POM ACO

TRANSFORMING HEALTH CARE TOGETHER

ACO Quality Measures Essentials

Wednesday, September 25, 2024

11:00 am – 1:00 pm

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Collaborative Care Organization

Metro Health
Integrated Network

Northern Michigan
Care Partners

OSP
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Welcome to Value-Based Care Essentials: The Role of ACOs!

- Course comprised of four sessions*, covering essential topics related to ACOs, including MSSP overview, coding, documentation, care management, and quality measures.
- After the activity, participants will be able to understand the role of ACOs and their functions, as well as apply knowledge learned in the course to better serve patients and fulfill CMS requirements.

Session 1: ACO Basics
September 10, 2024
11 am – 1 pm

Session 2: ACO Quality Measures Essentials
September 25, 2024
11 am – 1 pm

Session 3: Managing the Care of ACO Beneficiaries
October 8, 2024
11 am – 1 pm

Session 4: Specialists and ACO Beneficiaries
October 23, 2024
11 am – 1 pm

**1.75 CE Credits for each session attended*
(7 CE credits for all 4 sessions)

Today's Session

Speakers

- Paul Berg, MD, MSHAL
  Senior Vice President and Chief Medical Officer – MyMichigan Health
- Hanna Hillier, MSA, BS, CMA
  Senior Population Health Project Analyst – MyMichigan Collaborative Care Organization
- Tate Rugenstein, MPH
  Senior Manager, Business Planning – Physician Organization of Michigan ACO
- Nikki Greet, BS, MPA
  Senior Project Manager, Office of Patient Experience – Michigan Medicine
- Nancy Kuemin, JD
  Patient Experience Coach, Office of Patient Experience – Michigan Medicine

Objectives

- ✓Identify the impact of utilization management in ACOs
- ✓Define the relationship between quality and The Quadruple Aim
- ✓Understand Accountable Care Organization quality programming basics
- ✓Develop high-level understanding of key clinical quality metrics

ACO Basics: Session 1 Refresher

David Serlin, MD, FAAFP

ACO Quality and The Quadruple Aim

The goals of an ACOs include ensuring patients get the right care at the right time, avoiding unnecessary duplication of services, preventing medical errors, improving health outcomes, and managing cost.

- Helps members manage their chronic conditions
- Reduces burden of disease

1 Improve Population Health

2 Enhance Patient Experience

- Care needs are tailored to the individual member
- Encourages members to play an active role in their healthcare

- Prevents avoidable inpatient and ED utilization
- Focuses on preventative care

3 Lower Cost of Care

4 Improve Clinician Experience

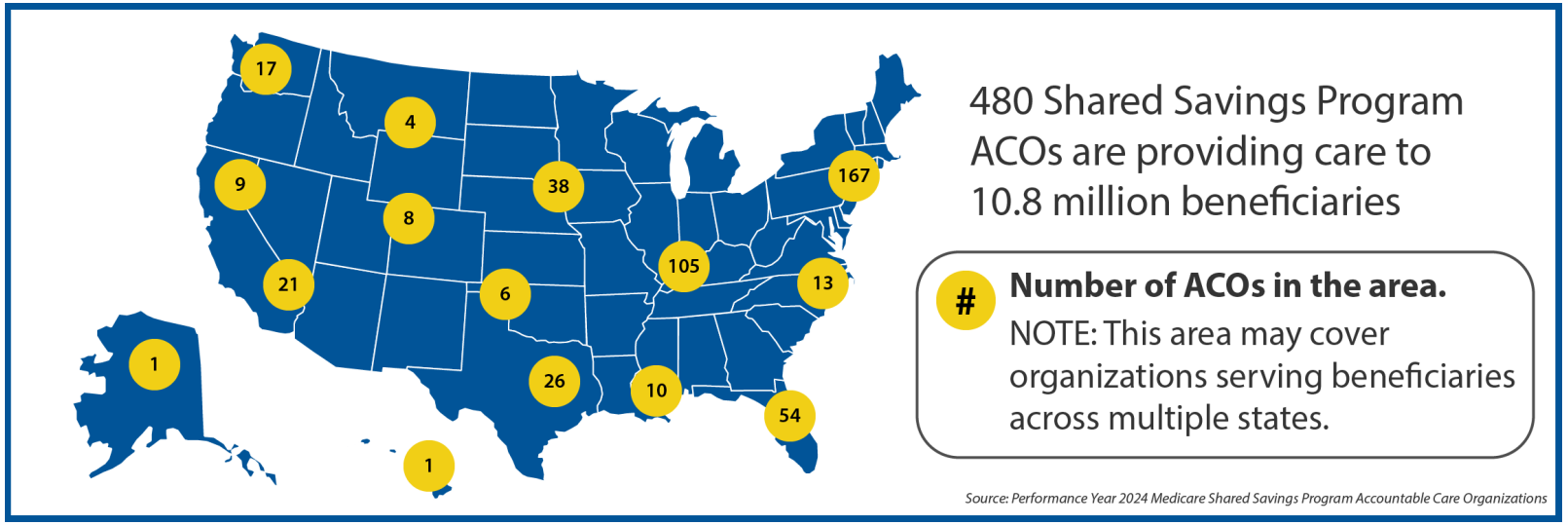
- Creates an open environment for learning and shared feedback
- Provides accessible tools

What are the goals of ACOs?

- ACOs focus on **keeping patients healthy**, rather than waiting until they get sick to get care.
- ACOs enable health care providers to work as a team to **coordinate care and better manage chronic conditions**.
- ACOs aim to **lower costs by avoiding unnecessary services or duplicate tests**, helping patients find affordable treatment options (like lower cost prescriptions, telehealth appointments, or connections to assistance programs).
- ACOs support patients and their families and caregivers by **coordinating follow-up care** and ensuring care plans meet their needs and preferences.
- **Through coordinated care, doctors are able to keep patients healthy and out of the hospital, thereby spending less money on health care.**

What is the Medicare Shared Savings Program?

- Medicare has several ACO programs that participants can choose to participate in.
- The Medicare Shared Savings Program (MSSP) is the primary Medicare ACO program. The MSSP was derived from the Physician Group Demonstration Project, which started during the George W. Bush administration, and the MSSP was permanently authorized by the Affordable Care Act.
- The Shared Savings Program has different participation tracks that allow ACOs to select an arrangement that makes the most sense for their organization.



Key Aspects of the Medicare Shared Savings Program

1. **A Population Management Incentive System**
   Medicare's voluntary Shared Savings Program (SSP) enables groups of providers forming accountable care organizations (ACOs) to earn bonuses if they can keep total population health expenditures below a target benchmark.

