“It isn’t hard to be good from time to time; what’s tough is being good every day.”

—Willie Mays

Over the last 15 years, Studer Group® has been privileged to work with more than 1,000 health-care organizations that, in turn, touch more than 200,000 practicing providers across the U.S. Throughout this journey, we have helped clinicians and groups—from small practices with just a handful of providers to large, system-affiliated groups with well over 1,000 providers—improve their patient experience and achieve high quality while delivering cost-effective care.

During this time, we have studied the impact patient experience has on the delivery of high-quality, cost-effective care. What we realized early on is that patient
experience and quality are deeply intertwined—in fact, they are two sides of the same coin. This impression has been substantiated over and over again through the years.

This is why Studer Group has never claimed to be a patient satisfaction company. We’ve always viewed “experience” through the lens of an organization’s ability to deliver high-quality, patient-centered care. Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG CAHPS) is no exception. And so we approach this book from the standpoint that its results are a metric that represents a patient’s perception of quality care.

It has been clear to us for a long time that CG CAHPS is about more than just “patient satisfaction surveys”—and that it will play an increasingly important role as transparency is expanded in the public arena and healthcare reforms move forward.

Most of the organizations we coach have also been focusing on the role of CG CAHPS questions within their practices. Even before the survey was adopted by public and private payers, many of the leaders of practices we worked with were asking questions about provider communication, access to timely appointments and information, and courtesy of their office staff—and have been benchmarking their performance against the results.

Through our Learning Lab, which is derived from a network of exceptional organizations, we’ve been able to test, validate, and harvest “leading practices” for CG CAHPS. During this process, we’ve paid careful attention not only to which practices improve results
but also to their ability to sustain those results over time. What’s more, we’ve worked to identify the best tactics that work across practices, regardless of type or size.

We have been privileged enough to talk with some of the smartest people working in healthcare today, experts known not only for their wisdom but also for their burning commitment to make healthcare better. These “fire starters” represent the most passionate and high-achieving leaders we have met during our journey. These are the leaders who, upon reaching ever-higher levels of achievement on CG CAHPS and other patient-centered outcomes, continue to push their organizations to move from good to great.

What we have learned in this process is that many of those tactics that Studer Group coaches healthcare organizations to adopt and hardwire on the inpatient side can also be leveraged, with minor tweaks, to improve and sustain high CG CAHPS results. We have also developed new tactics in conjunction with hospitals and physician practices that have been tested and honed in the crucible of real-world patient care delivery. And we have reconfirmed, once again, what we already knew: that a strong focus on a) connecting people to the why behind changes (the well-being of the patients) and b) holding them accountable for consistently executing outcomes-based tactics are pivotal to success.

Most important, we have learned that often, less is more.

A consistent theme that’s emerged from our work has been that selecting just a few tactics and focusing on
hardwiring them produces better results than trying to adopt many new practices at once. The mistake of trying to do too much at one time is so common many of our partners have developed a name for it: *flavor of the month*. Most of our highest performing CG CAHPS partners have, in fact, focused on just three or four tactics for years in their own journey.

So how do you know if you have hardwired a tactic in your own group? The test is actually pretty easy: Just ask, “Do patients and their families *always* receive care consistent with our standards and adopted practices?” The difficult part is the word *always*. When we at Studer Group say *always*, we have to ask ourselves whether patients who are seen on Saturday morning, or whose calls get returned at 3:00 a.m., or who talk to a temporary provider covering the phones on a holiday weekend receive the same standard of care that we hold ourselves accountable for at 10:00 a.m. on Monday. And do they recognize the consistent high standard of care and report it as such?

While this book is focused on improving CG CAHPS outcomes, it is critical to remember that these efforts are about far more than a practice’s performance on the survey itself. Working toward favorable CG CAHPS outcomes is about meeting the patient’s (and family’s) *what*. The “what” is that one thing that is foremost in a patient’s mind—the most important thing that, if addressed by providers, will make him or her feel listened to, understood, and cared for. In other words, it’s about measuring how consistently we deliver on things that matter to our
patients—how often we always deliver on their expectations.

And here is an interesting point: We have found that practices that receive the highest results on CG CAHPS do so without a care provider ordering more tests or prescribing more medications to meet patient demands. Indeed, they are actually lower utilizers of many of these services than their peers. In our experience, the idea that patients are seeking a lot of “extras” is a misconception. The vast majority of patients just want to understand why their provider is recommending something or nothing at all.

For example, some patients who enter a provider’s office with a common cold will ask for antibiotics. This is a fact. But many providers we work with do not prescribe the antibiotics the patient wants (because a cold is viral)—yet still receive high CG CAHPS results. This is because they have worked to find more effective ways to communicate with their patients so that they leave satisfied that the diagnosis and treatment they received were the right ones.

