

Achieving Excellence Across All CG-CAHPS Core Measures: Lessons from Top-Performing Medical Practices

October 2014 • Webcast

Speakers

Mon L. Yee, MD, Family Medicine, Meriter DeForest-Windsor Clinic, DeForest, WI

Julie Susi, Manager, Breast Care Specialists of Maine, Portland, ME

Moderator

Dale Shaller, Managing Director, CAHPS Database; Shaller Consulting Group, Stillwater, MN

Dale Shaller

Shaller (opening), Slide 1

Good afternoon or good morning, everyone, and welcome to our Webcast on "Achieving Excellence Across All CG-CAHPS Core Measures: Lessons from Top-Performing Medical Practices." My name is Dale Shaller, and I'll be the moderator for today's Webcast.

Shaller (opening), Slide 2

Our Webcast today is one in a series on CAHPS, which stands for Consumer Assessment of Healthcare Providers and Systems, produced by the CAHPS User Network. Although many of you are familiar with CAHPS surveys, just a few words of background. Primarily funded by the Agency for Healthcare Research and Quality, or AHRQ, the CAHPS program develops standardized surveys for assessing patients' experiences with their care and produces a number of products and services to support their use, including the National CAHPS Database.

Shaller (opening), Slide 3

The CAHPS family of surveys has expanded rapidly over the past two decades. As shown here, facility surveys include HCAHPS for hospitals as well as CAHPS for dialysis centers and nursing homes. The suite of ambulatory care surveys has expanded to include not just the Health Plan Survey, which is where this all began in 1995, but now CAHPS surveys for surgical care, behavioral health, home health and, most relevant to our Webcast today, for medical groups, practice sites and individual clinicians, the CAHPS Clinician & Group Survey, or CG-CAHPS.

Shaller (opening), Slide 4

The focus of today's Webcast is intended to highlight success stories from two medical practices that have been using CG-CAHPS, with the aim of answering this question: "What does it take to achieve survey scores above the 90th percentile on all of the CG-CAHPS core composite and rating measures?" Given the huge response to our Webcast today, with over 1,000 registrations, we know this is a really important topic, of interest to a large number of health care organizations around the country.



Agency for Healthcare Research and Quality
Advancing Excellence in Health Care • www.ahrq.gov

Shaller (opening), Slide 5

And to help explore this question we are pleased to feature speakers from two practices in different parts of the country and representing different specialties. Dr. Mon Yee, a family medicine physician from the Meriter DeForest Primary Care Clinic in DeForest, Wisconsin, just north of Madison, and Julie Susi, Manager of the Breast Care Specialists of Maine clinic, part of the Mercy and Eastern Maine Health System located in Portland, Maine. Again, my name is Dale Shaller, and I'm a member of the National CAHPS Consortium, and I'll be moderating today's discussion of how these groups achieved their high performance on their respective CG-CAHPS surveys and what lessons their experience can offer other health care organizations.

Shaller (opening), Slide 6

Before we get started, I just have a few of the standard housekeeping details to pass along.

If you need help at any time during the Webcast, use the Q&A icon. You can also join us by phone at any time by dialing this number -- 866-823-1364 -- and entering the conference ID number, 8562719.

Another common problem is that your computer may freeze during the presentations, and if that happens, you can just hit your F5 button to refresh your screen. But remember, that may be experiencing just a lag because of the internet connection speed that you have.

Shaller (opening), Slide 7

Given the large number of participants on today's Webcast, we'll be taking questions submitted online only. And to ask a question you click the Q&A icon to get the Q&A box to appear, and all you need to do is type your question in the text box and select Submit. Please feel free to send in your questions at any time during the presentations, and we'll address them during the Q&A sessions. And we know from previous Webcasts that this is a really important part of the whole experience, so we'd really love to hear from you. Please send in your questions.

Shaller (opening), Slide 8

Today's slides are available for downloading by clicking on the icon at the bottom of your screen that says Download Slides. That will generate a PDF version of the presentation that you can download and save as you wish.

Shaller (opening), Slide 9

We also have additional resources available for you to access under the Resources icon, and here you'll find things like links to the CAHPS Improvement Guide, other resources for improvement -- that includes case studies. We have links to the CAHPS site, the CAHPS Database site, and links to both the Meriter DeForest Clinic site and the Maine Breast Cancer Specialist site.

Shaller (opening), Slide 10

Now, to help set the context for a discussion of what it takes to achieve excellence on all CG-CAHPS measures; I just want to briefly note the increasing importance of CG-CAHPS in the health care environment today. We see growing use of CG-CAHPS measures in federal, regional and community public reporting initiatives. There is increasing use of CG-CAHPS as a component of value-based purchasing by both Medicare and the private sector, the use of the Patient-Centered Medical Home version of CG-CAHPS for medical home recognition, and other versions of CG-CAHPS for medical board certification. And all of these uses are leading health systems and practices to increasingly collect some version of CG-CAHPS to support their internal quality improvement efforts.