2. **Primary Care at the Heart of the ACO**
   Medicare ACOs will be structured around primary care groups but may include other providers, including hospitals and health systems, who agree to accept utilization risk for a population of patients defined by their primary care utilization.

3. **Program Options With, Without Risk**
   Participating providers have two program options to choose from: a financial model with exclusively upside potential for all three years, or a model that involves downside risk in all three contract years in exchange for a more-favorable shared savings rate.

4. **Benchmarks Based on Historical Performance**
   An ACOs target expenditure benchmarks will be tied to the historical service utilization of that ACO's patients. The target benchmark will be updated annually by the average national growth in per-beneficiary Medicare expenditures, enabling low-growth providers to more easily achieve shared savings payments.

5. **Preliminary Prospective Assignment Supplemented by Beneficiary-Identifiable Data**
   Although an ACO's patient population will still be attributed retrospectively, CMS will make available prospective predictions of those patients. CMS will also provide ACOs regular access to continuum-spanning patient data, unless patients specifically opt to prohibit such data sharing.

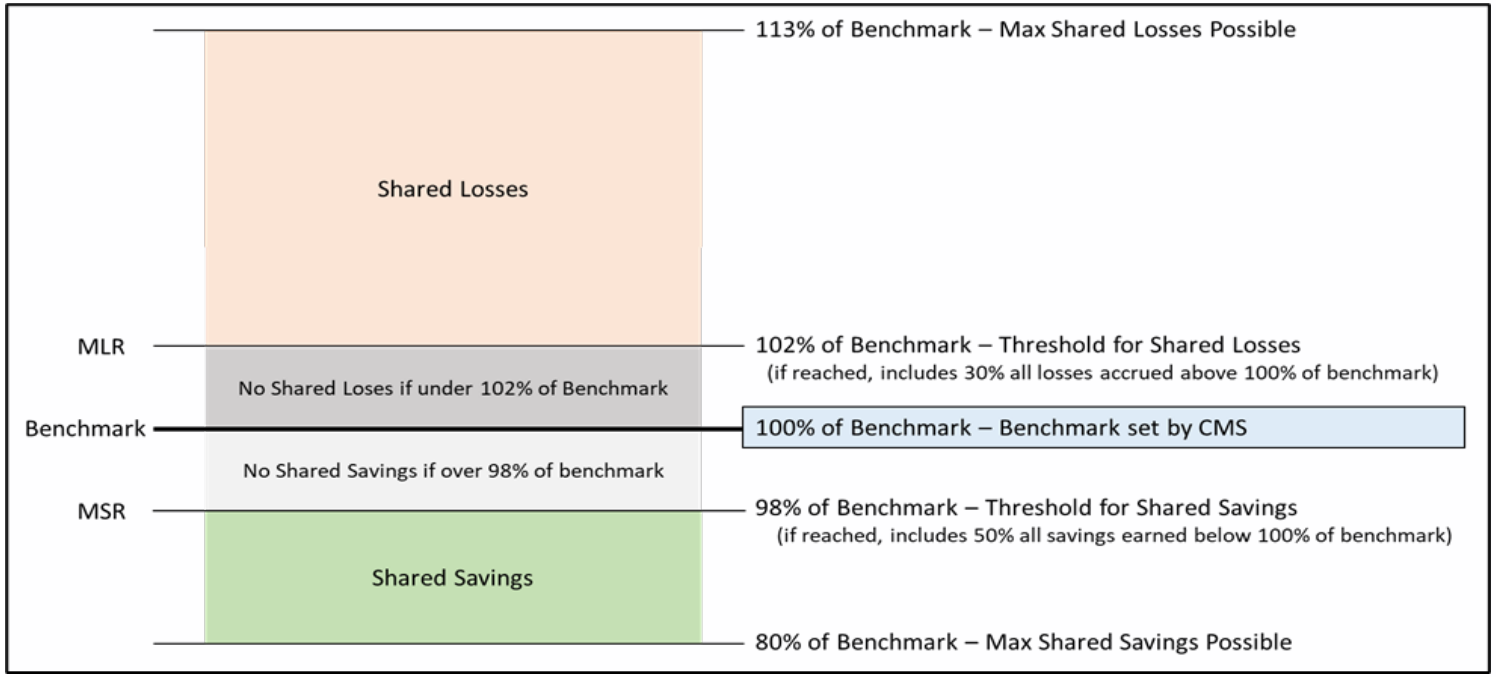
6. **No Restrictions on Patient Choice or Transparency**
   Although patients are attributed to ACOs for the purposes of shared savings calculations, providers may not restrict patient provider choice in any way; all patient-centered ACO marketing materials must be approved by CMS, and patients will be notified of their PCP's participation in SSP.

7. **Shared Savings Payments Adjusted for Quality Performance**
   ACOs will be evaluated on ACO specific quality measures, and the shared savings earning potential will be tied to an aggregate performance standard. Performance measures will be assessed both on an absolute basis and relative to other providers.

8. **Minimum Savings Rate (MSR) and Minimum Loss Rate (MLR)**
   The Minimum Savings Rate and Minimum Loss Rates are thresholds, calculated as a percentage of the ACO's historical benchmark. The ACO must meet or exceed to share in savings or to be liable for shared losses.

ACO Shared Savings / Shared Losses

- CMS calculates benchmarks for each ACO. The benchmark is based on the current participating TINs in the ACO, and their historic performance in those benchmark years for their Medicare beneficiaries at that time.
- At the end of a performance year CMS compares the updated historical benchmark to an ACO's assigned beneficiaries' per capita expenditures during the year.



Importance of Utilization Management to ACOs

Paul Berg, MD, MSHAL

Why Focus on Utilization?

GOAL

The right care, at the right place, at the right time.

- It is widely known in US Healthcare that a high portion of tests, procedures, and hospital admissions are medically unnecessary. We also see a minority number of high-utilization patients driving the majority of costs.
- **Utilization Management (UM)** focuses on reducing medically unnecessary healthcare services and promotes appropriate and efficient services
- Focusing on utilization management allows:
  - Duplicative services and costs to be avoided
  - Costs to be reflective of care needed; often reduced
  - Patients and providers to be less frustrated
  - Better access for all patients when unnecessary services are avoided
  - Services provided at the most appropriate setting

Utilization Management in Accountable Care Organizations

ACO's are responsible for the total cost of care and quality of care for attributed patients, emphasizing the coordination of care amongst providers

CMS uses readmissions and unplanned admissions as two **quality** measures, in addition to their impact on **cost**, and applicable penalties for payments

Risk sharing models make UM necessary for success

Utilization measures are prevalent in most value-based contracts, including federal and commercial plans

Cost and Quality Impacts

Key measures that ACOs are held to for quality:

- Readmissions
- Unplanned Admissions for Chronic Conditions
- Preventative Care:
  - Breast cancer screenings, colorectal cancer screenings, etc.

