Measuring Patients’ Experiences with Individual Physicians and Practice Sites: From Research to Practice to a National Standard

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Exploring Quality Management & Pay for Performance Strategies
Institute of Medicine

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Where Are We Going Today?

- Measuring patient care experiences and linking to outcomes
- Moving measures from an “idea” to “high-stakes implementation”
- Measure readiness for “high stakes” uses
- What do we know about improvement on these domains
Patient Experience Measures & Links to Outcomes
Research Model

Individual and Organizational Characteristics → Primary Care Performance → Outcomes
Essential Attributes of Primary Care Measured by the Primary Care Assessment Survey (PCAS)

- Clinical interaction
  - communication
  - physical exams

- Comprehensiveness
  - knowledge of patient
  - preventive counseling

- Integration

- Access
  - financial
  - organizational

- Continuity
  - longitudinal
  - visit-based

- Interpersonal treatment

- Trust
Outcomes for Which Links to Clinical Relationship Quality Are Established

- **“Business” Outcomes**
  - Loyalty to the practice (voluntary disenrollment)
  - Malpractice Risk
  - Recommending the practice

- **Health Outcomes**
  - Adherence to Clinical Advice
  - Symptom Resolution
  - Improved Clinical Indicators
Relationship Between Trust and Disenrollment

1996 Trust (percentile) vs. % Voluntary Disenrollment

- 95th percentile: 11.4%
- 75th percentile: 14.9%
- 50th percentile: 19.2%
- 25th percentile: 24.3%
- 5th percentile: 37.1%

Relationship Between Physician Communication and Medical Malpractice Risk

Source: Levinson et al. JAMA 1997; 277:553-559.
Patient Trust as a Predictor of Adherence: Successful Behavior Change

<table>
<thead>
<tr>
<th>1996 Trust Scale (percentile)</th>
<th>% Successful Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>95th</td>
<td>32.9%</td>
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<tr>
<td>75th</td>
<td>31.7%</td>
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<tr>
<td>50th</td>
<td>29.9%</td>
</tr>
<tr>
<td>25th</td>
<td>28.0%</td>
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<tr>
<td>5th</td>
<td>24.3%</td>
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</table>

Cost-Related Non-Compliance by Quality of Physician-Patient Relationship

Patient Preference for Active Involvement in Medical Decision-Making: Effect of a Patient Involvement Intervention


* p<0.001
Effects of an Intervention on Health-related Quality of Life: Functional Limitations

Mobility (scored 0 - 3)

- Experimental Group
- Control Group

Pre-Intervention: 0.85
Post-Intervention: 1.11

Physical (scored 0 - 5)

- Experimental Group
- Control Group

Pre-Intervention: 1.89
Post-Intervention: 2.25


* p<0.01
Effect of a Patient Involvement Intervention on Diabetes Control


* p<0.001
Barriers to Adherence

Cognitive

Financial

Motivational

Logistical
Moving from Research to Practice
Staged Development & Use of Performance Measures

Phase I
Development & Testing

Phase II
Initial Large-Scale Implementation

Phase III
Implementing Measures for “High Stakes” Purposes

Time 0
Initial measure implementation. Final measure validation/testing.

Time 1
Stakeholder Buy-in

Time 1
P4P Public Tiering Reporting
“1st Generation” Questions: Moving MD-Level Measurement into Practice

- What sample size is needed for highly reliable estimate of patients’ experiences with a physician?

- What is the risk of misclassification under varying reporting frameworks?

- Is there enough performance variability to justify measurement?

- How much of the measurement variance is accounted for by physicians as opposed to other elements of the system (practice site, network organization, plan)?

Source: Safran et al. JGIM 2006
Measures from the Ambulatory Care Experiences Survey (ACES), 2002

- Communication
  -· whole-person orientation
  -· health promotion/patient empowerment

- Integration
  -· team
  -· specialists
  -· lab

- Continuity
  -· longitudinal
  -· visit-based

- Comprehensiveness

- Organizational Access

- Trust

- Interpersonal Treatment

Source: Safran et al. JGIM 2006; 21(1):13-21
Physician-Level Reliability:  
A Measure of Concordance Among Patients

Source: Safran et al. JGIM 2006; 21(1):13-21
Sample Size Requirements for Varying Physician-Level Reliability Thresholds