Shaller (opening), Slide 11

Many of you are familiar with the CG-CAHPS set of surveys and what they measure, but for those who are not, the survey consists of a set of core questions that address three key domains of care that we know are important to patients. One is access to care and information. The second is communication with providers. And the third is responsiveness and helpfulness of office staff. There's also a question that asks respondents to rate the provider on a scale of 0 to 10.

In addition to these core measures, there are a large number of supplemental questions that can be added to the core to meet specific needs of users, such as PCMH measures, questions related to health information technology, cultural competence, health literacy and so forth. There are also adult and child versions of CG-CAHPS, and two different versions that ask respondents to report on their experiences either during their most recent visit, which is the Visit version, or the previous 12 months.

Shaller (opening), Slide 12

The CG-CAHPS scores that were used to compare against the scores of the two practices in our Webcast came from the national CAHPS Database, which is a free service supported by AHRQ, open to all users of CG-CAHPS as well as CAHPS Health Plan Survey users. Both the Meriter and the Maine practices voluntarily submitted their own scores to the CAHPS Database, along with hundreds of other practices, to contribute to the national database and to be able to thereby compare their results to a large number of similar practices. The CAHPS Database provides these comparative results through several platforms that include an Online Reporting System, annual Chartbooks, research data files. And I'll say a bit more about the products and services of the CAHPS Database at the end of the Webcast, also with information on how to participate.

Shaller (opening), Slide 13

Just one more piece of background before turning things over to our guest speakers. Since we're talking about performance at or above the 90th percentile, I wanted to just briefly explain what that means. This chart shows the distribution of CG-CAHPS scores in the national database for the 2013 Adult Visit version of the survey, which is the one that was used by the Meriter Clinic. You can see a set of three bars for the three composite measures related to access, provider communication and office staff, and also the provider rating.

The bars show the scores that correspond to the 10th, the 50th and the 90th percentiles for each of those measures. The 90th percentile is the score below which 90 percent of all practices scored, so it's a very high score. In other words, if your score is at or above the 90th percentile, you're in the top 10 percent of all practices for that measure.

Shaller (opening), Slide 14

So without further delay, I'm pleased to turn things over to our first speaker, Dr. Mon Yee, who, like Julie Susi, will address this list of topics in presenting their success stories: organization background; their CG-CAHPS scores; key factors contributing to their high performance; and thoughts about barriers, sustainability and lessons for other practices. Dr. Yee?

Mon L. Yee

Thank you very much, Dale. I appreciate the opportunity to participate in this discussion from that standpoint.

Yee, Slide 15

When we were first trying to figure out how to present for this particular discussion, we took a look at our own system just to try and reevaluate again what we have. The Meriter Medical Group itself is comprised of approximately seven primary care clinics along with seven specialty clinics, and is basically a primary and

multispecialty group linked with a secondary hospital and an insurance practice, as well. We have approximately 316 staff members, 112 physicians in the system and 26 advanced practitioners that way.

One of the underlying tenets or focuses has been to try and create an integrated health system wherein the continuity between inpatient and emergent care transitions smoothly to the outpatient setting, just thereby minimizing not only readmission rates but also improving the experience for each patient so that things go rather smoothly and in a time where often smoothness is not easily seen.

Our clinics are located in the Madison area. Several of them are in the city itself, with several in smaller, outlying areas, not far from the main system, but all admit to the central hospital at Meriter Hospital there.

Yee, Slide 16

When we take a look at our percentage scores, our -- just looking at what we focused on and to attempt to achieve the 90th percentile or greater, our greatest gains have been in the access of care region. And that's one of the areas we focused on greatly with regard to our primary care clinic in that regard. The remainder we'll address as we proceed forward with some of the topics at hand that way.

Yee, Slide 17

Our benchmark surveys and our statistical numbers have been used pretty aggressively by our system, not only at an interdepartmental level but also at a clinic level. At each clinic level our scores are reviewed with our clinic managers and at monthly staff meetings to help reinforce and to find areas of improvement that way. The other thing that does that has been really pretty integral is to provide a level of ownership for every member of our staff to really feel empowered to take charge of how we can make the experience for each patient the best possible experience that they can have that way.

In addition to the transparency that the scores have, even at department meetings there tends to be more of a progress where if there are particular providers that have excellent and excelling numbers, that information is then shared, and we try to learn from each other to make each other a bit better rather than a competitive environment. It's much more of a collaborative effort that way.

Yee, Slide 18

With regards to the actual dynamics of how we make this work, at the clinic level it tends to be something where we follow a pretty set regimen, but these are ones that have been based much on the patient-centered medical home. And the first part of this is essentially something we call the team huddle. And we meet on a regular basis every morning.

We go over the schedule of patients, look at open slots with both front reception, nursing staff and also ancillary care staff, from lab to x-ray, and start to look through at which point we can anticipate the needs of each individual patient. If one patient requires a little bit of assistance to even get back to their room or to get to x-ray or to lab, those are needs that we anticipate, in addition to where we can find time to help squeeze people in and meet other patients' expectations and needs as they call in throughout the day, as well. And, although it takes a few minutes to do, it's something that really that anticipatory prep time makes such big time in allowing the staff to meet and to really take care of people in a way that we think is right.