Cost impact of UM:

- By reducing duplicative and unnecessary services, the total cost of care is reduced, without impacting the care delivered
  - This creates an increased focus on driving high quality care vs high quantity care

Readmission and Unplanned Admission Reduction Strategies

Data tools to identify those at high risk of acute events	
Discharge planning	Immediate post-discharge care, and handoff to primary or specialty care Social work involvement Managing risk factors for readmission prior to discharge Close partnerships with post-acute care facilities and home health organizations
Access to outpatient services	Availability of Primary and Specialty appts, in addition to Urgent Care Patient Education and resources available to contact
Care management	Enrollment for chronic conditions patients Referrals post-discharge or by PCP
Management of SDoH factors	Addressing non-clinical needs such as transportation, ADL support, meal delivery, etc. to prevent clinical events

Additional Areas of Focus for Utilization

- Generic vs. Brand name medications
- Information sharing amongst providers RE: lab and other test results
- Increased outpatient vs. inpatient services
- Immunization clinics
- Standard screening referrals
- Virtual care options

Basics of ACO Quality Programming

Hanna Hillier, MSA, BS, CMA

CMS' Quality Payment Program

- CMS' Quality Payment Program (QPP) is the mechanism through which health care providers are paid by CMS and links payments to the quality of care provided.
  - Two tracks comprise QPP:
    - Merit-based Incentive Payment System (MIPS), or
      - Mimics traditional fee-for-service model
    - Alternative Payment Model (APM)
      - Value-based arrangement which bears financial risk
- ACOs are an Advanced APM (AAP) and have historically reported quality performance via the CMS Web Interface.
  - CMS Web Interface is both a platform and data collection type which facilitates reporting a sample of the ACO's Medicare patients for 10 clinical quality measures.
    - Requires manual abstraction from medical records.
  - In 2025, the CMS Web Interface collection type was sunset.
  - ACOs must report using one of the following collection types:
    - electronic Clinical Quality Measures (eCQMs), OR
    - Medicare CQMs

Quality Performance & Shared Savings

For an ACO to receive the maximum shared savings it must achieve a satisfactory quality performance score **and** meet the *Quality Performance Standard*.

For PY2026 and subsequent years, the quality performance standard is set at the 40th percentile of historical MIPS quality scores.

If the quality performance standard is not met, CMS has implemented a sliding scale to give ACOs some percentage of the earned Shared Savings (but not maximum).

(Maximum Sharing Rate for their ACO Track) x (final quality score) = final sharing rate

Quality Measure Collection Types

Clinical Quality

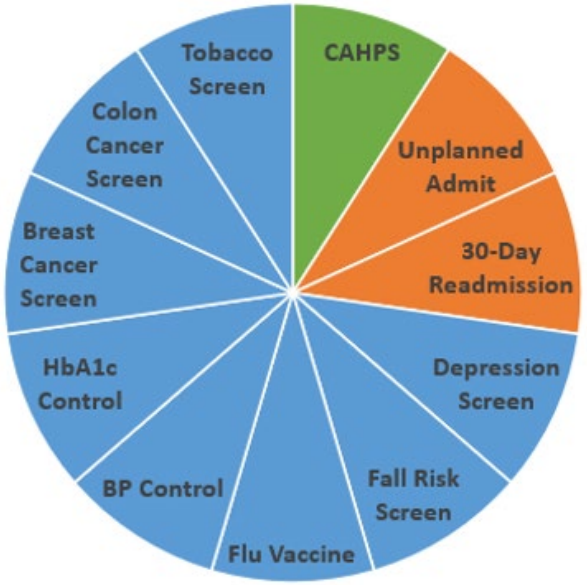
1. Electronic Clinical Quality Measures (eCQMs)
   - All patients, all payors
2. MIPS CQMs**
   - All patients, all payors
3. Medicare CQMs
   - All ACO patients
   - New and temporary

Claims

5. Unplanned Admission Rates for Patients with Multiple Chronic Conditions
   - Medicare Part B Claims
6. Hospital-Wide, 30-Day, All-Cause Unplanned Readmission (HWR) Rate
   - Medicare Part B Claims

Patient Experience

7. CAHPS for MIPS



Example: PY2024 Web Interface Quality Reporting Composition

Clinical Quality Measures

CMS Web Interface

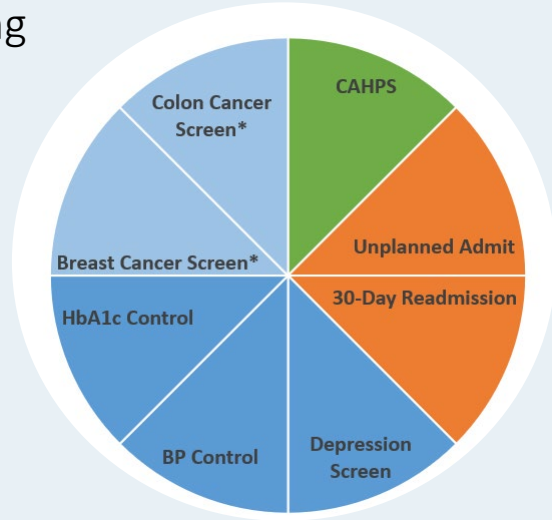
- Diabetes: Hemoglobin A1c (HbA1c) Poor Control
- Preventive Care and Screening: Screening for Depression and Follow-up Plan
- Controlling High Blood Pressure
- Falls: Screening for Future Fall Risk
- Preventive Care and Screening: Influenza Immunization
- Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
- Colorectal Cancer Screening
- Breast Cancer Screening
- Statin Therapy for the Prevention and Treatment of Cardiovascular Disease*
- Depression Remission at Twelve Months*

Measures Sunset

*Pay-for-reporting only. Not used in quality performance score calculation.

2026 eCQM//MIPS CQM/Medicare CQM

- Diabetes: Glycemic Status Assessment Greater than 9%
- Preventive Care and Screening: Screening for Depression and Follow-up Plan
- Controlling High Blood Pressure
- Breast Cancer Screening
- Colorectal Cancer Screening



eCQM Measure Guidance

Screening for Depression and Follow Up (CMS2v14)

- All patients 12+ without bipolar disorder must be screened once per calendar year AND if positive, follow-up plan documented.
  - Patients with depression are no longer *excluded* from the measure as of 2024.
  - Follow-up plan can include medication RX, referral to behavioral health, etc.
- Patient refusal and documentation of medical reason for not screening may be used as *exceptions*.
  - Medical reasons may include:
    - Cognitive, functional, or motivational limitation that may impact accuracy of results; OR
    - Patient is in an urgent or emergent situation and to delay treatment would jeopardize the patient's health status.
  - *Exceptions* remove that specific encounter from the denominator, they do not exclude the patient from the measure in totality.
    - Exceptions such as cognitive limitation must be documented at every visit (if applicable).

