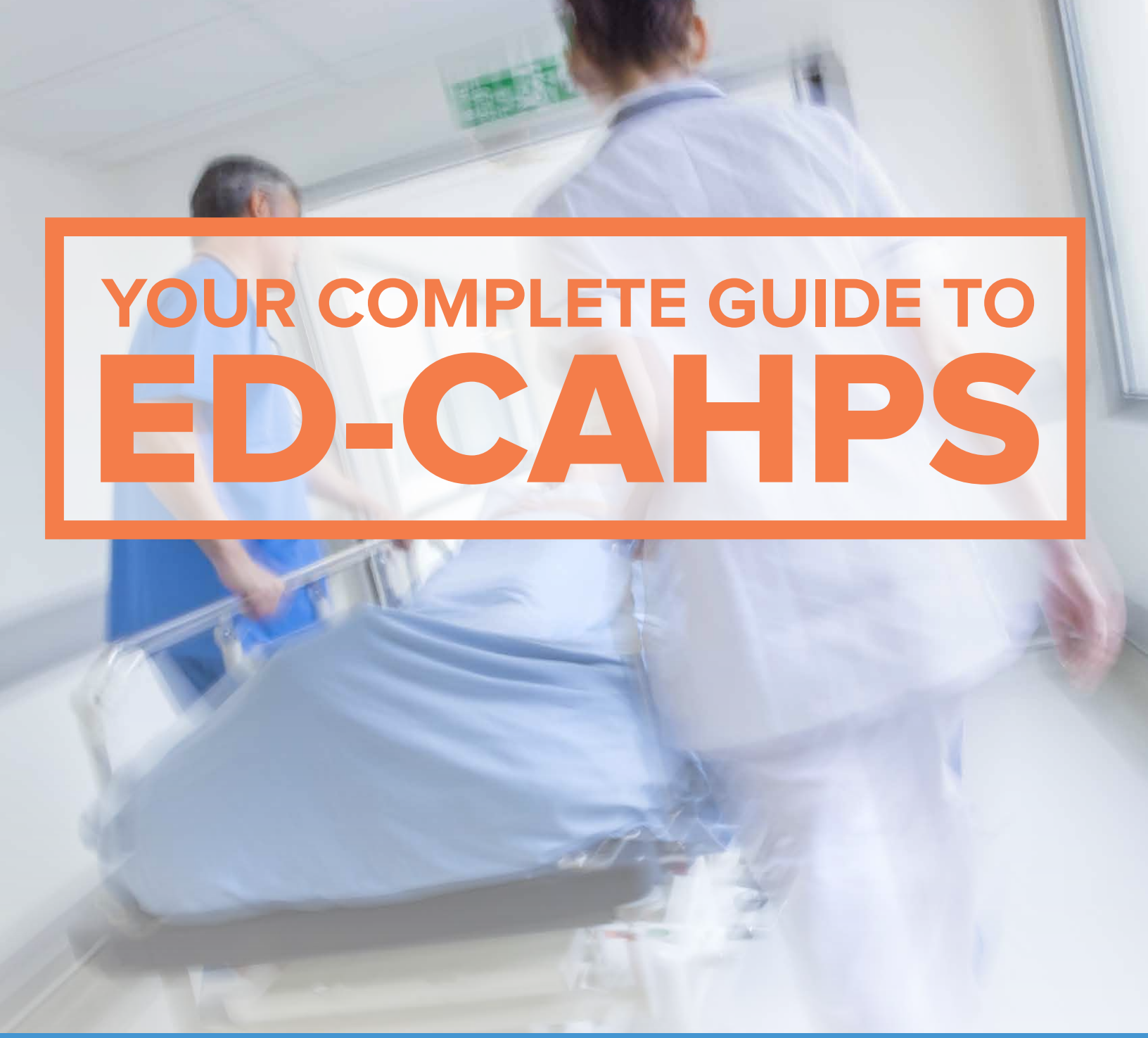

YOUR COMPLETE GUIDE TO ED-CAHPS

Learn how to ready your team for the upcoming ED-CAHPS survey measures.

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DTA ASSOCIATES

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INTRODUCTION

ED-CAHPS will soon be a reality. Organizations that start early, hardwiring processes and behaviors in alignment with the new tool, will debut at the top of the database. As an early adopter, your organization will have a headstart over those organizations taking a “wait and see” attitude. While not perfect, the ED-CAHPS survey will bring a level of transparency to emergency department performance nation-wide. Every year the HCAHPS database improves globally at a rate a little higher than one-percent. This means the CAHPS process is already helping to elevate patient experience within hospitals across the country. Hospitals and health systems now have even more opportunities to make an impact. By thoughtfully improving the ED experience, 30-60% of your overall inpatient population, your organization can have a dramatic impact upon the totality of your patient’s experiences of care at your facility. Your emergency department has the potential to set the tone for your entire organization. Now is the time to seize your opportunity!