At the same level, every member of the team feels that they're able to make those changes for the patients that come in, because everyone's on the same page with regards to taking care of needs and open slots, where they can flex the schedule to make that work. And that goes a long ways in the grand scheme of it, just being able to have anybody at any interaction level be able to jump in and say, "This is someplace where we could take care of someone a little bit better, or to make it work better for someone else who needs to be placed on the schedule

and to allow double-booking as that is available." It's just important and crucial. So many times we defer to the provider to determine the double-booking status, but when you can have that available and that ability to make that decision even as the patients call in, that only improves efficiency not only for the provider but also for the patients that way.

Extended hours have been another primary focus. Our clinics are open from 7:00 in the morning until 7:00 at night, and those hours are crucial, especially in the day, when so many of our employers are less forgiving of time off from work, and much appreciated by our patients. As a matter of fact, we've found some of those hours to be some of our busiest hours as that works for our patients.

The commitment of our staff is also another thing that we really find very lucky in a way that, quite honestly, there is an attitude of staying until the job gets done. And it is just a personal connection you develop over time to taking care of the people you care about. And also the fact that there's a high percentage of our staff that use our clinics for their own family's care, and the idea that we take care of our patients like our own families really makes a big difference, I think, that way.

Yee, Slide 19

Moving on to some of the barriers that we often have to taking care of or providing these kind of services, it's a challenge to taking care or meeting patients' expectations. In all honesty, patients aren't in a terribly great position to judge the quality of care. They can't determine if I'm choosing the correct medication or antibiotic. They can determine if they're getting better. But much of their expectation and their satisfaction is determined by the patient experience, and in order to meet the quality indicators that we're so measured on these days for all the numbers that we need to hit and the goals we need to make, you have to put in the prep time ahead of time.

And what I'm referring to is often what most of us know as meaningful use, or the ability to make sure that our quality indicators are also met. And in the interaction, if you're doing that with a patient at the same time that's helpful, but at the same time sometimes distracting from being able to focus on what they're trying to communicate to us.

And so you have to put the time in ahead of time, and that often means preparing your charts beforehand and to be able to put the time in before the patients are in, often the night before or days before, to evaluate their health care maintenance needs from a standpoint of immunizations, health care screening needs, so that when they are in for their acute need you can refer to that and just instantly make recommendations. It gives the sense that you're not only taking care of them but also on top of what their needs are, which goes a long ways toward confidence and trust, which is ultimately even more important in the relationship that we have with our patients that way.

With regards to the patients' expectations these days, quite honestly with our fast-paced world, when you can book your own airline tickets, you can book your own oil change appointment, we try to meet our patients' similar expectations by offering care access that is similar, and the use of an electronic medical record system that allows them to access that information, book appointments through the electronic medical record, and even ask questions that are responded to in a timely fashion really improves things.

We use a system called MyChart currently in our own electronic system that way, and that really does help improve things dramatically. It's just kind of reassuring to know that you can book an appointment with your doctor at 11:00 at night after you've sprained your ankle and still know that there's something open or available

that you can automatically take care of that way. That's just kind of an access that we focus on making sure we're able to meet our patients' needs and expectations that way.

It does get a little tricky sometimes with insurance issues. As -- when we all started there was less paperwork, I would say. But these days the nature of paperwork, and much of that has become the bane of our existence at times. And one of the things we've focused on to help make that a better experience for our patients is to devote specific teams toward taking care of things like insurance prior authorizations, medication needs and just to be able to move those and dedicate a specific team to that on a regular basis to expedite those care needs. And that truly has improved everybody's efficiency with regards to removing some of that paperwork to a separate section that way.

Yee, Slide 20

With regards to the sustainability of what we're trying to do, that's a really interesting question, because our system, at least with regards to our primary care clinics, has been doing this for about three years now, and we were rather focused on trying to make that happen. In order to get there, we devoted a significant amount of resources and our physician resources and staff resources at each level to forming a few committees that make just a big difference in how we achieved those goals.

The Service Excellence Committee has a focus on meeting on a quarterly if not monthly basis at times to reassess where we're going with regards to our numbers. There's also another committee that we have, and this goes down to the community involvement, but it's called a Patient Experience Committee, and it's comprised of patients in the community from ages 18 to 65 that meet on a regular basis with clinical representatives, patient representatives, to try to give us feedback and to try and see how certain areas can be improved, and who better to ask than the people we're taking care of what can be made better? Often, if we're not the ones on the receiving end we kind of think things might be better, but until we hear it from the people we care about it's hard to know. And so just really being involved in the community and allowing that participation seems to make a big difference.

There is a core set of educational materials that we have for our staff members, and we have linked with a group called the Beeson Group, and Dr. Beeson is a primary care physician in California who has really had the ability to really turn numbers around and make an exemplary model, and a lot of it has to do with how to really approach the patient interaction and to make sure we're addressing the needs of the patient, the concerns that the patient has as well as making sure we give them what they want in the sense that patients come with three basic things. They come with fears. They're afraid something's wrong. They have needs. They need an appropriate evaluation of their concern. And they want to feel better. And if you can really approach those needs and meet them in a manner that makes a difference for them, really you've kind of really taken care of what they're looking for at that stage.

