Through the Patient's Eyes: Enhancing Physician and Patient Satisfaction While Improving Practice Outcomes

Susan Edgman-Levitan, PA
Executive Director
John D. Stoeckle Center Innovation for Primary Care
Massachusetts General Hospital
October 15, 2009

MGH 1811 MASSACHUSETTS GENERAL HOSPITAL
The John D. Stoeckle Center for Primary Care Innovation

What is Patient-Centered Health Care

The Institute of Medicine defines patient-centered care as:

"providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions."

Source: Institute of Medicine. *Crossing the Quality Chasm, 2001.*

What is Patient-Centered Health Care: What Do Patients Care About?

Ambulatory Patients

- Access to care and wait times
- Communication with doctors and other clinicians
- Knowledge or and respect for preferences
- Timely reporting of test results and other clinical information
- Courtesy, respect, and helpfulness of staff

Hospital Patients

- Respect for preferences
- Communication with doctors and nurses
- Communication about medications
- Pain control
- Emotional support
- Family/friends involvement
- Coordination of care
- Discharge information

The Value of Patient- and Family-Centered Care

- Patients are the only source of information about many aspects of quality.
- The patient's experience is linked to great clinical care, reduced medical error, and outcomes.
- Improving the quality of work life for clinicians and staff goes hand in hand with improving the patient's experience of care.
- Patients and families bring a wealth of knowledge that clinicians and staff do not possess. Through involving patients and families in the redesign of care and quality improvement we improve our opportunities for quality, efficiency and better outcomes.

Measurement of the Patient's Experience of Care

- Clinician Group CAHPS
  - Public domain survey free to all
  - English/Spanish
  - Supplemental Item sets
    - Shared decision making
    - Literacy
    - Coordination of care
    - HIT
- Vendor surveys

Correlation Between MHQP Summary Measures and Patients' Willingness to Recommend their Physician to Family and Friends

	Correlation with Willingness to Recommend
QUALITY OF DOCTOR-PATIENT INTERACTION	
Communication	0.70
Knowledge of the Patient	0.68
Integration	0.51
Health Promotion	0.41
ORGANIZATIONAL FEATURES OF CARE	
Access	0.46
Visit-based Continuity	0.24
Clinical Team	0.43
Office Staff	0.41

Are Patient Experiences Associated with Clinical Outcomes?

- In randomized controlled trials, experimental patients were coached for 20 minutes on how to negotiate medical decisions with their physicians:
  - Ulcer patients: Significant decrease in limitations in physical and role activities; no significant change in ulcer pain.
  - Diabetes patients: Significant decreases in lost days of work due to illness and glycosylated hemoglobin.
  - Similar findings for hypertensive and breast cancer patients.
    - *The more "effective" patients were at interacting with their physicians, the better their overall health and the lower their functional limitations.*

Sources: Greenfield & Kaplan, 1985, 1988, 1989.

MGH 1811 MASSACHUSETTS GENERAL HOSPITAL

The John D. Stoeckle Center for Primary Care Innovation

Are Patient Experiences Associated with Clinical Outcomes?

- Design: Prospective cohort study
- Sample: Acute myocardial infarction (AMI) patients admitted to 20 New Hampshire Hospitals in 1996
- Data: Surveys mailed 1,3, and 12 months post-AMI

Source: Fremont A, et al. Patient-centered processes of care and long-term outcomes of myocardial infarction. J Gen Intern Med 2001; 16:800-808.