Of course, getting to this point means hardwiring the best possible communication tactics and behaviors—specifically, the ones we cover in this book. And that, in turn, requires leadership practices that simultaneously engage providers and staff members and instill the sense of accountability that drives the desired behaviors.

Perhaps the biggest challenge in improving CG CAHPS results is making the internal shift to a focus on engagement and accountability that is required to
become an *always* culture. *Always* is a high standard to achieve, and the culture required both to develop and sustain this is hard to create. It takes many of our partners years to create an *always* culture and hardwire it for sustainability. *Always* literally requires that every member of the team gets it right with every patient and their family every time.

An *always* culture is challenging to create in any industry, and healthcare is no different. Yet difficulty cannot become our excuse for accepting less—on the contrary, it needs to become our calling to deliver more. Given that our industry’s reason for existence is to care for people, can we accept anything less?

At Studer Group we have developed a set of strategic tactics and processes that, together, help organizations create just this kind of culture change. You will learn more about this leadership framework in the following pages. For now, just know that the goal is to help make your practice incredibly agile and responsive—well aligned and motivated to respond to the new demands that come your way (and, of course, in an era of continuous change, there will be many such demands) in a fast and effective manner.

At Studer Group, our mission is to make healthcare a better place for employees to work, physicians to practice medicine, and patients to receive care. We know this is a mission that you share.

We trust that you will find this book helpful on your own journey to achieve better patient outcomes and become a high-performing organization. This is *always* the
goal. The fact that your efforts improve CG CAHPS results and a strong reputation in the community are simply validation that you’re serving your patients well.
Chapter One:

CG CAHPS 101: What It Is and Why It Matters

“Where the art of medicine is loved, there is also a love of humanity.”

—Hippocrates

The New York Times recently published an op-ed piece titled “Doctor, Shut Up and Listen,” written by Nirmal Joshi, the chief medical officer for Pinnacle Health System. The article makes it clear that there is room for improvement in the listening and communication skills of many physicians. (Indeed, Joshi goes on to discuss the physician-training program he and his colleagues put in place and shares the dramatic improvement in patient satisfaction that resulted.)

Yet, this is far from a bad news piece. Its conclusion is a story that illustrates just how powerful it is when a physician takes the time to truly connect with patients—
and the extent to which he or she can impact outcomes. In Joshi’s words, “A good bedside manner is simply good medicine.”

A passionate diabetes specialist told me how she sat down with a patient to understand why he was not using his diabetes medications regularly, despite numerous hospital admissions for complications.

“I can’t continue to do this anymore,” he told her, on the verge of tears. “I’ve just given up.”

She placed a hand on his shoulder and just sat with him. After a pause, she said: “You have a heart that still beats and legs you can still walk on—many of my patients don’t have that privilege.”

Five years later, recalling this episode, her patient credits her with inspiring him to take better care of himself. The entire encounter took less than five minutes.

Moments like these are why people choose to practice medicine. All physicians, physician assistants, nurse practitioners, and the staff members who work with them want to provide the best possible care to patients. It’s not just what they do; it’s who they are. They train for years and years to examine, diagnose, and treat patients, and everything they do flows from a sincere desire to put that knowledge to work in a way that provides great clinical outcomes.

And it’s not just about facts, data, and metrics. Providers care about patients! It’s difficult to see people in pain and not want to help them get better, to hear them crying and not want to comfort them, to see them struggling with chronic conditions and not want to help them
improve their lives. So they want patients to have a good experience—but for a variety of reasons this goal isn’t always met.

Now that public reporting for CG CAHPS has begun, it’s time to bring providers’ good intentions together with practical tools that are proven to create better patient experiences and, simultaneously, better clinical quality. That’s why we wrote *The CG CAHPS Handbook*.

Later on in this chapter, we’ll go into more detail about the survey, but for right now we’ll just hit the high spots. Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG CAHPS) is a family of surveys, built around common core questions that each serve as a standardized tool to measure patients’ perception of care given by physicians and other providers in an office setting.

The Physician Compare website (http://www.medicare.gov/physiciancompare/) reports CG CAHPS results, along with certain quality metrics, for provider offices that see Medicare patients. Much like the Hospital Compare website, Physician Compare is designed to help consumers make informed decisions on where to receive care.

Another public CG CAHPS database available today is hosted by AHRQ. They have posted aggregate data for CG CAHPS surveys, and the data can be found at: https://cahpsdatabase.ahrq.gov/CAHPSIDB/Public/CG/CG_About.aspx.
Many practices are finding that conducting CG CAHPS surveys is becoming required to maximize Medicare, Medicaid, and private payer payments.