We do promote the MyChart just because of the access it allows and for them to be able to get to us in a timely fashion that way. It just really helps quite a bit.

The other part that we've kind of taken it to a level of is with regards to community involvement, we've actually tried to place our members of our staff in areas that they have interest in in the community, from Chamber of Commerce activities to allowing for discussions and even as simple as it sounds, movie nights for kids at our clinic. And although that sounds very small, hometown like, Madison is a metropolitan area of over half a million people, and with the state capitol, it definitely is something that we've been able to kind of give it that connected feel with our patients. And that makes a difference if we can interact with our patients in a level where they know that we know them and we have that level of connection, where it's not just that we're taking

care of their numbers, we're actually taking care of them. It makes a difference, and I think that in the grand scheme it makes a better method for providing care.

I want to say thank you very much for the opportunity to participate in this. And one of the things that is interesting is that as time goes by we tend to focus so much on the numbers -- our patients' blood pressure numbers, our diabetic numbers -- and although I think that is crucial for quality of care, one of the things that we want to focus on is also to really actually care about the people we provide care for and not just leave them at their numbers.

Thank you.

Dale Shaller

So, Dr. Yee, we want to thank you for your comments. And we have a number of questions that we'd like to direct your way.

Shaller, Slide 22

I'll start with one that came out early in your remarks. The person asks that the scores that you have are posted, but wanted some details on where the scores are posted and to whom the scores are made visible.

Mon L. Yee

Actually to everyone. The entire system, anyone in the hospital site could see our clinic performance or how our numbers look. You could be a lab tech at the hospital. You could be a lab tech in another clinic. All of our -- there's a level of transparency that really makes everybody part of the same team. Now, we typically post them in our break room from a logistical standpoint just so that everyone can see that, but we do distribute them at our monthly meetings, as well.

Dale Shaller

Great. Another question asks are the samples, meaning the survey samples, drawn at the individual provider or at the team level?

Mon L. Yee

Individual provider.

Dale Shaller

So you have enough of a sample so that you can actually compare one clinician to another, and those are the scores that you actually do then post?

Mon L. Yee

Yes, we do, and those are the ones that we compare at our department meetings, as well, to try and help each other improve in specific areas.

Dale Shaller

Another question related to access is wondering if patients actually schedule appointments through the electronic medical record or request appointments via some other ways, through a patient portal.

Mon L. Yee

That is the MyChart system that they use. It is wonderful, truly. For patients to be able to know that they have an appointment waiting for them the next morning without having to call at 8:00 a.m. and scramble is a godsend.

Dale Shaller

Right. And here's a question that's related to what percentage of your patients are actually using MyChart? Do you have an idea about that?

Mon L. Yee

That's a good question. When we actually try to look at our goals, we're trying to shift it to as much as we can, but currently it's probably around 60 percent. Our goal is to increase that. There are certainly some patients who don't have computer access in our area or aren't as savvy with a computer system. But our goal is to try and improve that to at least the three-quarter mark.

Dale Shaller

And what method do you use to actually gather the survey information? Do you use phone or paper or electronic?

Mon L. Yee

We're pretty old-fashioned. We use paper that way. It just makes it a little easier to keep track of, to be honest. And we do typically mail them out. We just want to remove any potential bias that might occur if they receive it at their visit or after the visit.

Dale Shaller

With respect to the team huddles, Dr. Yee, how do you ensure that they actually happen? Are they put on the physician schedule? Who is responsible for making them happen?

Mon L. Yee

All of us are. They will hunt us down and we will be at that meeting. Yes, it happens, no matter what. And truly when you can realize the benefit that it has, as a physician, I have to be honest, my motto has always been, we will take care of anybody who needs to be taken care of, and at that stage what it does is it allows our nursing staff to say, "Of course we'll take care of you." You don't have to say no if everybody's onboard. And at that point you get to be the good cop all the time, and it's just easier to take care of people that way. And so the huddle is key to that.

Dale Shaller

Right. There's a broad question here, and maybe one to reflect on for later discussion. Which -- do you know which intervention affects which measure, so in terms of linking the intervention to the aims of your improvement work? Or is it something that's just so much more kind of holistic that it all kind of comes together?

Mon L. Yee

You know, I would love to tell you that there's an earthy, crunchy answer to this, and I typically am not a very earthy, crunchy kind of person. But in the process of looking at this particular discussion and trying to sort out some of the answers for why we've been able to pull off what we've been able to pull off, ultimately it still came down to the last statement, which is ultimately we have to care about the people we take care of. And if that becomes the primary focus, everything else falls in place.

Dale Shaller

Very good. There are more questions, but I think what we should do at this point is move on to our next speaker, Julie Susi, who, as I mentioned at the outset, is Manager of the Breast Care Specialists of Maine.

Susi, Slide 23

Dr. Yee, we'll come back to you at the end and have an opportunity to field additional questions. So all of you continue to send in your questions. We will get to as many of them as we can. Julie?