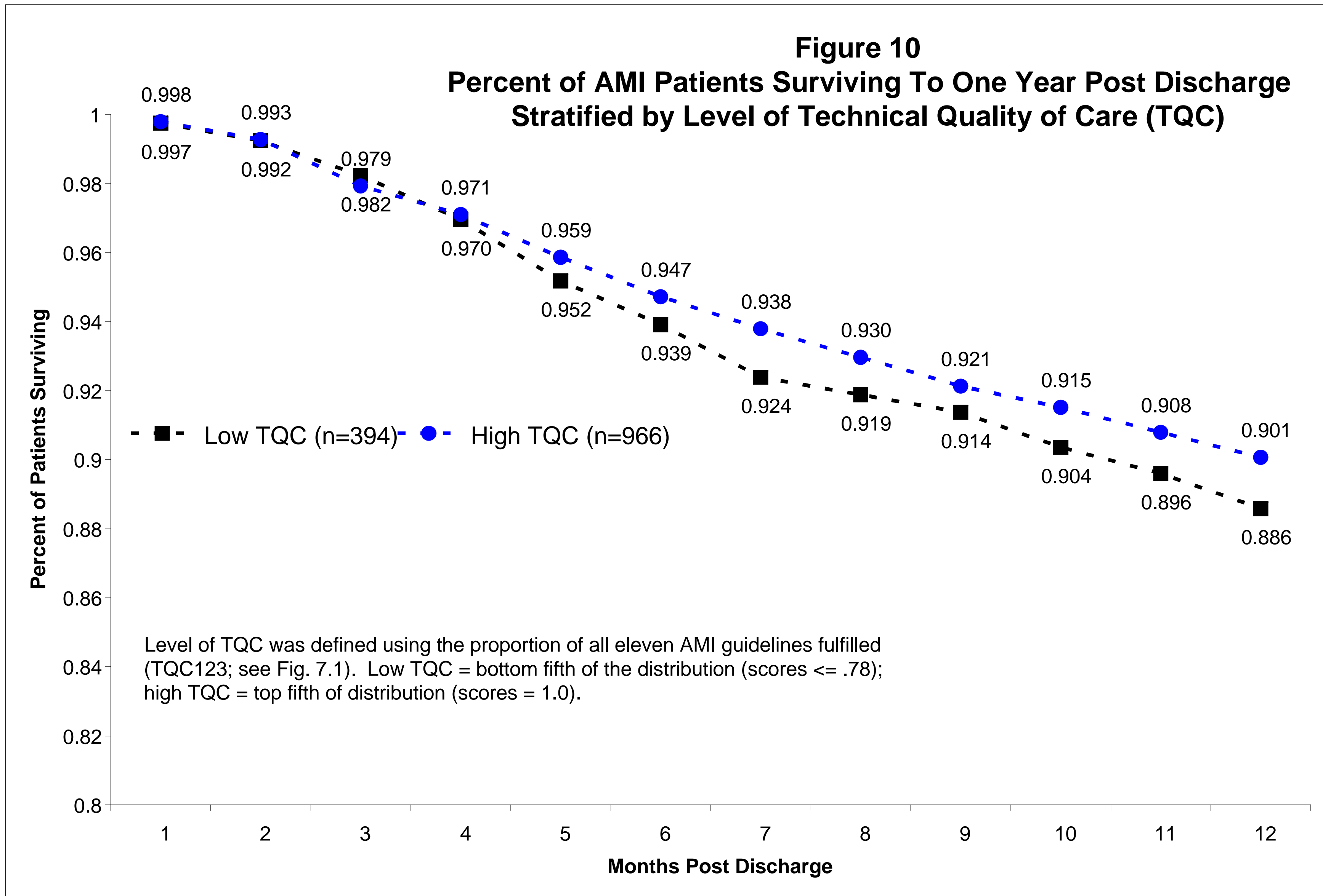
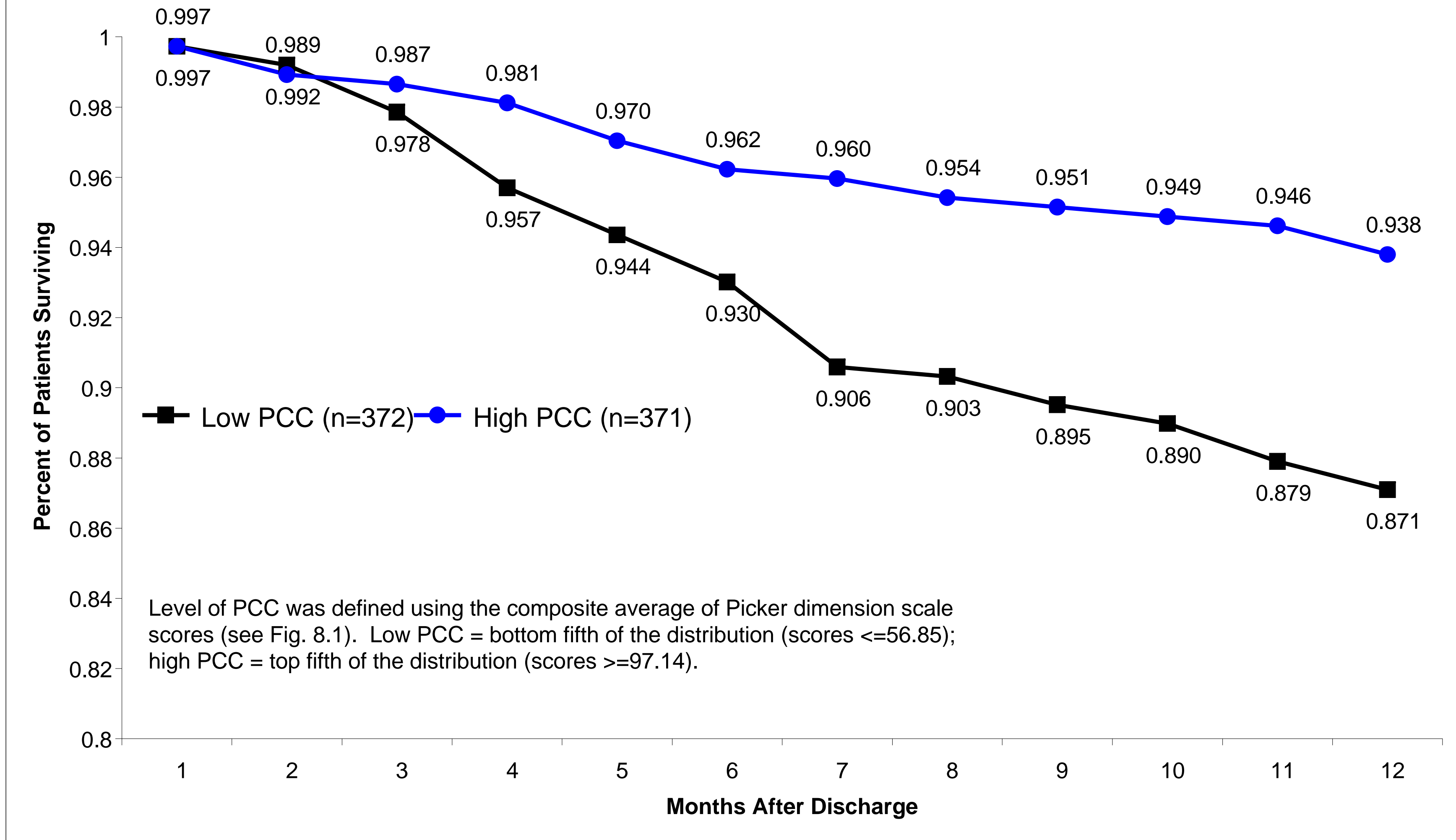