We at Studer Group® strongly feel that all provider practices need to focus heavily (sooner rather than later) on the patient experience as measured by CG CAHPS surveys. As we’ll discuss shortly, there are strong correlations between a patient’s perception of care—i.e., her “experience”—and her clinical outcomes. In other words, when we improve experience, we also improve quality. This, alone, is a compelling reason to prepare for CG CAHPS right now.

Another reason, of course, is financial. We all know that healthcare as an industry is moving toward value-based payment models. We also know that performance isn’t measured only by clinical numbers but also by patient experience. Some private payers, Medicare Advantage plans, and Medicaid managed care plans have already linked provider payments to CG CAHPS results. And CMS is moving to requiring CG CAHPS public reporting for all providers who treat Medicare patients over the next couple of years.

Certainly, where a practice falls on the Physician Compare website will have an impact on its reputation and, ultimately, on the number of patients who will frequent it. Also, of course, practices that provide a positive patient experience get more return business, more referrals, and better word of mouth.

Our experience has shown us that practices that are early adopters in conducting CG CAHPS surveys not
only achieve better results but sustain higher performance against their peers when reporting becomes mandatory. And the sooner you implement the most impactful evidence-based tools and tactics—in the right order and with the right coaching—the sooner you’ll see your results start to trend upward.

Studer Group has been focused on the patient experience since our beginning in 1999. Over the years we have gathered a wealth of evidence from our Learning Lab—made up of over 1,000 healthcare organizations—on which tools and tactics most affect how patients perceive their care. This book presents only the most powerful ones—the idea being to not overwhelm readers but to provide the fewest possible tactics that are nonetheless impactful enough to help practices meet their goals.

Not only that, we’ve developed and refined a framework—Evidence-Based LeadershipSM (EBL)—that helps organizations reduce variation in their leadership skills and practices to achieve a culture of high performance. This framework aligns organizational goals, behaviors, and processes in a way that moves and sustains results. It provides the structure for hardwiring the tactics described in this book, and it aligns the culture with a strong sense of accountability for executing them.

Once EBL is hardwired into a medical practice or any other organization, leaders have the right skill set to introduce changes—and providers (doctors along with PAs and NPs) and staff have the right mindset to quickly embrace and master them.
We’ll talk more about this in Chapter 15. For now, let’s explore what makes CG CAHPS such a pivotal part of the future of healthcare.

**The Evidence: Why CG CAHPS Matters**

The Institute of Medicine’s 2001 “Crossing the Quality Chasm” report identified patient-centeredness as a key healthcare quality aim. Since this time, patient-centered care has gained significant recognition across the healthcare industry, and measuring patient experience is becoming a keystone component of both certification and compensation programs.

Now, CG CAHPS is rapidly emerging as the national standard for measuring patient experience in the ambulatory settings for both quality and business reasons. Here’s why:

**The Quality Case for CG CAHPS**

For most healthcare professionals, providing quality care is the reason driving everything we do. There is plenty of research suggesting that patient experience and quality are two sides of the same coin. When you focus on one, the other also improves. Consider the following evidence:

**Patient experience and clinical quality process of care are related.** While patient experience measures reveal how the patient perceived the care they
received, these factors are not independent of clinical quality measures. Patient experience at both the provider and practice levels has been shown to be positively correlated with process of care measures for disease management and prevention.³

**Patient experience is positively correlated with patient engagement and adherence.⁴,⁵** It stands to reason that when a patient feels good about his relationship with a provider, he is more likely to pay attention to what the provider has to say and also to conform to the care plan. This is particularly important in treating patients with chronic conditions where patient commitment and action are critical to achieving positive outcomes.

For example, one study found that “adherence rates were 2.6 times higher among primary care patients whose providers had ‘whole person’ knowledge of them (95th percentile), compared to patients of providers without that familiarity (5th percentile).”⁶

**Patient experience is positively correlated with better health outcomes.⁷,⁸** In one study, patient’s perception of care was found to be directly linked to improved blood sugar control in diabetic patients.⁹ In another study, positive primary care follow-up was found to offset poor hospital experience and outcomes.¹⁰

**Public reporting of patient experience data has been shown to drive provider quality improvement.¹¹** As CMS, states, and other public and private enterprises publish CG CAHPS data, they are working to create
transparency and the improvement in quality that follows.