Julie Susi**Susi, Slide 23**

Thank you, Dale. I'm happy to be here, as well, today. The first slide that you see on your screen is just a picture of our campus. And to the right is the actual hospital and then to the left is the medical office building that pretty much houses the majority of our physician practices on this campus, which is where my practice, Breast Care Specialists of Maine, is located.

Susi, Slide 24

Breast Care Specialists of Maine, we are a two-surgeon practice. We take pride in offering timely, accurate consultation and treatment for benign and malignant conditions of the breast. We offer an integrated, coordinated multidisciplinary approach to breast health, with services that range from regular screening and diagnostic testing to helping patients prepare for surgery, chemotherapy or radiation treatments.

In April of 2014 we attained another three-year accreditation through the NAPBC, which is the National Accreditation Program for Breast Centers through the American College of Surgeons. This accreditation holds us accountable to 28 detailed standards regarding our Center's leadership, clinical management, research, community outreach, professional education and quality improvement. And currently we hold our certification as a Certified Quality Breast Center through the NQMBC, which is the National Quality Measures for Breast Centers through the National Consortium of Breast Centers.

Susi, Slide 25

Our team, or what we like to refer to as our center without walls, consists of two dedicated, female breast surgeons that are backed by an expert team of professionals, including two nurse navigators who provide detailed pre- and post-operative education and community outreach, experienced expert radiologists and pathologists, medical oncologists, oncology nurses, clinical trial nurses, an oncology dietitian and a licensed social worker. We also have lymphedema treatment therapists, radiation oncologists, and plastic surgeons.

Please note that some of these disciplines, like radiation therapy and our plastic reconstructive surgeons, are actually outside of our facility. They're not part of Mercy Hospital. Yet we work very closely with them, and all of our patients feel as though these disciplines are just another part of the team that is taking care of them. So it's a true center without walls.

Susi, Slide 26

As you can see from this slide, Breast Care Specialists of Maine has maintained over 90 percent for the past two years under the Provider Communication, Office Staff, Provider Rating, and I utilize many reports within CG-CAHPS -- Stoplight Reports, the Demand Reports -- to be able to drill down on my department and to take a look at the comments, as well, to see if there are any areas that we may need to either focus on or pay special attention to.

Susi, Slide 27

The implementation and use of the CG-CAHPS in the practice. As I mentioned, the Monthly Stoplight Report -- this is received via email to me, but I can go online at any time and take a look at it, which is a snapshot of our practice and our rating, both low and high scores. We focus on the specialty-based questions and the responses by utilizing the Demand Reports and the comments to determine any areas that may need focus.

I report monthly to my administration via a dashboard report. This dashboard report has everything from financial information, wait times, QI information, the patient satisfaction with a provider question from the CG-CAHPS, and it gives my director and my VP a snapshot of what my practice looks like, and this is done on a monthly basis.

Prior to CG-CAHPS, we conducted a department-specific satisfaction survey, because patient satisfaction and patient feedback is so important. This survey was anonymous, and at the bottom of the survey I would mark it with the month the patient was seen, as this was something that I tracked quarterly, and I need to know which quarter the response was actually from. And patients had the option to put their name and contact info in case they wanted to speak to someone from the practice, which was usually me as the manager, whether it was for positive or negative feedback, as we welcomed both. And all responses from that survey were reviewed, and assessments and changes to processes were made based on that feedback.

Susi, Slide 28

Key organizational and process elements that contribute to the high performance. Dedicated female breast surgeons -- we have two of them, and 100 percent of their practice is solely dealing with conditions of the breast. We have a 48-hour, or two business day turnaround time for appointments for all new cancer diagnoses or suspicious masses, and this has been our office policy since our inception in 1996.

We have a multidisciplinary team approach. At our inception in 1996 we pulled all the parties to the table -- radiologists, pathologists, oncologists, radiation therapists and our hospital administration -- to ensure that we were all on the same page and we would not be dealing with what they call turf wars, which I was very surprised to hear at some of the breast conferences that I go to. For those that are not familiar with that terminology, it's when radiologists and surgeons will fight over who's going to do the biopsy. This was something we never had to deal with. Our radiologists and surgeons have a great relationship, and they work collaboratively together.

Strong communication. Strong communication amongst all the disciplines is a must, and strong communication between provider and patients, as well.

Timely patient navigation. Timely and seamless navigation is so important. Due to our patient population, they've just had their lives turned upside down. Navigating them and arranging their upcoming consults, whether it's oncology, radiation, plastic, along with ensuring that the referrals for all of these appointments have been obtained through their PCP, takes the burden off the patient, and this is something that we do for them here in our practice. They are overwhelmed with all the information and decision making that needs to be done, and, providing the patient is ready, they leave our office with all of these appointments as appropriate, including a tentative or a solid surgery date.

Empowering the patient. They are empowered to be part of the decision making process, and they are in charge of which path they choose to take. They have control, and this is very important to many of them. Don't get me wrong. Sometimes there are patients that just want you to get in the driver's seat, and them asking what would you do if this were you is not an uncommon question that our providers get.

Community outreach. Getting out into your community to assess the need is so important. Getting out into your community and educating them in your area of expertise is important. And having a presence in your community is important.