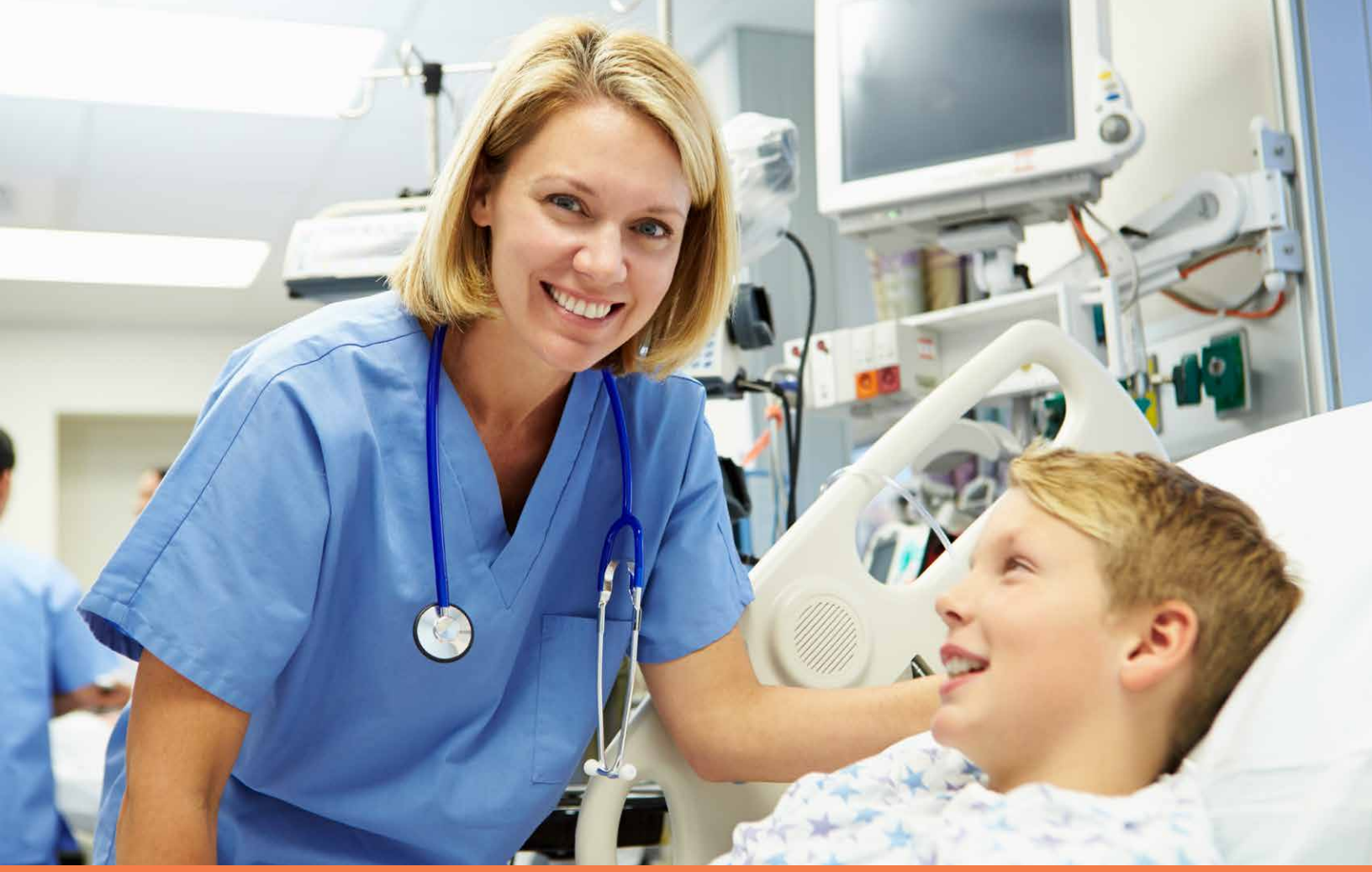
HISTORY OF CAHPS

Created by the Agency for Healthcare Research and Quality (AHRQ), CAHPS surveys ask patients about their experiences with healthcare. The surveys cover topics that patients are qualified to gage. From communication with care providers about medication to the environment of care, CAHPS surveys cover a wide range of topics across the continuum. Beginning with the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS), CAHPS surveys have expanded into Clinician & Group (CG-CAHPS) and the Home Health (HH-CAHPS) realm, among others. ED-CAHPS, focusing on the emergency department, will be next in the evolution of value-based surveying. [1]

The goal of CAHPS surveys of any kind is twofold. First, they provide standardized questionnaires that healthcare facilities can use to collect patients' feedback. Second, CAHPS surveys publicly report results to inform and empower the public to make decisions on where they should receive care. Additionally, CMS (Centers for Medicare & Medicaid Services) uses these survey scores along with other measures of quality to help determine reimbursements. [1]

The very subjective nature of these survey questions have led to pushback from many providers. With such a great emphasis on patients' opinions, won't quality of care be diminished? In short, no. It's very hard for many patients to separate the more objective metric of quality of care and the softer metric of experience. They also often don't have the expertise to question the outcomes of their healthcare visit.