Diabetes: Glycemic Status Assessment Greater Than 9% (CMS122v13)

- All patients 18-75 with diabetes whose most recent hemoglobin A1c or glucose management indicator was >9%.
  - Lower performance is better.
  - Result must be discretely documented in EMR.
  - Numerator uses most recent reading in the year.
  - No result = numerator compliant.
- Patients excluded from the measure include:
  - Hospice care or palliative care.
  - 66+ in long term care.
  - 66+ with frailty and documentation of advanced illness.
  - 66+ with frailty and dementia medication.

Controlling High Blood Pressure (CMS165v13)

- All patients 18-85 years of age who had a diagnosis of essential hypertension whose most recent blood pressure was adequately controlled (<140/<90 mmHg).
  - Numerator uses most recent reading in the year from any qualifying visit (including urgent care and specialty office visits).
  - No BP during the year = patient assumed to have BP out of control.
  - If there are multiple blood pressure readings on the same day, the lowest systolic and the lowest diastolic reading will be used. Repeat those BPs!
- Patients excluded from the measure include:
  - Hospice care or palliative care.
  - 66+ in long term care.
  - 66+ with frailty and documentation of advanced illness.
  - 66+ with frailty and dementia medication.

Breast Cancer Screening (CMS125v13)

- All women 42-74 years of age who had a mammogram to screen for breast cancer in the 27 months prior to the end of the performance year.
  - Numerator uses primary screenings only.
  - Result must be discretely documented in EMR.
- Exclusions:
  - Women who had a bilateral mastectomy
  - History of a bilateral mastectomy
  - Hospice care or palliative care.
  - 66+ in long term care.
  - 66+ with frailty and documentation of advanced illness.
  - 66+ with frailty and dementia medication.

Colorectal Cancer Screening (CMS130v13)

- All patients 45-75 years of age who had appropriate screening for colorectal cancer.
  - Result must be discretely documented in EMR.
- Appropriate screenings include:
  - Fecal occult blood test (FOBT) – 1 year
  - Stool DNA (sDNA) with FIT test – 3 years
  - Flexible sigmoidoscopy – 5 years
  - CT Colonography – 5 years
  - Colonoscopy – 10 years unless otherwise specified
- Exclusions:
  - Patients with a diagnosis or past history of total colectomy or colorectal cancer
  - Hospice care or palliative care.
  - 66+ in long term care.
  - 66+ with frailty and documentation of advanced illness.
  - 66+ with frailty and dementia medication.

The Future of Quality Measure Reporting

Aligning Quality Measures Across CMS: The Universal Foundation

Domain	Measure Identification Number and Name
Wellness and Prevention	Colorectal Cancer Screening Breast Cancer Screening Adult Immunization Status
Chronic Conditions	Controlling High Blood Pressure Hemoglobin A1c Poor Control (>9%)
Behavioral Health	Screening For Depression & Follow-up Plan Initiation and Engagement of Substance Use Disorder Treatment
Seamless Care Coordination (Claims Measures)	Unplanned All-cause Admission for Chronic Conditions, OR All-cause Hospital Readmissions
Person-centered Care (Patient Experience)	Consumer Assessment of Healthcare Providers & Systems Overall Rating Measures (CAHPS)

CMS's Proposed Tiers to Reporting The Universal Foundation

2026

- Diabetes: Glycemic Status Assessment Greater than 9%
- Screening for Depression and Follow Up
- Controlling High Blood Pressure
- Breast Cancer Screening
- **Colorectal Cancer Screening**

2027

- Diabetes: Glycemic Status Assessment Greater than 9%
- Screening for Depression and Follow Up
- Controlling High Blood Pressure
- Breast Cancer Screening
- Colorectal Cancer Screening
- **Initiation and Engagement of Substance Use Disorder Treatment**

2028

- Diabetes: Glycemic Status Assessment Greater than 9%
- Screening for Depression and Follow Up
- Controlling High Blood Pressure
- Breast Cancer Screening
- Colorectal Cancer Screening
- Initiation and Engagement of Substance Use Disorder Treatment
- **Adult Immunization Status**

Take Aways

- Utilization Management focuses on ensuring patients get the right care, at the right place, at the right time.
- Poor Quality = Less $ Opportunity
- ACO quality measurement expanding to all payor reporting, not just Medicare.

Ready for a Knowledge Check?

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Q & A

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The Patient Experience: CAHPS Overview

Tate Rugenstein, MPH

QPP Collection Types

1. CMS Web Interface measures (<< not available in 2025)
   - Clinical Quality
2. eCQMs (Electronic Clinical Quality Measures)
   - Clinical Quality
3. MIPS CQMs (previously called Registry measures)
   - Clinical Quality
4. Medicare CQMs (new for 2024)
   - Clinical Quality
5. Medicare Part B Claims measures
   - Unplanned Admission Rates for Patients with Multiple Chronic Conditions
   - Hospital-Wide, 30-Day, All-Cause Unplanned Readmission (HWR) Rate
6. CAHPS for MIPS survey
   - Patient Experience

CAHPS for MIPS Survey: What You Need to Know

What is the CAHPS Survey?

CAHPS = Consumer Assessment of Healthcare Providers and Systems

A national survey to understand patient experience of care.

Administered annually to a random sample of Medicare beneficiaries who received care from the ACO's providers.

Why is it Important?

CAHPS is one of the metrics used in calculating the ACO's quality score.

Quality scores are factored into any shared savings payments.

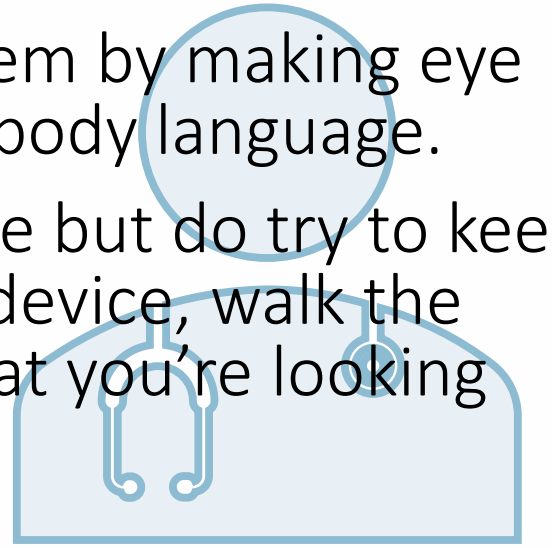
These shared savings are distributed to providers like you.