Leadership and administrative support. Full support from our hospital administration is imperative. Let's face it. If we need capital or backing for something, it's our administration that we're going to, our VPs and our CEO.

Staffing/resources. Having appropriate levels of staffing and resources to ensure the delivery of safe quality care is key, and this is not always easy. We all felt the recession that hit in 2009, and many practices had to learn how to do more with less, and how do you do that and still maintain a high level of quality care? It's a delicate balance, and it is definitely a team effort.

Work-life balance. It's plain and it's simple. If you do not take care of yourself, you cannot take care of anyone else.

Susi, Slide 29

Overcoming barriers -- cultural. We are a department of a hospital, and we do have a Mission Effectiveness Department that helps us with a lot of this, things like what is our process for accessing interpreters, contacts in the community? We have a VP of Mission Effectiveness that has a solid presence in our diverse communities in our area. Daily we are faced with cultures that feel very differently about what type of medical care they will even seek, whether or not their provider has to be male or female. The hesitancy in some of these smaller, diverse communities where the interpreter may actually know the patient has become a roadblock, and thankfully we have a Mission Effectiveness Department that works very closely with us on that.

Lack of family and/or support, finding appropriate support for those patients that have none. Our nurse navigators and oncology social worker assist the patients with community resources to ensure they have the support that they need, whether it's a ride to their next appointment or home health to assist with their care.

Insurance and financial. Our hospital's mission at Mercy is to serve the poor and the disadvantaged. We live in a world where health care and payments are ever changing or sometimes nonexistent, and this is probably the most frustrating barrier we face. No practice or organization can survive by giving away free care day in and day out all the time, and we work with financial counselors who work with our patients to see if they're eligible for MaineCare, Medicare, the Maine Breast and Cervical Health Program, to ensure that all of our patients receive the care that they need and are assisted with resources to obtain coverage.

Staffing and resources. As mentioned before, ensuring appropriate staffing levels to allow us to deliver high-quality care is a budget balance act. And with that comes the other side, flexing down during low peak or low-volume days and being proactive in projecting when these times may come. You have a physician out on vacation or they're out on CME. By flexing down during low-volume times you can justify bumping up your hours during high-volume times. And, again, it is a delicate balance.

Implementation of electronic health record. We went live in January of this year, and the fact is there is no perfect electronic medical record. It just doesn't exist. And working closely with the team to reinvent workflows and processes that work for your office is time-consuming, but it is a definite need. Any new software implementation is a challenge. You need to know the system. You need to know the key players. And you need to know your practice. And this is the only way to ensure that you develop and implement workflows and a system that will assist you in taking care of your patients.

Susi, Slide 30

Plans for sustainability -- remain patient centered; collaboration with hospital administration; community needs assessment. Take part in that. Know what your community needs. In our case it's one of our standards as per the Commission on Cancer for our oncology certification. And continue all the quality work that we do with the NQMCB.

Susi, Slide 31

Take-home points for specialty practices. Remain patient centered. Always put the patient first. Empower the patient. Continuing education for your clinical staff to remain up to date, in our case with NCCN guidelines, or whatever guidelines they're following, standards of care.

A dedicated multidisciplinary team. Bring all the parties to the table and work collaboratively. We're all working for the same goal, to take care of our patients.

Staff -- choose wisely when hiring. Hand pick your team and allow all staff to participate in the final hiring decision. Now, while I understand this is not always easy, depending on the size of the department you have, I have always included my current staff in the hiring process. I vet all the candidates. I bring back the top two, because I feel that either one could do the job. They meet with the entire staff. I then let my staff choose who they want me to pick for that final candidate. By including them in this process, it gives them ownership of a program that they are fully vested in, and this has proven to be part of our success and the longevity that we have with our staff.

Leadership/administrative support. Foster collaborative, respectful relationships to navigate the hoops that we have to jump through when we need something.

Community outreach. Know the wants and the needs of your community. Educate. Have a presence there.

And maintain a work-life balance, because, like I said, if you cannot take care of yourself it is so hard to take care of your patients. Working in the cancer arena, I see every day that life is too short. And the last slide that I will share with you is actually a quote that one of our cancer survivors shared with me. I think she was more of an inspiration to me than we probably were able to even be to her through her journey. But she always had a positive attitude. And the one thing that having cancer showed her was that life is too short and to not sweat the small stuff.

And with that is now my favorite quote. It popped it back. Hold on.

Dale Shaller

Susi, Slide 32

You got it back.

Julie Susi

I got it back. Thank you. Life is too short. Life is not a journey to the grave with the intention of arriving safely in a pretty and well-preserved body, but rather to skid in broadside, thoroughly used up, totally worn out, and loudly proclaiming, wow, what a ride.

Thank you all.

Dale Shaller

Julie, great. Thanks so much. It was a great presentation, and we have a lot of questions that have come in. Many Dr. Yee has answered directly via the Q&A function. Others remain, and, Julie, I'm going to start with one that's kind of a broad question. How do you know the key organizational and process elements are the ones that contribute to above the 90th percentile?

Shaller (closing), Slide 33

Are these elements common in other breast cancers? So how do you know that these drive high performance?

