



Using Care Experience Data for Quality Improvement

CAHPS User Group Meeting
March 30, 2006

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Presentation Overview

- ◆ Review recent efforts to improve patient care experiences in our multi-specialty medical group
- ◆ Thoughts on what it takes to achieve and sustain improvements



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The Crisis in Primary Care



"The committee is confident that Americans can have a health care system of the quality they need, want, and deserve. But we are also confident that this higher level of quality cannot be achieved by further stressing current systems of care. The current care systems cannot do the job. Trying harder will not work. Changing systems of care will."

Crossing the Quality Chasm, Institute of Medicine 2001



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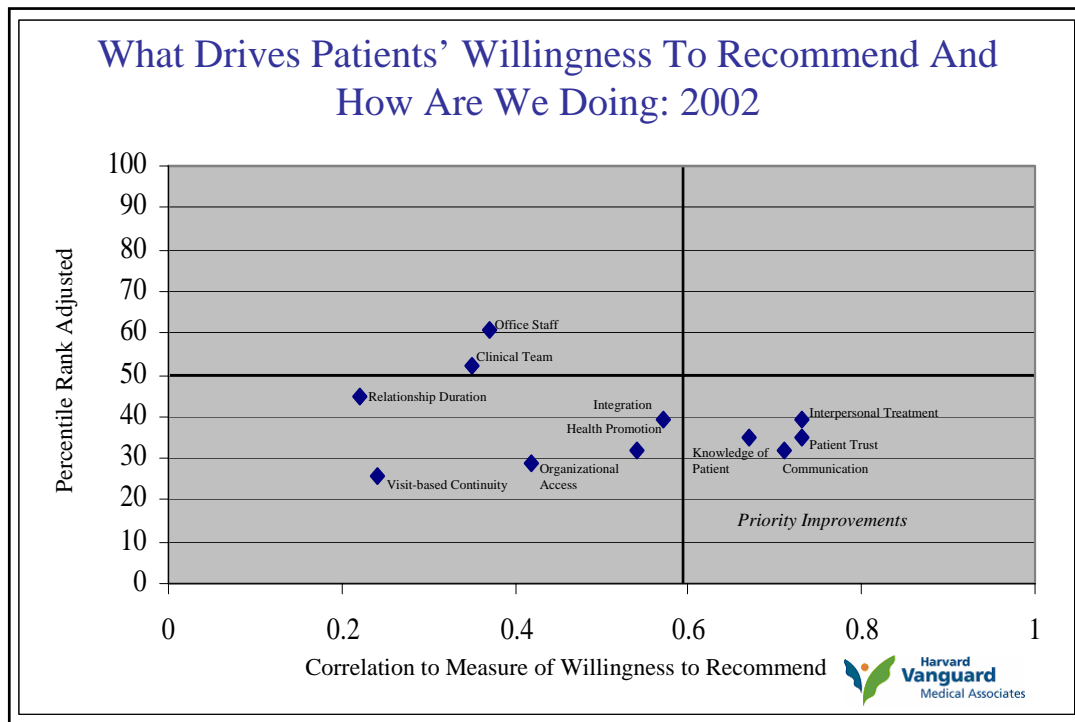


Harvard Vanguard Practice Improvement Initiative 2001-present

- ◆ In 2001, identified the need for transformation of primary care
- ◆ Key issues: physician dissatisfaction, undoable job, no practice growth
- ◆ Many patients had relationship with system, but not with individuals in system
- ◆ Lack of relationship with an individual PCP a key driver of patient dissatisfaction and turnover
- ◆ Validated with staff and with focus groups
- ◆ Patient perception of care data confirmed concerns



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Constructing a New Care Model: Defining the Basic Concepts

- ◆ Patients desire care from physicians who know them as individuals and in whom they have trust
- ◆ We need teams to provide the quality of care patients want
- ◆ We must use data more strategically to improve clinical care
- ◆ These improvements require methods beyond the traditional office visit for maximum success

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Intervention

- ◆ Restructure primary care practices to increase patients' contact with their own physician and make roles of all team members explicit and transparent to patients
 - ◆ decrease panel size
 - ◆ decrease use of same day urgent care/doc of the day
 - ◆ new role for nurse practitioners and physicians assistants: providing care to those with chronically ill patients as part of the PCP's team (chronic care model)
- ◆ Support change with ongoing provision of patient care experience data

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Implementation of Intervention

- ◆ Intervention team assigned to go from office to office
- ◆ Restructure care delivery process: phone scripts for booking appointments, management of large panels, role of staff members
- ◆ Work one-on-one with clinicians to obtain buy-in for change



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On-going Measurement

- ◆ **Intervention practices: 14-office medical group**
 - ◆ Provision to practice of 2002 data (late 2003)
 - ◆ Ongoing data collection of patient perception of care at the individual physician level (Beginning January 2004)
 - ◆ Quarterly reporting of data to individuals (Beginning July 2004)
 - ◆ Pilot practices (n=5): Improvement team in residence (January-June 2004)
 - ◆ More widespread roll out of plan, 2005, to finish in early 2006
- ◆ **Control Group:** Affiliated practices (n=5)
 - ◆ Identical data collection and reporting
 - ◆ No focused intervention



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Use of data with physicians

- ◆ Presentations of individual level data
- ◆ Overcoming skepticism about data and data integrity: importance of scientific validity of information for physicians
- ◆ Gaining commitment to improvement: what is the “burning platform”?