For example, let's consider a patient that is receiving treatment for a broken rib. He may have received the best treatment in the country, but if the physician treated him without respect--he will feel as though he received very poor care. That should matter to every care provider. Patients want to be treated with courtesy and respect. That being said, patient experience cannot be measured in isolation. Outcomes go hand in hand with patient experience, neither one can be ignored to focus on the other.



IMPORTANCE OF THE ED

The emergency department is one of the most important departments within a hospital. Anywhere from 30-60% of all hospital inpatient admissions come from the emergency department. So, a patient's overall perception of quality of care is greatly dependent on their experience in the ED. Issues that go unresolved in the ED can have a negative impact on an entire organization's reputation, even if excellent care is provided in other departments. Improving the care in the emergency department presents a daunting challenge. Though, the reward is high if executed properly.

There's another element to success in the ED -- it's hard to play catch-up. David Maister, in his article The Psychology of Waiting Lines introduces the concept of "The Law of Service."

"The corollary to this law is the proposition that there is a halo-effect created by the early stages of any service encounter, and that if money, time and attention is to be spent in improving the perceived quality of service, then the largest payback may well occur in these early stages," Maister writes. [2]

How this law applies to the ED is simple. If a patient has a relatively pleasant experience in the emergency department, they will be predisposed to be satisfied throughout the duration of their stay at the hospital. Investing time, money and training into the ED will lead to rewards for the entire organization.

The rewards of an excellent ED have been proven through many studies. Beyond improving a hospital's reputation overall, it can also improve an organization's bottom line. Most hospitals estimate that two percent of patients leave the ED without ever being seen. If EDs can retain even two additional patients per day, that improvement could bring in as much as $200,000 - $300,000 in additional revenue for the hospital. [3]

WHAT TO EXPECT FROM ED-CAHPS

As of October, 2015, ED-CAHPS were in their second round of development and testing. Before ED-CAHPS is "CAHPS" accredited, it is referred to as the Emergency Department Patient Experience of Care (ED-PEC) survey. The official ED-CAHPS survey is slated to be released in 2016.

The three ED-PEC survey versions that were released for testing focused on recording feedback from two different groups of people:

1. Patients that were discharged directly into the community from the emergency department. This survey has a total of 63 questions and includes seven survey sections.
2. Patients admitted for an inpatient stay and discharged from the hospital who were eligible to receive the HCAHPS survey. These participants received either:
    a. A 57 question survey that asks exclusively about the patient's experiences in the emergency department.
    b. The traditional HCAHPS survey questions with additional items about the Emergency Department experience. [4]

The existing ED-PEC surveys provide insight into what you can expect from the accredited ED-CAHPS surveys when they are released. ED-PEC has been broken down into 4 sections that relate to:

- **Going to the Emergency Room:** Questions in this section mainly revolve around the timeliness of care and the arrival at the emergency room.
- **During Your Emergency Room Visit:** Questions in this section are related to timeliness of care, communication about medication, and pain management. There will also be a new question, for those who are familiar with the HCAHPS survey, that asks directly about interpreter services provided.
- **People Who Took Care of You:** Questions center around how nurses and doctors communicated with the patient.
- **Leaving the Emergency Room:** Questions in this section focus on discharge care instructions and follow up care, or transitions in care to an inpatient setting. [5]

The framework of ED-CAHPS will be similar to the baseline that has already been set by the inpatient HCAHPS survey. So, the ED-CAHPS questions may not come as much of a surprise.

You may also be concerned about patient experience measurement in the ED in general. After all, many ED patients arrive at the hospital in some sort of crisis. Some patients may be under the influence of a substance, or simply not in a state where they'd otherwise be able to make rational judgments with regard to communication and service. There are however some mitigating factors to consider to offset this concern. First, you're not alone. Every other ED in the country will face these same issues to one degree or another. Second, you will have the ability to benchmark against similar peers. The mere existence of a nationally-mandated survey instrument means you'll soon have visibility into how you stack up against similar facilities in similar cities. Third, you'll get some credit for your patient population. While not perfect, ED-CAHPS will be adjusted to take into account the acuity level and other factors for your patients.

If you haven't already checked it out, you can preview the EDPEC Survey at

www.CMS.gov

HOW TO IMPROVE ED-CAHPS

While the ED presents many of its own complications and complexities, many of the initiatives you may have already implemented to excel for HCAHPS will also help with ED-CAHPS.