Julie Susi

Our practice has been up and running for 19 years. So some of this is truly trial and error. Some of this -- 19 years ago there weren't many breast centers around the Portland area. We were one of the first. And now breast

centers have popped up all over the place, so it's also seeing the trial and error of other breast centers and what works and what doesn't. And we have actually -- I don't want to call them our competitor hospital, because we are all here for the same reason, to take care of the patients, but they're actually three blocks away, and we've, over the 19 years, been able to see what hasn't worked for them, and it seems to be some of these things, the multidisciplinary approach, the timely navigation, the 48-hour turnaround time. So some of these we've just seen after 19 years of being up and running of trial and error.

Dale Shaller

Okay. Great. A couple of questions on the survey data itself. Who creates the Monthly Stoplight Report that you referred to?

Julie Susi

CG-CAHPS. I get it right from online from NRC Picker.

Dale Shaller

NRC Picker being your vendor.

Julie Susi

Correct.

Dale Shaller

Okay. And then there's another related to the survey questions. Do you customize questions to meet issues related to your particular specialty?

Julie Susi

No, that's the only -- that's why I put the piece in my slide show. Prior to us having actually access and being part of the CG-CAHPS and NRC Picker being our vendor, I did create a department-specific, with specific questions just related to our patient population, and was able to get a lot of feedback from that. With the CG-CAHPS that Mercy Hospital participates in, there are many questions that are more primary care related, which is why we kind of focus on the specialty ones. So they're not necessarily our specialty department specific.

Dale Shaller

And you can add -- any user of CG-CAHPS, just as a general comment, can add specialized questions at the end of the survey and make that part of your ongoing operations.

Julie Susi

Yes.

Dale Shaller

This is a question. You talked about community outreach, and the question is, can you elaborate a little bit on how you go out and assess the health needs of your community?

Julie Susi

Through a company that Mercy Hospital works with. They actually did what they call a Community Needs Assessment. And this is actually done by three different groups that work together through the Greater Portland area that they do surveys and they try to figure out what is lacking, what are the gaps within the community.

But above and beyond that we work very closely with the American Cancer Society. Also our VP of Mission Effectiveness, who actually in our diverse communities -- our Somali population, our African population that are in the Greater Portland area -- she has very strong ties, so she actually meets with them on a monthly basis, and she brings back to us they are really lacking on education on colon cancer or breast cancer, whatever it might be. So we also have that avenue.

I actually chair an outreach, community outreach subcommittee, which is part of our Cancer Committee group that works closely with American Cancer Society, so that we kind of have it coming from all different avenues.

Dale Shaller

Here's a question just, again, related to the survey process. The question is related to do both practices use a certified vendor to administer CG-CAHPS. I think you just answered that, Julie, and I think, Dr. Yee, you're still on the line, you also use a certified vendor.

Mon L. Yee

NRC Picker, as well.

Dale Shaller

As well? Okay. So let me invite you back in, too, Dr. Yee. You've answered a number of these questions on your own, which is terrific. One question I don't think you hit is can you provide any additional information on the Beeson Group that you mentioned?

Mon L. Yee

Dr. Beeson is a group out of California that truly they actually, as -- to hear him speak -- we brought him -- our leadership was so committed toward creating a patient experience that was significant that they brought him out to give basically his technique or his speech about what it is that it means to actually have an interaction with a patient where they value and want to come back and still be able to provide the level of care you want to. And so Dr. Beeson, it's B-E-E-S-O-N, out of California, he has a group that pretty much now does primarily patient-focused care and being able to improve the quality indicators.

We actually have subscribed to his Web site, and it sounds bad, I almost -- I hope he's still practicing, because he's pretty impressive at what he does. They were -- they had some of the lowest scores in the entire region, and he -- he's just a clinical practicing physician, and he was asked by his medical staff to lead the medical staff in developing or somehow getting their system to numbers that would be functional, even. And lo and behold within a matter of about two years they brought their numbers up to the 96th percentile on all indicators. And that was really phenomenal that way.

Dale Shaller

Great.

Mon L. Yee

Some of that required some transparency.

Dale Shaller

Yes. Here's a question for the both of you, and, Julie, I'll ask you to respond first. How do you get physician buy-in with regard to your survey results? The person says, "Our physicians will dismiss the results based on the sample size or only disgruntled patients will complete the surveys." How do you respond to that?

Julie Susi

Our physicians, the two surgeons we have, are pretty active with the survey questions. It was much easier when we were able to just detail it and the only questions on the survey were specific to our practice. But they also understand that the feedback, whether it's negative or positive, we can glean something from that. So even if it were just negative responses, which I'm thankful in our practice, and maybe it's because of the patient population we deal with -- people are coming to us and we're taking care of their cancer, and the majority of time they're leaving very happy -- well, we can glean information. That's how we better our practices, even from the things that we could be doing better, and my physicians understand that.

Dale Shaller

Dr. Yee, comments on physician buy-in?