CAHPS for MIPS Survey Domains

- Patient's Rating of Provider
- Getting Timely Care, Appointments, and Information
- How Well Your Providers Communicate
- Access to Specialists
- Health Promotion and Education
- Shared Decision Making
- Courteous and Helpful Office Staff
- Care Coordination
- Stewardship of Patient Resources

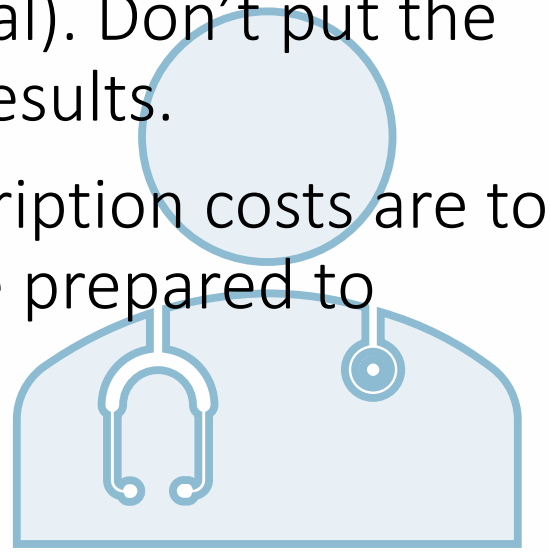
Beneficiary Recommendations for an Excellent Patient Experience

1. During the visit, set an agenda with the patient by asking open-ended questions that puts the patient in the driver's seat, e.g., "what are the top priorities on your mind?" or "what's bothering you?"
2. Healthcare is not a routine experience for your patient, it is important to not minimize patient symptoms; hear them out and ask clarifying questions.
3. Let the patient know you're actively listening to them by making eye contact, not interrupting them, and using positive body language.
4. Patients understand technology is necessary to care but do try to keep your focus on the patient. If you need to look at a device, walk the patient through what you're doing or tell them what you're looking up.



Beneficiary Recommendations for an Excellent Patient Experience Cont.

5. Set clear expectations for a specialist visit. Share what is an acceptable wait-time based on their condition. If there is urgency in seeing a specialist, clearly outline the urgency and explain the value the specialist will bring to their care.
6. Ensure someone from the care team communicates tests results and explains what they mean (either via phone or portal). Don’t put the ownership on the patient to follow up to get test results.
7. Create an avenue for patients to reach out if prescription costs are too high. Understand possible alternatives exist and be prepared to discuss those with the patient.



Q & A

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Patient Experience

What Matters Most to Patients and Families

Nancy Kuemin

Nikki Greet

Learning Objectives

- Participants, at the conclusion of this session, will be able to demonstrate how to provide a positive experience for patients and families, in their role, and how the patient experience impacts our patients and families, as well as the health system itself. Through reflection and active engagement during a session, knowledge will be measured by responses to questions posed and responses through platforms such as Slido.com and the chat feature. Lessons learned will help impact better patient health outcomes and higher survey ratings and allow for analysis and flexibility to identify areas of improvement.

- Participants will be able to understand and implement behaviors that demonstrate empathy to our patients and families. Learners will understand specific ways to communicate, using the Three Cs of Empathy: Care, Connect and Communicate, while also learning how to provide support to our patients and families using verbal and non-verbal body language, and implementing service recovery when needed. Knowledge will be tested through reflection and active engagement via Slido.com, the chat function and videos, and how those behaviors can positively or negatively impact the patient experience.

- Participants will be able to understand and implement behaviors that deliver what matters most to patients and families when they receive medical care. Participants will be able to identify the top three highest priorities for patients and families, including courtesy and respect, listening and clear communication. Knowledge will be tested through reflection and active engagement during a session by using platforms such as Slido.com and the chat feature to measure understanding.

What is Patient Experience?

Delivering the Michigan Experience

Safe

High Quality

Patient and Family Centered Care

OPE Vision: *To collaborate to model a patient-centered healthcare experience for all*

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Think of a time…

When you (or a loved one) were the patient:

- What were you thinking?
- What were you feeling?

Fear

Anxiety

Vulnerability

What Matters Most to Patients?

What do you think patients need from us when the come for care?

What matters most?

High priority for patients & families:

1. Treat me with courtesy and respect.
2. Listen to me.
3. Communicate clearly and ensure that I understand.

To build trust, we must demonstrate that we *care about* our patients and families in addition to providing care for them

Priority 1:

Treat me with courtesy and respect.

- See me as an individual.
- Understand my feelings of vulnerability.
- Make a personal connection
- Exercise cultural humility

Adjectives Used to Describe the “Ideal…”

Doctor	Nurse
• Honest • Sincere • Compassionate • Kind • Warm • Calm • Empathetic • Confident	• Calm • Compassionate • Welcoming with smile • Gentle • Patient

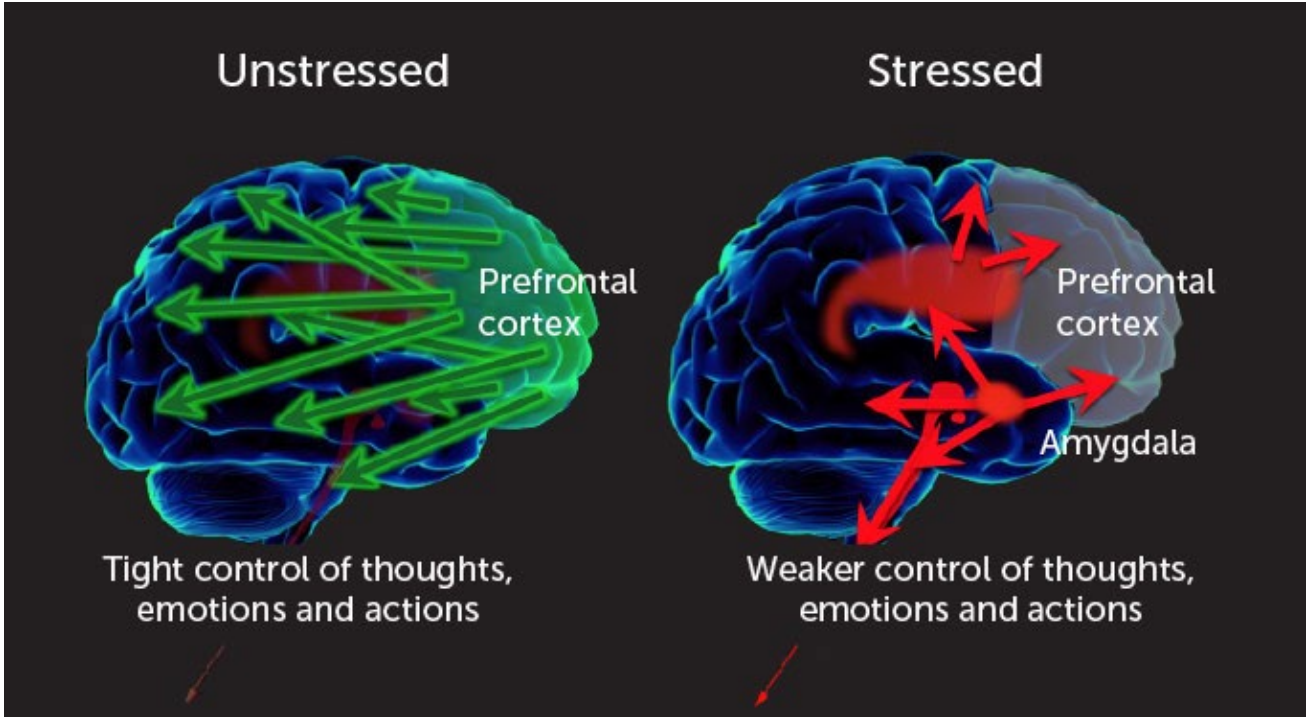
Patient Experience e-Advisor Survey, 2010