KNOW THE TOOL

When HCAHPS was first required, those organizations which had already adopted the tool debuted near the top of the public database. It is widely expected the same phenomenon will occur with ED-CAHPS. First and foremost, you'll need to compare any survey instruments you're currently using with the preliminary versions of ED-PEC and eventually ED-CAHPS. The ED-PEC, like HCAHPS, will ask how often certain behaviors or processes occurred. If your staff is accustomed to other response scales, now is the time to start training for the frequency scale.

Pre-fielding the current version of the ED-PEC survey will provide your staff and leadership with a head-start for improvement. With just a few months of data, your teams can start to understand those areas of weakness exposed by pre-fielding this new survey instrument. Pre-fielding the survey also helps to educate your staff about what behaviors and processes are being measured. For some organizations, current processes will have to be reevaluated or overhauled to have the most positive impact on ED-CAHPS results. Overhauling process is rarely easy, so best to start before your ED-CAHPS results make a public impression.

KNOW YOUR VENDOR

If you already work with a survey vendor, you've likely been receiving updates with regard to the ED-PEC and CAHPS tool. Most hospitals are already fielding some

sort of an ED survey, perhaps one designed by their vendor. The best survey vendors will already be testing their home-grown ED survey instruments against the ED-PEC to determine where there is overlap or how the legacy survey items might correlate to the new survey tool. Now is the time to start vetting your survey partner. Has your vendor already mapped results from your current instrument to the ED-PEC? Has your vendor offered consulting or training time to prepare your staff for the transition to the new instrument?

Something to consider beyond preparation for the survey content is that ED survey response rates are historically very low. Does your vendor have a methodology to help you achieve the maximum return possible? It's not unusual to see survey return rates of 10-15% on an ED survey. Additional waves or phone calls can help to a point, but there's yet to be a "silver bullet" solution for enhancing response rates.

PEOPLE: ENGAGING YOUR ED STAFF

Having the right people on board and keeping those people are THE most essential pieces of any great healthcare facility. Developing or sustaining a healthy culture within healthcare organizations, can be a big challenge -- especially in the high-stress environment of the ED. However, employers that can successfully create and sustain a satisfied staff will see returns beyond employee-centric metrics, such as retention and overall satisfaction. Employee satisfaction and engagement has implications for patient experience, patient safety and outcomes.

Historically ED staffs have been in dire need of rejuvenation. A survey of 436 U.S. hospitals found that in the ED employees are most commonly dissatisfied with:

1. Administrators understanding the needs of their department
2. Feeling understaffed in their departments
3. The organization's efforts to keep its good employees

Employees also noted that they felt under recognized and also wanted more open communication from their leaders. 6 The first step in correcting these issues is to make sure you have the right people on your team.

Hiring is the first area to look at while analyzing how to make your ED better. Since the ED environment is fast-paced and every person is essential, when there is an opening there is a sense of urgency in filling that position. This is the first mistake that can lead to unintentionally building a weak culture. Paul Glatzhofer, consulting manager for Select International and an industrial psychologist focused on this issue in a 2013 talk. Glatzhofer noted that when you focus on metrics such as "time-to-fill" rather than finding the absolute best first for the position can have a negative impact on your employee retention and broader patient satisfaction scores.

In the same session, Dr. Todd Hold, president of Georgia Emergency Services and associate medical director of the emergency department at Gordon Hospital in Calhoun, GA. mentioned his findings that Gordon

Hospital could trace a decline in its patient experience scores to only two recently hired employees. “When you bring in a bad hire, it’s a black eye and it’s a strike,” said Dr. Hold.

Instead of just looking to fill the position as soon as possible, take a breath and a step back. Glatzhofer recommends focusing on three areas while hiring: interview, screening, and development. Make sure your interviewers are adequately informed of your specific needs and have a standardized format to the interview, a decision matrix can come in handy here. During the screening process, consider if this person will be a good fit within your organization and your requirements for patient satisfaction, regardless of experience. Asking candidates to provide examples of how they view their role in patient experience and to share how they have helped participate in a successful service recovery are important items to include in the discussion. Good interviews will help you determine the personal and professional weaknesses, knowing these will greatly help you while you develop your selected hires. [7]

Once you are assured that you are hiring the best, you now must focus on retaining and developing your employees. Rounding with employees and educating them on patient-centered communication, outlined in the following sections, are the best ways to develop your staff.

ROUNDING WITH PATIENTS AND STAFF IN THE ED

Rounding is a simple, but powerful tactic that ED leaders should implement into their ED process to help build a patient-centered culture. There is a spectrum of rounding within the ED. It starts with senior leaders rounding on staff, progresses to clinical leaders rounding on patients and on those in the waiting room, and then includes purposeful hourly rounding by staff with patients. Hospitals around the country who have focused on rounding have seen improvements in staff and patient communication by addressing issues in real-time, and improving quality of care, safety, and staff engagement as well as and the overall patient experience. These results have not just been seen in an inpatient settings, but have been reflected in emergency departments as well.