Mon L. Yee

I would agree. It's -- thankfully, typically we don't have too many, but all of our complaints are actually handled on an individual basis to see where we can improve at any one step. It's really about the process, not about the individual. And if we can make it something where we take out that "you did this wrong" or "you did that wrong" it becomes something where it's "how can we do better" instead. And I know it sounds kind of generic, but really don't make it personal, and make it about taking care of people.

Dale Shaller

Dr. Yee, another question for you. Can you elaborate on what your Service Excellence Committee is and does?

Mon L. Yee

They basically meet to process all the data that we have, trying to reevaluate on where our percentiles are going. We've hit these particular benchmarks, but initially when we were first starting it was a struggle to try and find where we're at and to try and see where we're going next and what our next goal would be.

And so with almost monthly meetings initially to try and change our course or our track, it really took us a while to get to find some of these avenues, access being one of them, and then trying to make sure we had particular forums where we could have some of our concerns kind of brought up and kind of brainstormed were really helpful. They've been focusing a lot on employee buy-in to the idea of focused patient care, and that's really something that right now we're focusing on more than anything else, now that we kind of have the process better.

Dale Shaller

And, Julie, let me ask you. I know you touched on this, but can you say a little bit more about the involvement of patient and family advisors in your process? To what extent do patients and families actually participate in any of your quality and/or safety committee, your process improvement activities?

Julie Susi

In the quality, we have actually a Risk Quality Committee that is housed by -- it's built by Mercy Hospital, and they do actually have a patient on the Quality and Risk Council. They have physicians. They have like RNs. So they have multiple clinical people that are on it. And then each department within Mercy Hospital has to submit what they are going to be looking at for quality indicators on a yearly basis, and it's something that's tracked. And then we have to go before the Risk Council and I don't want to say defend, but say this is why we're tracking this, and this is why we didn't meet. This is what we found out. So it's kind of like a hospital based.

As far as the other QIs being part of the National Quality Consortium, the NQMBC, that's like nationally, and that's actually putting our information into a database where it benchmarks us against other breast centers that are like our size.

Dale Shaller

Just a couple more minutes left for Q&A, and then we'll have to move to wrapping things up. But here's a question for one or both of you. Are any of the provider scores that you collect used to actually determine compensation for your clinicians?

Mon L. Yee

Not at this point.

Dale Shaller

Okay.

Julie Susi

Same here. Not at this point.

Dale Shaller

Okay. Do either of you encourage specific scripting by staff or physicians to address how staff and clinicians interact with patients?

Mon L. Yee

Yes, particularly our front office staff. That's pretty much your key front door to everything, and if you don't have front office staff that just are aware of what to say, when to say, and to be an appropriate connection, it can shut the door immediately.

Julie Susi

And I would agree with Dr. Yee, the same. Most of our scripting has been done like with more from a front desk standpoint.

Dale Shaller

I think we need to move toward the kind of wrap-up. I want to just thank you again for a terrific job, both of you, Dr. Yee, Julie Susi, for your comments.

Shaller (closing), Slide 34

Before we go I just want to mention the CAHPS Database is a resource for all practices in the country that want to compare their CG-CAHPS scores. This is a screen shot that shows the URL address for the CAHPS Database Online Reporting System. It currently has 2013 comparison data available for CG-CAHPS on the Visit version, the 12-Month version and PCMH. It can be viewed in a variety of ways, through tables and bar charts, percentiles, and you can build your own report.

Shaller (closing), Slide 35

We also produce a Chartbook for those who don't want to build their own. This is an image of the most recent Chartbook and an example of kind of comparison bar chart displays that it includes that show scores for composites and ratings for every survey version for selected practice characteristics such as region or specialty, provider type and even the size of the practice.

Shaller (closing), Slide 36

Coming up we want to announce our timetable for the next data submission period for the CG-CAHPS survey. So in 2015, it will happen next March, for the two-week period from March 16th through the 27th. And we anticipate reporting results in June of next year. For the Health Plan survey database, submission will happen during the summer of 2015, and we will be reporting results in the fall, likely October, which is what we did this year with the production of our 2014 Health Plan Survey Chartbook just last week.

Shaller (closing), Slide 37

So we also want to encourage you to sign up to receive email updates about CAHPS. It includes announcements of future events like this. You can visit the AHRQ Web site and select Email Updates from the top navigation bar, and then you'll be able to sign up for CAHPS-specific updates.

Shaller (closing), Slide 38

So, finally, again, I want to thank all of you for attending today's Webcast. We didn't get to all of your questions; we got to many of them. We hope that you will take time to fill out the evaluation survey which will pop up onto your screen. And when you are done please complete the survey, because obviously your feedback is important to us, but you'll need to hit the Submit Survey button when you're done with the survey. You can also contact the Survey User Network at the information posted on the site right now on your screen by email or by using our toll-free phone line or by accessing the CAHPS Web site at the URL.

So, again, I want to thank Dr. Yee, from the Meriter DeForest Clinic in Wisconsin, Julie Susi, from Breast Care Specialists of Maine in Portland, Maine, thank all of you for your time and your participation today, for sending your question. We hope this has been beneficial to you. We encourage you to stay in touch with us via all these mechanisms, and we want to wish you all a great rest of your day. Thanks so much.