Figure 10
Percent of AMI Patients Surviving To One Year Post Discharge
Stratified by Level of Technical Quality of Care (TQC)
Percent of Patients Surviving
Months Post Discharge
Low TQC (n=394)
High TQC (n=966)
0.998
0.997
0.993
0.992
0.979
0.982
0.971
0.970
0.959
0.952
0.947
0.939
0.938
0.924
0.930
0.919
0.921
0.914
0.915
0.904
0.908
0.896
0.901
0.886
Level of TQC was defined using the proportion of all eleven AMI guidelines fulfilled
(TQC123; see Fig. 7.1). Low TQC = bottom fifth of the distribution (scores <= .78);
high TQC = top fifth of distribution (scores = 1.0).



MGH 1811 MASSACHUSETTS GENERAL HOSPITAL

The John D. Stoeckle Center for Primary Care Innovation

Doctor Patient Communication Outcomes

- OBJECTIVE: To identify specific communication behaviors associated with malpractice history in primary care physicians and surgeons.
- DESIGN: Comparison of communication behaviors of "claims" vs "no-claims" physicians using audiotapes of 10 routine office visits per physician.
- SETTINGS: One hundred twenty-four physician offices in Oregon and Colorado.
- PARTICIPANTS: Fifty-nine primary care physicians (general internists and family practitioners) and 65 general and orthopedic surgeons and their patients. Physicians were classified into no-claims or claims (> or =2 lifetime claims) groups based on insurance company records and were stratified by years in practice and specialty.

Levinson W, Roter DL, Mulloly JP, Dull VT, Frankel RM. Physician–patient communication. The relationship with malpractice claims among primary care physicians and surgeons. JAMA 1997;277:553–9