When Baptist Hospital of Miami implemented hourly rounding in its high-volume ED, it increased its ED patient satisfaction scores from the 6th to the 99th percentile in one year. [3]

The premise of rounding is simple. Rounds are scheduled, structured activities in which ED leaders, administrators, managers, supervisors and even frontline care teams purposefully walk through their organizations talking to staff members and patients. Usually the main concern while implementing rounding in the ED is that staff don’t have the bandwidth for an additional activity. However, rounding will actually help your facility reduce inefficiencies. If you have a digital rounding tool, you will also be saving time by avoiding manual data entry and analysis.

The mere act of taking the time to personally talk with individuals has been proven to improve patient satisfaction and staff engagement. However, if data is collected in an organized and standardized way it can be used to help hospital leaders make data-driven decisions based on current data.

Hundreds of MyRounding customers have found this to be one of the most greatest benefits to using the MyRounding application. With a process to systematically collect data that can be analyzed through the MyRounding Analytics Platform, leaders are empowered to make incremental improvements across their organization based on real-time data.

There are many different types of rounds that are beneficial in an ED environment, but the top four center around staff and patients.

1. **Leader Rounding with Staff:** Leadership rounding with staff can have benefits in any area of your organization, but it can be very powerful in the ED. This type of round opens up a conversation where staff share concerns, ask questions and connect with supervisors. Beyond engagement, leadership rounding with staff gives leaders an opportunity to reinforce good behavior, coach on improvements, and recognize success.
2. **Leader Rounding with Patients:** When leaders round with patients, they reinforce the facility's commitment to providing excellent care for the patient. Rounding with patients also allows hospital leaders to break down the barriers to information that often arise from the frontline. There's no better way to learn how you can improve patient experience at your facility, than by asking the patient directly.
3. **Rounding with Patients in the Waiting Room:** The waiting room is oftentimes the area where patients are feeling the most anxiety and concern. The waiting room is also where perceptions and expectations around wait times can be set. Rounding in the waiting area is one of the simplest ways to illustrate your concern and care for the patient, set expectations, and answer any questions that a patient may have. A "round" in the ED lobby can be addressed to one patient, or involve an entire group of patients and done more as an announcement. The ED waiting room is also going to weigh heavily in the ED-CAHPS survey.

There are more best practices for your reception area on
page 13

4. **Purposeful Hourly Rounding with Patients:** Staff are recommended to round on patients in the ED every hour or half hour. While this might seem like a big task for your team, most patients are being checked in on at least every hour. The addition of rounding will standardize the process. While staff are rounding with patients they can collect feedback and address issues that arise. Often these rounds are shared between two disciplines like nursing and techs or aides.

The questions you choose to use in your rounds are very important. It is now more important than ever to start explaining to your patients, in the most transparent way possible, what you are doing and why you're doing it. There is science around "scripting" it really works. Statements like "I hear what you're saying" or questions like "What can I explain for you?" will improve the patient experience, and your ED-CAHPS results.

PROCESS: REDUCING WAIT TIMES

Reducing wait times is one of the most unique issues that the ED faces. Although this has always been an issue that EDs are aware of, the coming ED-CAHPS specifically reference the patient's experience in the waiting room.

There are at least two new questions in ED-PEC survey that address ED efficiency:

- "When you first arrived at the emergency room, how long was it before someone talked to you about the reason why you were there?"
  - Less than 5 minutes
  - 5 to 15 minutes
  - More than 15 minutes
- "During this emergency room visit did you get care within 30 minutes of getting to the emergency room?"
  - Yes/No

As others studying ED-CAHPS have noted, these two specific timelines will become the new standard that EDs will need to meet. Given this fact, it's a good idea to start now before the mandates kick in, and do some self-assessment of your own ED wait and time-to-care touch points. [5]

PROCESS: LEAN IN THE ED

"It is not enough to just do your best or work hard. You must know what to work on." Dr. W. Edwards Deming is one of the fathers of process improvement. This quote is important as it reminds us that we have to be strategic - even in how we deploy our own time and intellect. Dr. Deming's point is that talent and hard word aren't enough. We have to know where to start to make the improvements we seek. [8]

Lean process improvement methodology is great for just that - knowing where to focus. It's next to impossible to talk about patient flow and reducing wait times in the ED and not mention Lean. So very many organizations and emergency departments have begun to incorporate principles of Lean as a process improvement methodology. The central tenant in Lean is focus on reducing waste and improving flow. The emergency department is the perfect place to deploy this methodology given the many, many processes and the central flow of the patient throughout the department.

In addition to leading Lean projects, the team at DTA Associates has had success with patient-level observations as a means for seeing some of the improvement opportunities from a firsthand patient perspective. Spending time accompanying patients on their journey in the ED affords the opportunity to not only see the potential wasted times and inefficiencies, but it also can provide the opportunity for mapping the care team communication from the patient's perspective.