Priority 2:

Listen to me.

- Be responsive to needs.
- Give your full attention.
- Validate feelings.

People react differently under stress



Source: https://www.sciencenews.org/article/coronavirus-covid19-stress-brain

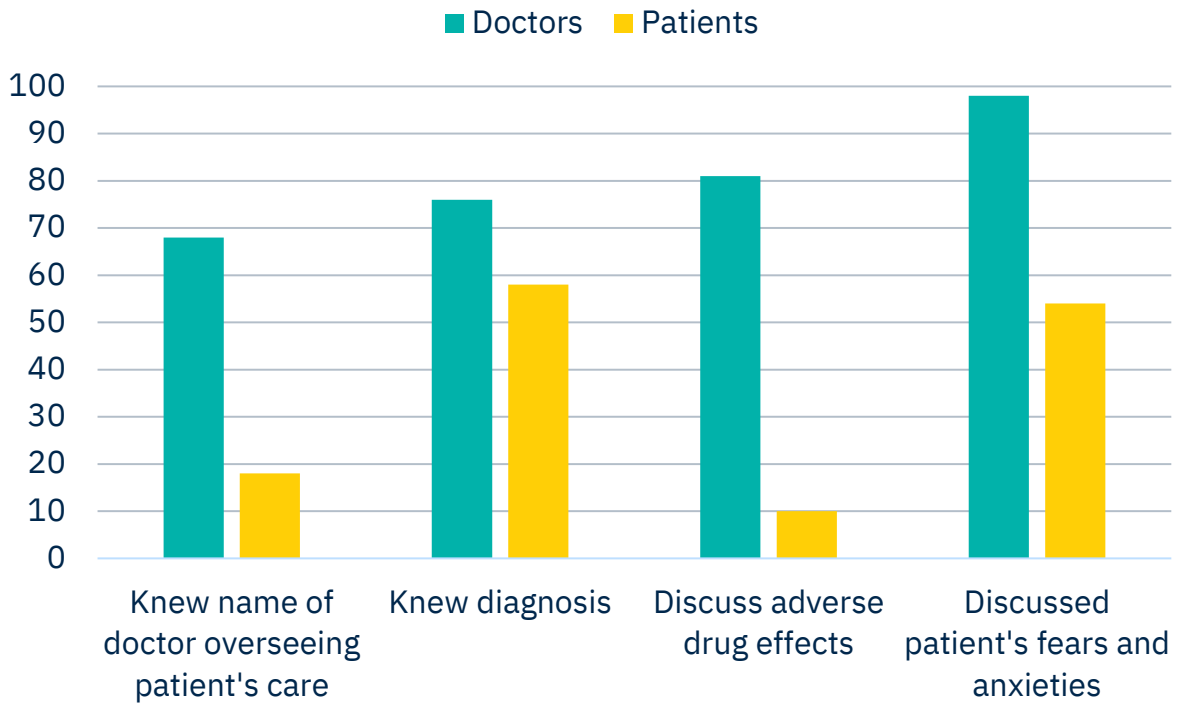
Priority 3:

Communicate clearly and ensure that I understand.

- Provide accurate, timely, and frequent information.
- Encourage questions.

The Communication Gap

Researchers at the Yale School of Medicine asked 89 patients and 43 doctors about the patients' hospital experiences. They found startlingly different perspectives between the two groups.



Source: Archives of Internal Medicine, 2010

Strategies for Communicating

Encourage Patient to Speak Up

- “Tell me more. This is really helpful.”
- “What do you think caused the problem?”
- “What are your thoughts about how we should address this?”
- “What’s worrying you most at this point?”

Invite Family to Share

- “Would you mind telling me a little more about your father? It will help me provide better care to get a sense of him as a person.”
- “Could you tell me about your mother’s routine outside the hospital, so we can best help her prepare to go home?”

Language of Caring

Why Does Patient Experience Matter?

The Clinical Case for Improving Experience

- Good patient experience is associated with good clinical processes and outcomes
  - Patients' experiences with their care, particularly communication with providers, correlates with adherence to medical advice and treatment
  - Patients with better care experiences often have better health outcomes
- Measures of patient experience can also reveal important system problems