**Patient experience measurement identifies systemic quality issues.** For example, at one of Studer Group’s partner organizations, it revealed gaps in communicating lab results. Later, it showed that the processes put in place to fix those issues were working. Specifically, communication between members of the care team is correlated with clinical performance measures.  

**The American Board of Medical Specialties (ABMS) has endorsed the adoption of CG CAHPS questions as part of the Maintenance of Certification (MOC) process for its 24-member boards.** Specifically, collection of CG CAHPS survey data will fulfill some of the Part IV Performance Assessment requirements for MOC.

**The Business Case for CG CAHPS**

Focusing on CG CAHPS and taking action to improve results can help practices directly maximize reimbursement in the future, but can also immediately create an environment that helps maximize efficiency, keeps patients happy and healthy, sparks growth, and reduces the likelihood of litigation. Consider the following facts:

**CG CAHPS is tied to financial incentives/value-based purchasing (VBP) with payers.**

- Centers for Medicare and Medicaid Services (CMS) started collecting baseline data related
to CG CAHPS for many programs in 2014 and has proposed starting to link CG CAHPS to specific payments for FY2015. These programs include:

- Medicare Shared Savings Program (MSSP)
- Medicare Pioneer ACO Model
- Physician Quality Reporting Systems (PQRS)
- Comprehensive Primary Care (CPC) Initiative
- Multi-payer Advanced Primary Care Practice (MAPCP)
- Federally Qualified Health Centers (FQHC) Advanced Primary Care Practice Demonstration

- **Medicaid and Children’s Health Insurance Programs (CHIP)** in many states are leveraging the CG CAHPS surveys instrument in either pilot or full adoption models. In many of these states, this is being done as part of Patient Certified Medical Home (PCMH) programs.

- **Some private payers** are using survey results to determine reimbursements. For example, Blue Cross Blue Shield of Massachusetts has created an Alternative Quality Contract compensation model that ties a portion of payment to CG CAHPS survey results. Similarly, the Integrated Healthcare Association in California, which ran the largest non-government pay-for-performance (P4P) program in the United States in 2014, uses the survey results in its performance calculations.
Measuring and improving patient experience contributes to a high-quality culture. According to one study, “a quality-centered culture and outside reporting of results are the strongest predictors of high-performing medical practices.”17 By measuring and reporting patient experience, you will help achieve both of these conditions. Additionally, patients and staff are perceptive of clinician attitude, and a negative attitude will not only be reflected in lower patient experience scores but also in higher employee turnover and lower staff productivity.18

Patient experience drives patient retention and growth. It just makes sense that patients will stay with providers with whom they have had positive experiences and leave when they have negative experiences. One study found that “patients who have poor-quality relationships with their providers are three times more likely to voluntarily leave the practice vs. those with high-quality relationships.”19 Another showed that “treatment with respect, the rating of care received, and the helpfulness of the person at the front desk are the strongest predictors of patient satisfaction…patient satisfaction is highly correlated with intent to return and intent to recommend services.”20

Patient experience is correlated with lower malpractice risk.21,22,23 In one study, researchers found that 46 percent of malpractice risk was linked to physician-specific characteristics, including patient experience.24

The Measure Applications Partnership (MAP) has advised the Department of Health and Hu-
man Services (HHS) to consider CG CAHPS across all clinician performance measurement programs. The MAP was created under the Affordable Care Act and addressed CG CAHPS in their initial report, “Coordination Strategy for Clinical Performance Measurement” in 2011. The report states, “The addition of Clinician-Group CAHPS…would greatly enhance the measure set.”

National Committee for Quality Assurance (NCQA) and Utilization Review Accreditation Commission (URAC) require Patient-Centered Medical Homes (PCMHs) they recognize to conduct patient experience surveys. Certification by NCQA and/or URAC is, in turn, critical to a provider’s ability to participate in many emerging ACO and PCMH plans with both private and public payers.

A Brief Introduction to CG CAHPS

Now let’s talk about CG CAHPS itself. The Clinician and Group Consumer Assessment of Healthcare Providers and Systems is a family of surveys that measure patient experience with healthcare in a provider practice setting. There are separate CAHPS surveys designed to address patient experience in other care delivery settings, including the hospital (HCAHPS), the Emergency Department (ED CAHPS), Surgical Care (S CAHPS), Home Health (HH CAHPS), and Nursing Homes (LTC CAHPS).
CAHPS surveys provide feedback for those areas in which patients (that is, healthcare consumers) are the best or only source of information. The surveys were developed and released into the public domain by the Agency for Healthcare Research and Quality (AHRQ). The acronym “CAHPS®” is a registered trademark of AHRQ.