MASSACHUSETTS GENERAL HOSPITAL

The John D. Stoeckle Center for Primary Care Innovation

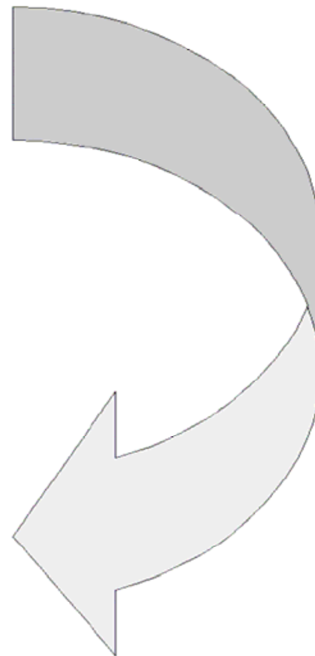
Doctor Patient Communication Outcomes

- RESULTS: Significant differences in communication behaviors of no-claims and claims physicians were identified in primary care physicians but not in surgeons.
  - 80% of primary care physicians were accurately classified by malpractice risk based on their communication styles-30% improvement over chance.
  - Sued doctors:
    - Had shorter visits by three minutes – 15.3 VS. 18 minutes
    - Used less partnership type of exchanges - soliciting patients' opinions, checking understanding, and encouraging patients to talk
    - Less orientation to the flow of the visit and less humor

Levinson W, Roter DL, Mulloly JP, Dull VT, Frankel RM. Physician–patient communication. The relationship with malpractice claims among primary care physicians and surgeons. JAMA 1997;277:553–9

Model of Successful Communication Practices

Focus on the patient's agenda



Draw out the story
- Use active listening responses
- Listen to 3-5 uninterrupted sentences
- Give opportunity to express fears
- Ask questions about patient's concerns
- Use physician self-disclosure

Demonstrate understanding
- Respond empathically
- Show caring
- Show familiarity with patient's medical or social history

Provide detailed explanation
- Explain what is happening and why
- Present options to the patient

Complete the patient's agenda

K. Tallman, T. Janisse, R. Frankel, S. Sung, E. Krupat, J. Hsu. "Communication Practices of Physicians With High Patient-Satisfaction Ratings".
The Permanente Journal/ Winter 2007/ Volume 11 No. 1

Communication Factors ***Not*** Correlated with Performance

- Length of the visit
- Asking open-ended questions at start of the visit.
- Heavy use of close-ended questions
- Attitudes toward the use of computers in the exam room
- Heavy use of closed-ended questioning vs. mixed open- and closed-ended questions
- Reassurance

K. Tallman, T. Janisse, R. Frankel, S. Sung, E. Krupat, J. Hsu. "Communication Practices of Physicians With High Patient-Satisfaction Ratings".
The Permanente Journal/ Winter 2007/ Volume 11 No. 1

The Impact of Disruptive Behavior

Failure to Address Disruptive Conduct Leads To:

- *Team members adopting disruptive person's negative mood/anger (Dimberg & Ohman, 1996)*
- *Lessened trust among team members which can lead to lessened task performance **(always monitoring disruptive person)...***
- *Affects quality and patient safety (Lewicki & Bunker, 1995; Wageman, 2000)*
- *Having colleagues at unnecessary risk for malpractice*

Felps, W et al. 2006. How, when, and why bad apples spoil the barrel: negative group members and dysfunctional groups. Research and Organizational Behavior, Volume 27, 175-222.

MGH 1811 MASSACHUSETTS GENERAL HOSPITAL
The John D. Stoeckle Center for Primary Care Innovation

Malpractice Research

- *1-6%+ hosp. pts injured due to negligence*
- *~2% of all pts injured by negligence sue*
- *~2-7 x more pts sue w/o valid claims*
- *Non-$$ factors motivate pts to sue*
- *2-8% of doctors attract more suits*
- *High risk today = high risk tomorrow*

- *MGPO CRICO Review: 3 unsolicited patient complaints in 2 years = 4 X risk of being named in a malpractice suit*

www.mc.vanderbilt.edu/CPPA

MGH Credo

- As a member of the MGH community and in service of our mission, I believe that:
- The first priority at MGH is the well-being of our patients, and all our work, including research, teaching and improving the health of the community, should contribute to that goal.
- Our primary focus is to give the highest quality of care to each patient delivered in a culturally sensitive, compassionate and respectful manner.
- My colleagues and I are MGH's greatest assets.
- Teamwork and clear communication are essential to providing exceptional care.
- As a member of the MGH community and in service of our mission, I will:
- Listen and respond to patients, patients' families, my colleagues and community members.

MGH Credo

- Ensure that the MGH is safe, accessible, clean and welcoming to everyone.
- Share my successes and errors with my colleagues so we can all learn from one another.
- Waste no one's time.
- Make wise use of the hospital's human, financial and environmental resources.
- Be accountable for my actions.
- Uphold professional and ethical standards.