We use both data and story

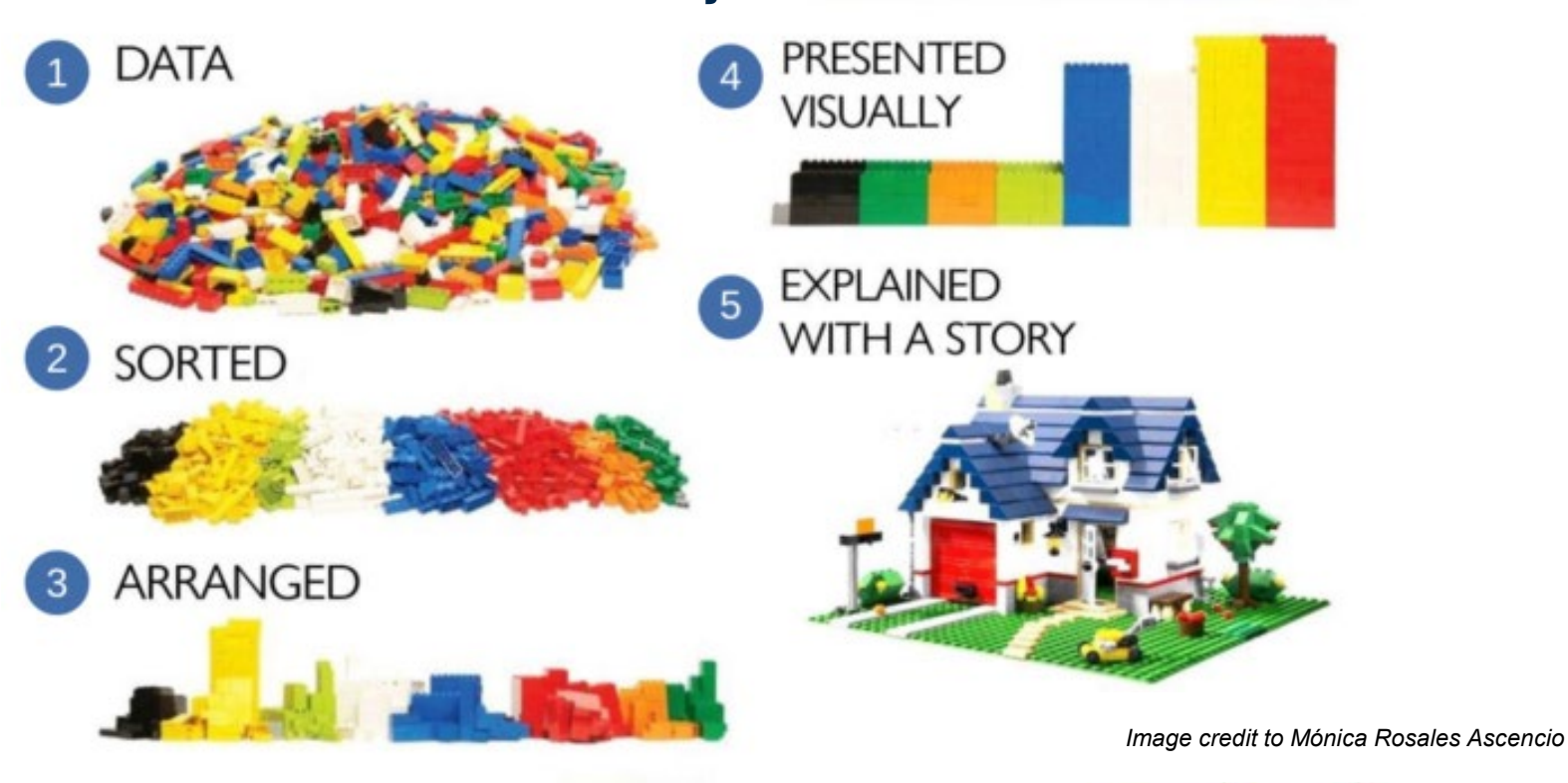


Image credit to Mónica Rosales Ascencio

Metrics: Patient Voice in Surveys

- Press Ganey Surveys
  - Listen to me
  - Treat me with courtesy and respect
  - Communicate clearly with me and ensure I understand

Patient Voice in Story

Before

- Reputation
- Website
- Getting an appointment
- Filling out paperwork

During

- Welcoming people
- Clean environment

After

- Billing + insurance
- Follow up by team
- Discharge instructions

Measuring patient experience results in ***improved health outcomes***

How Do We Improve the Patient Experience?

4 Step Approach To Practice

EMPATHY

Perspective taking. or put yourself in someone else's shoes.

Stay out of judgment and listen.

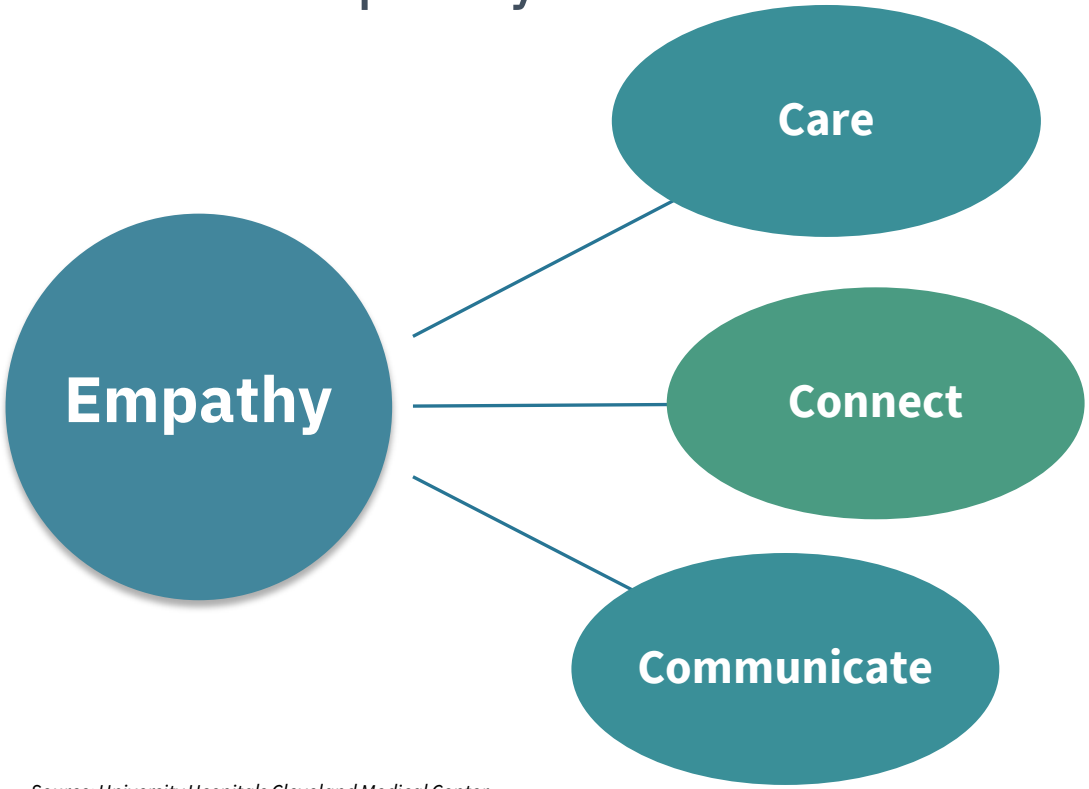
Recognize emotion in another person that you have felt before.

Communicate that you recognize that emotion.