~~TRANSFORMING THE WAITING ROOM~~ RECEPTION

As discussed earlier, it's hard to play catch up with a patient experience. If your reception area helps foster the beginning of a good experience, there is a much greater chance that the patient leaves satisfied. This is why the waiting room is so important. Your waiting room is your EDs first impression. There's no second chances, so it's essential to get it right.

Set Expectations

Maister outlines this unique concept in *The Psychology of Waiting Lines*.

Satisfaction = Perception - Expectation

Satisfaction is the target. We want happy, satisfied patients. However, patient satisfaction is not based on outcomes exclusively. This illogical phenomena is most physicians' dilemma with patient-experience based methodologies. Luckily, we actually can influence our patient's perception and expectations as much as the outcomes.

Maister says it this way: "The point, of course, is that both the perception and the expectation are psychological phenomena. They are not the reality. In a benevolent world, both the perception and the expectation will have some connection to reality, but they are not reality. Accordingly, all service managers must pay attention to three things: what was actually done to or for the client, what was perceived by the client, and what the client expected." Your facility probably does a good job with "what was done," working on the other softer aspects -- expectations and perceptions -- will help strengthen your performance on the upcoming ED-CAHPS survey. [2]

So how can you set reasonable expectations with your patients in the waiting room? Vague recommendations such as "speed up your process" provide no actionable steps. Maister outlines several key strategies. While some are simple and others more complicated, all recommendations are clear and precise.

~~Waiting Room~~

Remove "waiting room" from all signage and strike it from your vocabulary. Your EDs lobby or reception area is not a place for "waiting." You must begin to think of it as the place where care begins. Try calling it "reception" or "lobby." You could even throw the idea to your staff or to your Patient and Family Advisory Council to see if they can come up with a creative name.

Under Promise and Over Deliver

This is one of the key mantras for setting achievable expectations. When giving patients a time estimate, err on the side of overestimating. When you under promise and over deliver, they will be much more satisfied. Patients report again and again that they don't care of the estimations that we give them are wrong, they just want us to keep them informed. Keeping them apprised as times change will help them manage their fears and anxieties of the unknown.

Occupy Time

Recognize that occupied time feels shorter than unoccupied time. Filling a customer's time will help the wait go by faster. It's the common phrase "a watched pot never boils." If a patient is distracted while they wait, their time goes by faster. If you round on patients in your waiting room (as outlined in the previous section) this is a great topic to bring up. Ask your patients what they would like to have for entertainment in the waiting room. Make sure that you also have entertainment and options for them once they are in their patient room as well.

Reduce Anxiety Through Communication

Work to reduce anxiety. Unlike most other service settings (like a restaurant or a hotel), people who are coming to the ED feel a great amount of anxiety. Try to empathize with the patient on what may be causing them anxiety and do everything you can to reduce it for them. Their anxiety may be caused by rational or irrational fears. Both of these need to be addressed with the same amount of respect and care.

- **Explain why they are waiting.** Unexplained waits feel longer than waits caused by logical reasons. This is true in the treatment phase as well - If they know that it takes 45 minutes for a CT result to come back, then it's easier to wait for those 45 minutes.
- **Focus on value.** Ensure them that they will be receiving the highest level of care possible once they are seen. If there are wait times associated with a specialist, communicate this to them.

- **Help them understand their experience.** Explain why someone may have been served before them.
- **Give them a sense of time.** The greatest source of anxiety in waiting is how long the wait will be. Uncertain wait times greatly increase anxiety, try to give them a high estimate on how long they will be in the waiting room.
- **Your words matter.** How you communicate is key to reduce anxiety and set expectations. Focus on using words that are apologetic and empathetic, as well as clearly explain the ED process. If you have set scripts and question sets for your staff to use in their conversations, they will be one step ahead in this area. It's an easy way to direct staff members to use the right phrasing and words that reduce anxiety and set appropriate expectations.

People Want to Get Started

Remember that people want to get started. This is a truism of human psyche. People want to feel like the service has begun or else they feel at risk of being forgotten, thus increasing their anxiety level. Think of shifting your culture to in-process waits, rather than out of process ones. This is one of the reasons why restaurants provide menus and a drinks bar for waiting customers. These service-related time-fillers give the sense that service has already begun. Some EDs that have taken this strategy to heart, and have implemented tactics such as bedside registration, direct bedding, split flow and even some have had a physician greet the patient in the triage process. [2]

TREATMENT PHASE: THE PEOPLE TAKING CARE OF YOU

Focusing with staff and physicians on the important role they play in communicating effectively with their patients is key. Patients want to be cared for clinically and medically but they also want to be cared for as a person, emotionally. Staff who are able to communicate about both aspects of the patient are better able to connect and sustain enhanced interactions with patients. This is especially important when trying to achieve greater levels of patient engagement.