To be clear, CAHPS surveys are not patient satisfaction surveys. Rather, they focus on the patient experience by measuring how often the care providers demonstrated behaviors that result in quality patient care and service.

**What We’ve Learned from HCAHPS**

For the past few years, we at Studer Group have worked with healthcare organizations seeking to hardwire the tools and tactics that improve HCAHPS results. Here are some of the lessons we’ve learned:

- Of all the components in the value-based purchasing initiative (which also includes process of care, outcomes, and efficiency measures), patient experience is the toughest to move.

- If an organization isn’t improving, it’s falling behind. Government and patient expectations create a “downward-moving escalator” effect: There is no way to stand still and maintain great results.

- Patient experience results correlate with quality results. For example, when we at Studer Group compare hospitals that patients rated in the top
The survey results from CG CAHPS can be used broadly to address two strategic needs:

1. To improve the quality of care provided by individual providers, sites of care, medical groups, or provider networks

2. To provide information to healthcare consumers and payers to help them choose physicians and other healthcare providers, physician practices, or medical groups

“Clinicians and Groups” can be a confusing label for this set of CAHPS surveys. We often get questions as to whose performance these surveys are really meant
to measure. The answer is “providers,” which could be a doctor, nurse practitioner, or physician assistant. The surveys work for a wide range of doctors, including Doctors of Medicine, Doctors of Osteopathy, Doctors of Podiatric Medicine, and Doctors of Chiropractic.

**CG CAHPS History**

Today’s CG CAHPS survey has its roots in work that was begun in the 1990s to develop a CAHPS survey for group practices via several initiatives.26,27 Around this same time, the CAHPS Consortium, working with the California HealthCare Foundation, developed a preliminary survey instrument known as the CAHPS Group Practices Survey (G-CAHPS), which was published in 1999.

The CAHPS Consortium, supported by the AHRQ, continued to evolve the instrument in the 2000s (as part of the CAHPS II grant) at which time it became known as the Ambulatory Care CAHPS (A-CAHPS) survey.28,29,30,31,32 The evolution was guided by the A-CAHPS Advisory Group, whose members participated in the development process on an ongoing basis by providing input into both content issues (e.g., composites, topics within composites, item content, and response scales) as well as survey administration issues (e.g., telephone versus mail, sample sizes, frequency of surveys). The A-CAHPS Advisory Group included members from the American Board of
Medical Specialties, the American Board of Internal Medicine, the American Medical Group Association, and the Medical Group Management Association among others.

On August 18, 2004, AHRQ issued notice in the Federal Register that the A-CAHPS survey was ready for field testing. More than a dozen physician groups participated.33

In March of 2006, AHRQ formally launched the 1.0 version of the Clinician & Group CAHPS instrument into the public domain. In July 2007, the National Quality Forum (NQF) endorsed the 1.0 version of the Clinician & Group Survey as a measure of patient experience with ambulatory care.

AHRQ has continued to work with stakeholders to study and evolve the CG CAHPS instruments34,35,36 and released version 2.0 of the surveys in October 2011. Important to the release of version 2.0 was the clarification of Core Questions & Supplemental Questions, along with the use of the word provider (in place of doctor). While all CG CAHPS surveys should incorporate the core questions, the supplemental questions allow flexibility to meet the needs of various stakeholders and address areas such as culture competency, health information technology, health literacy, and patient-centered medical homes.

AHRQ has also helped develop and release two more ambulatory/CG CAHPS-related surveys in recent years: the CAHPS Patient-Centered Medical
Understanding the CG CAHPS Family

CG CAHPS is best viewed as a family of surveys designed to evaluate patient experience in an ambulatory clinical setting. There are multiple surveys in the family, and it is important that we become familiar with them so we pick the right tool for our needs. This is critically important: Different payer organizations and clinical needs may require different CG CAHPS surveys for the patients in your practice.
There are several major variations of the CG CAHPS surveys:

- **Longitudinal (6 or 12 months)** or **Episodic (Single Visit)**
- **Adult (18+)** or **Child (<18)**
- **Core Questions** or **Core + Supplemental Questions**

Below, we’ll discuss each one.

**Longitudinal or Single Visit?**

One set of the CG CAHPS surveys is designed to measure patient experience longitudinally (i.e., over a period of time), and one set is designed to measure a single clinic visit. In practice, most everyone is using the surveys designed to measure over a longitudinal time period.

In addition, every CG CAHPS-related payer initiative in which Studer Group partners are participating requires the longitudinal surveys. Therefore, we will focus on the “longitudinal” surveys throughout this book and strongly recommend you do as well. However, almost everything we will discuss can be applied to the single visit surveys should you use them.