MGH Boundaries

- As a member of the MGH community and in service of our mission, I will never:
- Recklessly ignore MGH policies and procedures.
- Criticize or take action against any member of the MGH community raising or reporting a safety concern.
- Speak or act disrespectfully toward anyone.
- Engage in or tolerate abusive behaviors.
- Look up or discuss private information about patients or staff for any purpose outside of my specified job responsibilities.
- Work while impaired by any substance or condition that compromises my ability to function safely and competently.

Road Map for Improving the Patient's Experience of Care and Physician Quality of Life

- Create a vision for the practice
- Identify strong leaders with visionary and practical expertise
- Create a code of conduct
- Use system resources, if available, e.g. HR, technology, financial
- Set *realistic* expectations for time and effort required
- Focus on process improvement skills and support
- Essential to link improving the patient's experience with enhancing the quality of work life for the clinicians and staff
- Make technology your friend but recognize barriers openly: typing, time investment, cost, don't ask, just tell…

Characteristics of High Performing **Practices**: *Through the Eyes of the Patient*

- Organizational Culture
  - Excellent leadership: visionary, operational, and financial
  - Flat hierarchies
  - Emphasis on teamwork and communication
  - “Family” environment

Characteristics of High Performing **Practices**: *Through the Eyes of the Patient*

- HR practices
  - Longevity of staff/RN/MD
  - Careful recruitment of physicians and other staff
  - Orientation and training
  - Reward and recognition programs
- Technology
  - EMR's
  - Wireless communication methods
  - Health education resources and portals
- Patient involvement
  - Informal vs. formal

Characteristics of High Performing **Practices**: *Through the Eyes of the Patient*

- Practice Models/Physical Design
  - Staffing patterns
    - MA/RN/MD relationships
    - Triage functions
  - Ease of communication
  - Collegiality and emotional support for staff and clinicians
  - Stable care teams
  - Patient's point of view

Characteristics of High Performing Practices: *Through the Eyes of the Patient*

- Financial Performance
- Use of Quality Measures
  - Patient experience of care data
  - Internal physician-level reporting & dashboards

Getting Started…

- Identify motivational drivers for practice leadership and staff, e.g.,
  - P4P
  - No access in primary care
- Choose a process improvement method
  - LEAN
  - PDSA/small tests of change
  - Other?

Getting Started…

- Choose data metrics for a dashboard:
  - Quality
  - Patient Experience of Care
  - Financial
  - Loyalty/Growth
  - Peer/staff reviews
- Inventory current demands on practice staff
  - P4P
  - Organizational

Start with a perceived need…

- Find an open door or stress point, e.g., “Please fix my….”
  - Office staff
  - Access
  - Communication
  - Work load

Observations of staff and practice flow

- Anthropological approach to observe the "tribe"
- Share observations(facts) to help link opinions with reality

Example of a practice request

- How long do patient visits really take?
- Why does it feel so busy?
- How can we increase quality while decreasing stress?

Common Findings

Operations

- Much of the visit time is non-patient oriented.
- Patients wait a really long time without an explanation.
- Physician style/preference determines the length of the visit.
- Broken equipment stays in the supply pool.
- Supplies are unavailable when and where needed.

Common Findings

Environment

- Little focus on creating a clutter-free, organized space.
- Lots of chatter, little communication.
- There is a skills and investment gap among support staff.

Impact on the Practice

- Decisions are based on the “style,” of the individual rather than the needs of the practice.
- People do not speak up even when they know a process does not work.
- People agree to a process and then ignore the process.
- Individuals create systems or processes that work for them without regard for the team.
- Judgments are based on opinions/perceptions rather than fact.

Those who say it cannot be done should not interrupt the person doing it.

-Chinese Proverb

Resources

- *The CAHPS Improvement Guide* *https://www.cahps.ahrq.gov/qiguide/default.aspx*
- **Patient-Centered Care: What Does It Take? Dale Shaller**
  - **http://www.commonwealthfund.org/Content/Publications/Fund-Reports/2007/Oct/Patient-Centered-Care--What-Does-It-Take.aspx**

Resources

- P. A. Nutting, W. L. Miller, B. F. Crabtree et al., "Initial Lessons from the First National Demonstration Project on Practice Transformation to a Patient-Centered Medical Home," *Annals of Family Medicine* May/June 2009 7(3):254–60.
- K. Tallman, T. Janisse, R. Frankel, S. Sung, E. Krupat, J. Hsu. "Communication Practices of Physicians With High Patient-Satisfaction Ratings" The Permanente Journal/ Winter 2007/ Volume 11 No. 1