It is only when patients feel like they have been treated with courtesy and respect, listened carefully to and had things explained to them in a way that they can understand, that they are more likely to be activated to participate in their own care. Think of a patient that needs to make lifestyle changes that will impact their health, be it drug or alcohol use, weight loss or exercise - if they have connected with their care team and feel cared for by them, the patient will be more likely to engage in the changes that they personally can make.

One of the most effective strategies to help improve physician and staff communication with patients is through care team coaching. DTA Associates has had great success with coaching physicians, PAs, nurses, techs, coordinators, social workers, registration staff, etc. in their daily interactions with patients. This has been especially true in the emergency department. There's something so intensely personal about the way

we communicate and how we "show up" in a patient's' room that necessitates a very personal approach to improvement.

Many of us think we do a great job of showing courtesy and respect, listening carefully or explaining things in a way that patients can understand. It's only with that powerful feedback from real time examples in a coaching relationship that can help to really bring around changes in behavior and subtleties in communication. Additionally, this is a strategy that can really help to boost morale. As one ED staff member recently said, "It makes me feel good to work for an organization that cares enough to invest in us with a supportive strategy like coaching."

INPATIENT ADMISSION PROCESS

An area of waiting that you also should not overlook is the wait that's associated with the inpatient admission process. There will be some number of questions on the ED CAHPS survey regarding ED experiences that will address transition to inpatient from the ED. For example, one such question asks, "Once you found out you would have to stay in the hospital, were you kept informed about how long it would be before you went to another part of the hospital?" [5]

Think about your backdoor processes and whether there are simple and inexpensive ways to improve procedures in this area. Are there communication systems that can help ED nurses see when inpatient beds become available? Should you assign a specific staff member to coordinate the transition process?

HANDLING ISSUES AT THE POINT OF CARE

Handling issues at the point of care is always a best practice in any department of the hospital, but it is especially essential for the Emergency Department. In the words of Quint Studer, "With inpatient stays, a hospital usually has several days to rectify any problem. Providing quality care and service is much more urgent in the ED." [3]

Addressing issues as soon as possible is essential to the success of your ED. Unresolved issues will resurface again and again, ultimately impacting the patient's perceptions of all of the points of care.

Set up a process to rapidly addressing issues that arise. This system could be hardwired into technology you utilize, or a systematic protocol on pen and paper. It is recommended to have a digital issue management tool that allows you to open issues and track them to resolution.

MyRounding customers utilized the issue management feature while rounding. Issues can be opened at the patient bedside and tracked through resolution, and analyzed for trends and repeated issues. Often major issues are resolved within a matter of minutes. The resolution is then communicated to the patient. This closed-loop feedback is essential for a strong ED.

POST DISCHARGE COMMUNICATION

Care doesn't stop when a patient is discharged from the ED. Follow-up phone calls from a nurse/physician is a big ask for many care teams, but it is worth the added effort. Get their phone number during the visit, and share your own number. Patients will always be grateful you gave them a call. It gives you an opportunity to answer any questions.

There have been several studies that suggest that following up with patients after they have been discharged from the ED leads to higher satisfaction and overall perception of the ED. There are also major consequences for ignoring this best practice. According to the Studer Group study, none of the EDs studied that provided follow-up calls to patients received satisfaction rankings below the 70th percentile, and, in most cases, these hospitals reached the 90th percentile. Few hospitals that did not provide such calls received rankings above the 50th percentile. [3]

These phone calls should be conducted 1-2 days after the patient has been discharged. They are usually performed by a nurse. This opportunity can be used to generally check in on the patient and show that you care, thus improving satisfaction. However, beyond satisfaction, post-discharge calls provide a great opportunity to repeat discharge instructions and receive feedback from a patient. This increases the likelihood that the patient will follow their post-discharge instructions and it will reduce the number of readmissions.

CONCLUSION

The emergency department can be an intense time for patients and families. In many cases their experience in the ED is only the beginning of their journey. The staff and physicians of the emergency department play a key role in setting the stage for the patients' perceptions of their entire care experience.

With the advent of ED-CAHPS, there's even more heightened focus on the emergency department and their impact on patient experience. There are many strategies and techniques to incorporate that can help to transform the experience of patients in the emergency department. Those organizations that begin to implement and focus on these now will be better prepared for what is to come!

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EMPOWERING PEOPLE. ACCELERATING CHANGE. IMPROVING CARE.

ACCELERATE TOWARD VALUE-BASED HEALTHCARE DELIVERY.