**Adult or Child?**

The adult survey is designed for individuals who are 18 or older. It has been adjusted to support use with children (under 18 years of age) by expanding the provider communication composite, adding two more composites and phrasing questions to the parents instead of the patient (i.e., the child).
The expanded Provider Communication composite has four additional *never, sometimes, usually,* and *always* questions.

The new composites are Provider’s Attention to Your Child’s Growth and Development, consisting of six yes/no questions, and Provider’s Advice on Keeping Your Child Safe and Healthy, consisting of five yes/no questions. We have not covered these 11 questions in this book as we believe they primarily represent a checklist of 11 items for a provider to discuss with a child’s parent or guardian.

If you are implementing CG CAHPS in a practice that includes pediatrics, we suggest you review these questions and ensure that they are covered in your checklist of standard questions that providers discuss with their patients. The core questions and the additional questions related to the child longitudinal survey can be found in the Appendix of this book.

**Core Questions or Core + Supplemental Questions?**

One critical concept to understand about CG CAHPS is that there are two sets of questions: “core questions” designed to be asked as part of every CG CAHPS survey and supplemental questions designed to be utilized based on specific needs (e.g., Patient-Centered Medical Homes).
Every CG CAHPS survey should contain the core questions. This across-the-board consistency makes it possible to compare results between providers and across different versions of the surveys.

There are 34 total core questions in the 12-month CG CAHPS version 2.0 survey for adults. Only 15 of these questions are the critical questions that are normally reported as measures of patient experience rolled up into five overall composites: Access to Care/Information, Provider Communication, Office Staff Courtesy/Helpfulness, Lab Results Follow-up, and Overall Rating of Provider.
The remaining questions are focused on demographics and survey navigation. A copy of the complete 12-month Adult Core Questions 2.0 survey can be found in the Appendix.

There are several AHRQ-published supplemental question sets available to use in creating customized CG CAHPS surveys. These supplemental questions may be added either individually or in composites, depending on the survey designer’s needs. The supplemental question sets include:

- Cultural Competence Item Set (10 questions in 2 composites)
- Health Information Technology Item Set (9 questions in 3 composites)

Figure 1.2 CG CAHPS Core Questions and Composites
• Health Literacy Item Set (4 questions in 1 composite)
• Patient-Centered Medical Home Item Set (see below)

The decision regarding which survey to use is primarily driven by the patient’s payer; it’s quite likely that a given practice may need to use multiple versions of CG CAHPS to address patients who have different payers.

Figure 1.3 Survey Family Tree
Three Special Versions of the CG CAHPS Survey

Because we are focused on the CG CAHPS core questions in this book, we will not be discussing the following three unique CG CAHPS surveys in detail. However, we thought it might be useful to give a quick overview of each one.

Keep in mind that all of these surveys include the CG CAHPS core questions that we are discussing in this book, plus supplemental questions. You can find out more about tactics we recommend to address these surveys and their supplemental questions on our website at www.studergroup.com/CGCAHPS.

**CMS ACO CAHPS and CAHPS for PQRS Surveys**

CMS has created versions of CG CAHPS surveys for their ACO and PQRS programs. These surveys
include all the CG CAHPS core questions plus additional supplemental questions.

They were used by CMS to start publicly reporting patient experience information regarding provider groups in 2015. CMS plans to continue to evolve these surveys and increase the number of practices that they publicly report data for over the next several years. Ultimately their plan is to report CG CAHPS patient experience data at both the practice and individual provider levels.

**The CAHPS Patient-Centered Medical Home (PCMH) Survey**

The CAHPS PCMH survey represents an expanded version of the CG CAHPS survey designed for providers and groups participating in patient-centered medical homes and/or accountable care organizations. It includes all the CG CAHPS core questions and then adds supplemental PCMH questions to the survey. There are both adult and child versions.

This survey is required for use by patient-centered medical homes seeking recognition under NCQA’s “Distinction in Patient Experience Reporting” program. It is also recommended to organizations seeking recognition under URAC’s PCMH accreditation program.
The CG CAHPS Handbook

Evaluating CG CAHPS Results and Reporting on Them

CG CAHPS measures are designed to be aggregated into composites for public reporting. Think of these composites as bundles consisting of either one question or multiple related questions. The 15 scored core questions in the CG CAHPS 12-month adult version 2.0 survey are mapped to five composites as indicated in the following table:

<table>
<thead>
<tr>
<th>Composite/Item</th>
<th>Questions</th>
<th>Response Choices</th>
</tr>
</thead>
</table>
| **Access to Care (5)** | • When you phoned this provider’s office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?  
  • When you made an appointment for a check-up or routine care with this provider, how often did you get an appointment as soon as you needed?  
  • When you phoned this provider’s office during regular office hours, how often did you get an answer to your medical question that same day?  
  • When you phoned this provider’s office after regular office hours, how often did you get an answer to your medical question as soon as you needed?  
  • Wait time includes time spent in the waiting room and exam room. How often did you see this provider within 15 minutes of your appointment time? | Never, Sometimes, Usually, Always |
| **Provider Communication (6)** | • How often did this provider explain things in a way that was easy to understand?  
  • How often did this provider listen carefully to you?  
  • How often did this provider give you easy-to-understand information about these health questions or concerns?  
  • How often did this provider seem to know the important information about your medical history?  
  • How often did this provider spend enough time with you?  
  • How often did this provider show respect for what you had to say? | Never, Sometimes, Usually, Always |
| **Lab Results (1)** | • When this provider ordered a blood test, x-ray, or other test for you, how often did someone from this provider’s office follow up to give you those results? | Never, Sometimes, Usually, Always |
| **Office Staff (2)** | • How often were clerks and receptionists at this provider’s office as helpful as you thought they should be?  
  • How often did clerks and receptionists at this provider’s office treat you with courtesy and respect? | Never, Sometimes, Usually, Always |
| **Overall Provider Rating (1)** | • Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider? | 0 to 10 |

Figure 1.5 The 12-Month Adult Survey Questions Mapped by Composite
Most CAHPS questions have been standardized to four response options, and CG CAHPS has adopted this standard in version 2.0 of the surveys. The four response options are: *never, sometimes, usually,* and *always.* The overall rating of provider question in the CG CAHPS core questions is measured on an 11-point scale from 0 to 10. There are several common ways to examine and report CG CAHPS scores based on these responses.

The method that CMS uses for public reporting is called “Top Box.” Top Box scoring is the number of respondents who provided an “always” response divided by the total number of respondents who gave a response at all. (In the case of the overall provider rating, it’s the number of individuals who rated the provider a 9 or 10.)

So, for example, let’s assume 100 patients each answered the question, “How often did this provider listen carefully to you?” for two different providers. The data for our example is shown below:

<table>
<thead>
<tr>
<th>Clinic</th>
<th>Never</th>
<th>Sometimes</th>
<th>Usually</th>
<th>Always</th>
<th>Top Box</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinic A</td>
<td>0</td>
<td>5</td>
<td>40</td>
<td>55</td>
<td>55%</td>
</tr>
<tr>
<td>Clinic B</td>
<td>15</td>
<td>15</td>
<td>20</td>
<td>55</td>
<td>55%</td>
</tr>
</tbody>
</table>

Figure 1.6 Sample CG CAHPS Results for Studer Clinic

In looking at the Top Box results (which is what most public reporting focuses on), you likely noticed both Clinic A and Clinic B received the same Top Box score of 55 percent, despite having a different distribution of other responses. This is because both of them received 55
As you perform CG CAHPS surveys, it is common to want to understand how you rank compared with others. As we at Studer Group work with organizations across the country, we’ve found a valuable way to perform this comparison is using “national percentile ranking.”

National percentile rankings are published by most of the CG CAHPS vendors and by AHRQ. (It is important to note that different vendors may produce different results based on their survey population.) The national percentile rankings tell you how you place relative to others on a given question or composite. So for example, you may have a Top Box result of 70 percent on Access to Care (i.e., 70 percent of the patients you surveyed answered “always”) but score in the 82 percent on a national percentile ranking. This means your results are better than 82 percent of the other providers and only 18 percent scored higher than your results.

Here are Top Box national percentiles at the 25 percent, 50 percent, and 75 percent level for reference. This data was published by AHRQ in August 2014 and represents more than 200,000 surveys related to 12-month adult 2.0 survey core questions conducted in 2013. One thing to notice right away is that the 50 percent national percentile maps to a different Top Box result for each composite. Overall, the Access to Care composite was the lowest scoring nationally, and the Provider Communication composite was the highest scoring nationally in 2013.
AHRQ recommends another way to analyze CG CAHPS results to improve your practice by using average scores. In general, average scores are not recommended for public reporting, but we at Studer Group find that they can be valuable in helping a clinician and/or group work on improvement.