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Results: Quality of Clinician-Patient Interactions

- ◆ “Intervention Group” (14 practice sites)
 - ◆ Significant improvement on all indicators of clinician-patient interaction quality
 - ◆ Communication quality
 - ◆ Knowledge of patient
 - ◆ Integration of care
 - ◆ Health promotion
 - ◆ Gains were not equal across all 14 practice sites
 - ◆ “Pilot” and “wave-2” sites achieved similar levels of improvement
 - ◆ Wave-3 sites: no significant improvement
- ◆ “Control Group” (5 practices): No significant change on any measure



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MHQP Patient Experience Survey 2006: Where we stand today

MHQP (Massachusetts Health Quality Partners) data released publicly on March 9, 2006, shows IM practices overall around 50th percentile in patient perception of care

- ◆ Site to site variation significant
- ◆ Significant differences in performance by domain measured



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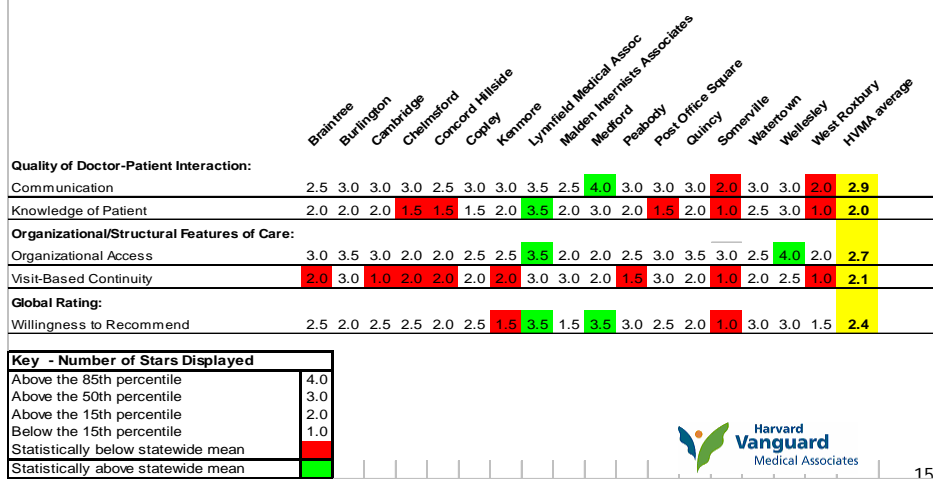
Patient Experience Survey - Internal Medicine Data

Internal Medicine Harvard Vanguard - Patient Experience Survey	Number of Sites with Reported Data	4 stars	3 Stars	2 Stars	1 Stars
Quality of Doctor-Patient Interaction:					
Communication	16	2	12	2	0
Integration of Care	16	2	7	6	1
Knowledge of Patient	16	1	3	10	2
Health Promotion	16	2	5	4	5
Organizational/Structural Features of Care:					
Organizational Access	16	4	8	4	0
Visit-Based Continuity	16	0	4	9	3
Clinical Team	16	1	8	6	1
Office Staff	16	7	4	5	0
Global Rating:					
Willingness to Recommend	16	2	8	5	1



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Patient Experience Survey - Internal Medicine Data



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Factors That May Have Contributed to Results

- ◆ Leadership committed and engaged
- ◆ Strategic goals aimed at organizational transformation
- ◆ Intervention had not yet occurred at majority of sites when data was collected for MHQP survey
- ◆ 30 year old culture of "clinic" model, with lack of focus on personal relationships




Further interventions to improve performance

- ◆ Continue to work on infrastructure
- ◆ In-person communications training
- ◆ Leadership training
- ◆ Team training
- ◆ Remedial course work for those who are failing



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Interventions in 2006 to improve performance in communication and knowledge of patient: Practice Infrastructure

- ◆ Continue increasing percent of own patients seen, and transparency of team to patients
 - phone scripts, template management
 - team structure and functioning: visible teams
 - refer to individuals, not to offices or departments



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Interventions in 2006 to improve performance in communication and knowledge of patient

- ◆ Develop a course for MDs to enhance communication during the office visit
 - most likely model similar to the "Four Habits" course developed by Kaiser Permanente
 - validated to improve physician-patient communication
 - also shown to improve physician job satisfaction



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The Four Habits Model

- ◆ Invest in the beginning of the visit
- ◆ Elicit the patient's perspective
- ◆ Demonstrate empathy
- ◆ Invest in the end of the visit




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The Four Habits Model: How?

- ◆ Voluntary training initially
- ◆ Priority given to individuals with poorer communication scores
- ◆ Teams can also volunteer for training




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Interventions: Training for local leaders

- ◆ Leadership training for chiefs/managers to enhance ability to follow-up/hold the gains
- ◆ In Kaiser Permanente experience, ongoing follow-up and continued discussion of communication ability reinforced impact of initial training



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Next steps for Harvard Vanguard

- ◆ Further work at individual physician and team level to increase focus on communication skills and knowledge of patient
- ◆ Continued provision of data for physician self-monitoring crucial
- ◆ Continued work on infrastructure required
- ◆ Understand that changing conservative clinical culture takes time and persistence, don't give up too soon



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