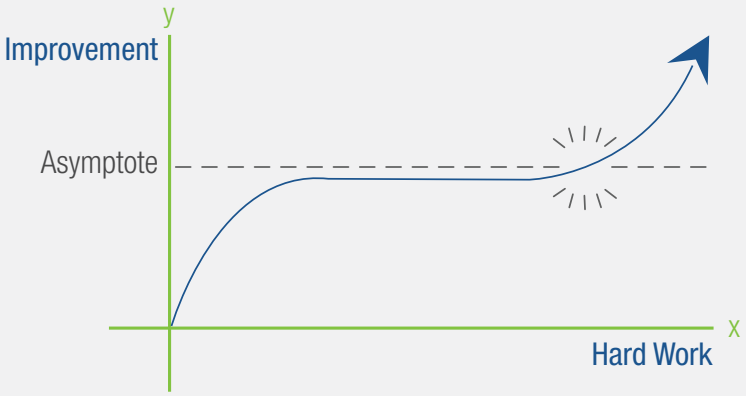
WHAT WE DO

Need help improving your quality, patient experience or analytics? We can guide you down the most efficient path to your patient-centered improvement objectives. Our approach is fast, friendly and tailored to build on the strengths of your staff and organization.

We position your organization to thrive under value-based healthcare delivery. Learn how to eliminate waste and improve productivity, maximize staff capabilities and leverage your technology in a manner that's tailored to your organization's reality.

DTA: DEFY THE ASYMPTOTE

DTA stands for "Defy the Asymptote." An asymptote is a mathematical term for an imaginary line (or limit) that an equation approaches but never touches. In the graph, no matter how big X gets, Y will get closer and closer to the asymptote but will never reach it. We use it as a tongue-in-cheek way to describe healthcare challenges that seem impossible to overcome.



Your asymptote may be patient satisfaction scores that have plateaued. Or frustrated teams that meet frequently, yet are not able to attain quality goals. Or a request backlog that never gets smaller. The only way to overcome an asymptote is to defy it, like you defy gravity. That's what DTA Associates is here to help you do.

What asymptote do you need to defy? We can help.

SOLUTIONS FOR MID-SIZE PROVIDER HOSPITALS, CLINICS AND SYSTEMS

REDESIGN QUALITY

- Develop performance road map to align strategic goals with pragmatic action by discipline
- Evaluate analytic and performance improvement competencies to meet the demands of value-based delivery
- Assess staff to ensure capabilities and roles align with functions
- Support and mentor staff to get each person working at the top of their license
- Conduct Lean process improvement activities to maximize efficiency and effectiveness in care delivery

BUILD A SERVICE CULTURE

- Instill an organization-wide service culture that is customized to the organization
- Develop service standards that resonate with staff and physicians as well as patients and families
- Create customized training from patient, family and employee input
- Provide a train-the-trainer model to allow for internal sustainability

ACCELERATE PATIENT EXPERIENCE PERFORMANCE

- Create a road map for success
- Improve communication through care team and provider coaching
- Create Patient & Family Advisory Councils that inform the strategy and develop improvement within patient experience

DEVELOP YOUR DATA INFRASTRUCTURE

- Customized Enterprise Data Warehouse (EDW)
- Business Intelligence tool selection and development
- Mentor staff to increase EDW proficiency
- Assess, evaluate and trim EMR report catalog
- Develop actionable predictive analytics

DEVELOP STRATEGIES, REDESIGN CORE FUNCTIONS AND ALIGN MEASUREMENT

- Develop multi-year goals that align measurement infrastructure and strategy
- Guide strategies for regulatory and pay-for-performance measures and management
- Redesign the care management function to support care across the continuum

QUALITY LEADERSHIP ACADEMY

- Mentor physician leaders and middle managers
- Ensure long-term organizational self-sufficiency through project-based cohort learning
- Deliver tangible results (quality, cost and experience)
- Build a stronger performance culture through meaningful work

BUSINESS INTELLIGENCE CATALOG (BIC)

- Flexible, web-based BI object inventory
- Automate Crystal Report documentation for impact analysis

Questions about how our services will work for you?

Contact us today to learn how our custom solutions can help you improve clinical outcomes, enhance patient experience, and impact healthcare affordability. Email: **contact@dtaassociates.com**

About MyRounding

The MyRounding application is a cloud-based, HIPAA-compliant platform used by hospitals, clinics and practices to collect quality, safety, satisfaction and other audit and compliance data for analysis and reporting – as well as help organizations capture larger federal reimbursement revenues. When applied and used in patient settings for daily and hourly patient rounding, the MyRounding application has led to increases in HCAHPS scores by over 33%. Beyond patients, the application can easily be configured by local administrators to create custom surveys and audits. The application is highly customizable and very easy to use. From hand hygiene audits to family rounds, to recommended practices, the MyRounding application is used by hospitals in a variety of ways.

- Individualized dashboard gives you visibility and accountability into daily rounding activity
- Instant trending reports at every user level
- Preloaded scripts and question sets that can be customized
- Continued implementation and optimization support
- Track, assign and manage issues
- Available on any mobile or desktop device

SET UP A DEMO:

We'd love to share how MyRounding can help your organization.

Online: www.myrounding.com/demo
Call: 877-503-9226
Email: info@myrounding.com

RESOURCES

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