An average score is based on assigning weights to each response and then measuring the average. AHRQ recommends using weights based on a 1-to-4 scale mapped to the four responses as follows: Always = 4, Usually = 3, Sometimes = 2, and Never = 1. If we review our example using average scoring, we will find different results for our providers as follows:

<table>
<thead>
<tr>
<th>Composite</th>
<th>Response Counted</th>
<th>25th Percentile</th>
<th>50th Percentile</th>
<th>75th Percentile</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to Care</td>
<td>Always</td>
<td>58%</td>
<td>65%</td>
<td>72%</td>
</tr>
<tr>
<td>Provider Communication</td>
<td>Always</td>
<td>82%</td>
<td>86%</td>
<td>90%</td>
</tr>
<tr>
<td>Lab Results</td>
<td>Always</td>
<td>67%</td>
<td>74%</td>
<td>81%</td>
</tr>
<tr>
<td>Office Staff</td>
<td>Always</td>
<td>74%</td>
<td>80%</td>
<td>86%</td>
</tr>
<tr>
<td>Overall Provider Rating</td>
<td>9 or 10</td>
<td>76%</td>
<td>81%</td>
<td>86%</td>
</tr>
</tbody>
</table>

Figure 1.7 Sample CG CAHPS Results for Studer Clinic
If we were the leader over both Clinic A and Clinic B, this graphic would tell us a lot. In looking at the average score, it is now clear that Clinic A is performing better on this question than Clinic B. If our goal is to improve the results on this question, Clinic B will need more work and support to achieve an improvement than Clinic A will.

When your organization reviews its results, be sure to look at them in various ways so that you can identify those areas that truly need work. In our work with organizations across the country, we have found that those are the areas that should be addressed first. We urge you to follow this principle, using the tactics you’ll find in the upcoming chapters.

To jump ahead for just a moment, please be aware that Chapters 15 and 16 will give you more information on EBL and how it works (as mentioned earlier), as well as on how to tackle the important task of goal setting and CG CAHPS improvement. We urge you to read it carefully—perhaps even before you read the tactical chapters. This will give you the context for thinking about the changes you need to make and how they fit into the bigger picture.

<table>
<thead>
<tr>
<th>Clinic</th>
<th>Never (1 pt)</th>
<th>Sometimes (2 pts)</th>
<th>Usually (3 pts)</th>
<th>Always (4 pts)</th>
<th>Top Box</th>
<th>Average Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinic A</td>
<td>0</td>
<td>5</td>
<td>40</td>
<td>55</td>
<td>55%</td>
<td>3.5</td>
</tr>
<tr>
<td>Clinic B</td>
<td>15</td>
<td>15</td>
<td>20</td>
<td>55</td>
<td>55%</td>
<td>3.1</td>
</tr>
</tbody>
</table>

Figure 1.8 Sample CG CAHPS Results for Studer Clinic
Finally, remember that like healthcare itself, your practice is a work in progress. It will take time to get things right, and you will likely never achieve 100 percent perfection—but that is no reason not to strive for it. By working tirelessly to achieve the best possible clinical quality and the best possible patient experience, your practice lives up to its highest sense of purpose. What an incredible gift—not just for the patients you serve, but for every provider and staff member who has chosen to follow this calling.
WHEN YOU IMPROVE THE PATIENT EXPERIENCE, QUALITY AND PRACTICE PERFORMANCE IMPROVE, TOO.

Plenty of evidence shows that patient experience and clinical quality are two sides of the same coin. You already want to provide the best possible care. And now that Clinician and Group Consumer Assessment of Healthcare Providers and Systems is here, there’s a new reason to focus on patient perception: CG CAHPS will impact ACOs, PQRSs, PCMHs, and many other programs, and survey results will link to payments in 2015.

But it’s not just about maximizing reimbursement. Taking action right now to improve CG CAHPS results can immediately create an environment that helps maximize efficiency, keeps patients happy and healthy, sparks growth, and reduces the likelihood of litigation.

The CG CAHPS Handbook—written by Jeff Morris, MD, MBA, FACS; Barbara Hotko, RN, MPA; and Matthew Bates, MPH—will help. It is your guide for consistently delivering on what matters most to patients and their families and for providing exceptional care and improved clinical outcomes. You will discover:

• How to engage and partner with patients for a true shared care agenda to increase compliance and impact clinical outcomes
• Tactics to help you improve patient access without adding additional staff
• Tips for managing patient expectations from the minute they walk into the reception area until you follow up with test results
• Best practices to help adjust and refine the steps you are already doing to maximize effectiveness
• Tactics to help you zero-in on the core questions for the CG CAHPS composites that will impact every survey and improve your results

The CG CAHPS survey has major implications for your future. Much like the HCAHPS survey, it gives patients and payers standardized comparative data that enables them to make informed decisions when choosing their healthcare providers. CMS, states, and private payers are working to collect and make CG CAHPS results public. Now is the time to be preparing your providers and their practices to excel in the patient experience.