SOURCE: DR. BRENÉ BROWN

IMAGE: JACOB MORGAN

3 Cs of Empathy



- Put yourself in the patient's shoes
- See the world through the patient's eyes

- Give your full attention
- Make eye contact
- Use touch, if appropriate
- Connect with their needs

- Non-verbal: Use body language, voice tone to show you care
- Verbal: Choose words that show you care
- Validate patient's feelings and concerns

Source: University Hospitals Cleveland Medical Center

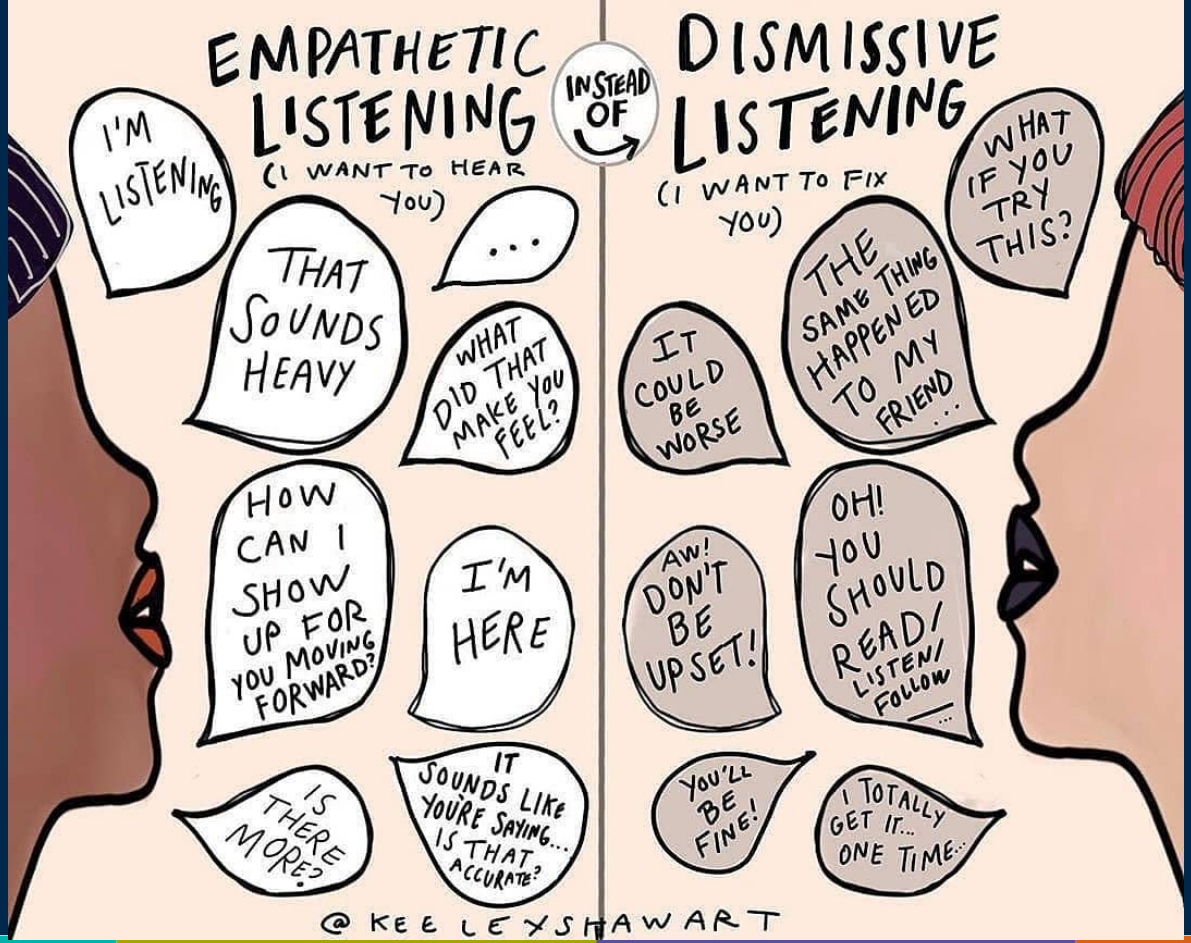
Empathy: Dos and Don’ts

Empathy Don’ts:

- Don’t say, “I understand how you feel.”
- Don’t jump right to solving the problem.
- Don’t try to “silver lining” – avoid starting responses with “at least…”

Empathy Dos:

- Say, “I’m sorry you’re having to go through this.” Say, “This must be hard.”
- Ask, “What’s the main thing you’re concerned about right now?”
- Validate what the patient is feeling: “It sounds like…you are worried about…”


EMPATHETIC LISTENING
(I WANT TO HEAR YOU)
INSTEAD OF
DISMISSIVE LISTENING
(I WANT TO FIX YOU)
I'M LISTENING
THAT SOUNDS HEAVY
...
WHAT DID THAT MAKE YOU FEEL?
HOW CAN I SHOW UP FOR YOU MOVING FORWARD?
I'M HERE
IS THERE MORE?
IT SOUNDS LIKE YOU'RE SAYING... IS THAT ACCURATE?
WHAT IF YOU TRY THIS?
IT COULD BE WORSE
THE SAME THING HAPPENED TO MY FRIEND...
AW! DON'T BE UPSET!
OH! YOU SHOULD READ/ LISTEN/ FOLLOW...
YOU'LL BE FINE!
I TOTALLY GET IT... ONE TIME...
@KEELEYSHAWART

At work each day, ask yourself, "*what can I do* to show this patient that I care about them?"

Service Recovery

Service Recovery: The LAST Framework

Listen

Give the person your full attention and acknowledge their concern. Try not to become defensive or give excuses.

Apologize

Apologize sincerely for their experience, without assigning or taking blame.

Solve

When possible, make every attempt to correct what went wrong. If you can't solve the issue right away, let them know how you will follow up.

Thank

Thank them for bringing the concern to your attention, so that you can do something about it.

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How did we do?

1. Demonstrate how you, in your role, can provide a positive experience for our patients and families
2. Explain how patient experience impacts both the patient and the health system
3. Employ behaviors, both verbal and nonverbal, that show we care about our patients as unique individuals
4. Perform empathetic behaviors consistently and completely to influence positive patient experience scores
5. Utilize the four key components of service recovery to manage service failures without taking or assigning blame
6. Specify how your individual purpose, values, and strengths align with your contributions to the experience of patients and families

“People will forget what you said. People will forget what you did. But people will never forget how you made them feel.”

Maya Angelou

THANK YOU

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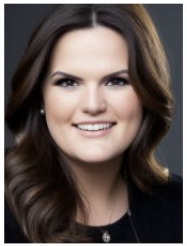

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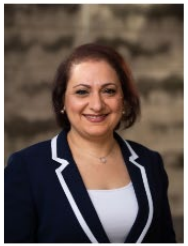

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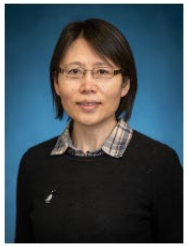

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For questions about the course or how to obtain your CE credits, please contact Eman Sater at emank@med.umich.edu

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