<table>
<thead>
<tr>
<th>Organization/Structural Features of Care</th>
<th>Number of Responses per Physician Needed to Achieve Desired MD-Level Measurement Reliability</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Reliability: 0.7</td>
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<tr>
<td>Organizational access</td>
<td>23</td>
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<tr>
<td>Visit-based continuity</td>
<td>13</td>
</tr>
<tr>
<td>Integration</td>
<td>39</td>
</tr>
<tr>
<td>Doctor-Patient Interactions</td>
<td></td>
</tr>
<tr>
<td>Communication</td>
<td>43</td>
</tr>
<tr>
<td>Whole-person orientation</td>
<td>21</td>
</tr>
<tr>
<td>Health promotion</td>
<td>45</td>
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<tr>
<td>Interpersonal treatment</td>
<td>41</td>
</tr>
<tr>
<td>Patient trust</td>
<td>36</td>
</tr>
</tbody>
</table>

Source: Safran et al. JGIM 2006; 21(1):13-21
Risk of Misclassification

- Not simply 1- $\alpha_{\text{site}}$
- Depends on:
  - Measurement reliability ($\alpha_{\text{site}}$)
  - Proximity of score to the cutpoint
  - Number of cutpoints in the reporting framework

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<thead>
<tr>
<th>15th</th>
<th>50th</th>
<th>85th</th>
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Source: Safran et al. JGIM 2006; 21(1):13-21
Allocation of Explainable Variance: Doctor-Patient Interactions

Source: Safran et al. JGIM 2006; 21(1):13-21
Allocation of Explainable Variance: Organizational/Structural Features of Care

Source: Safran et al. JGIM 2006; 21(1):13-21
Widespread Adoption of Physician-Level Survey Measures

Organization and Individual → Primary Care Assessment Survey (PCAS) → Outcomes

Ambulatory Care Experiences Survey (ACES) Project, 2002

Defining the National Standard

C/G CAHPS® → CMS DOQ

ABMS → NQF

Large Scale Implementation: Public Reporting, P4P

MA- MHQP → PBGH → BTE

Large QI Initiatives

HVMA → ICSI
Measure Readiness for “High Stakes”
Measuring Patient Experiences: Where Are We?

Phase I
Early developmental
- Health literacy
- Cultural competence

Phase II
Initial Large-Scale implementation & testing
- Health promotion
- Chronic care self-management
- Shared decision making
- Patient activation

Phase III
High-Stakes Implementation

Clinician Patient Interaction
- Communication quality
- Interpersonal treatment
- Knowledge of patients

Organizational Features
- Access
- Integration
- Office staff
Barriers to Adherence

Cognitive

Financial

Logistical

Motivational
How “Improvable” Are These Areas of Performance?
“My trouble is that the energy for this action group died a quiet death. There really isn't anything to report. The administrator never really came on board and without his support the rest of the team lost enthusiasm.”

--Participant in Patient-Centered Care Collaborative
MA Practice Improvement Initiative: A Success Story

- Intervention: A multi-site primary care practice (n=14 sites)

- Senior leadership-initiated improvement
  - Key motivator: Statewide survey results (2002)
  - New business model

- Likely contributors to success:
  - Ongoing, visible priority of senior leadership and the board
  - Cultural: Practice-wide “messaging”
  - Informational: Ongoing data collection and reporting (Beginning January 2004)
  - Structural: Increased continuity (Beginning 2003)
  - Behavioral: Skills training (Beginning 2006)

- Control Group: Affiliated practices (n=5)
  - Identical data collection and reporting
  - No focused intervention
Improving Patients’ Care Experiences: How Are We Doing? Changes in 2 Important Metrics: Jan 2002 - Jan 2005

Correlation to Measure of Willingness to Recommend

Priority Improvements

Knowledge of the Patient

Communication

Percentile Rank Adjusted

2002

2003

2004

2005
Two decades of measure development and validation preceded the widespread uptake of patient care experience measures for “high-stakes” purposes.

Substantial evidence links patient care experiences – particularly the quality of clinician-patient interactions – to important outcomes of care.

Continued development and testing of measures since 2002 has demonstrated the feasibility and value of this area of measurement (e.g., sample sizes feasible, variability sufficient to warrant measurement).

There are important gaps in the set of measures ready for “high stakes” that should be a priority as we look to improve population health through measuring the quality of care.

Early evidence of “improvability” is encouraging – but it requires a fundamental change in how individuals and organizations think about patient care.
For More Information:

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