

# 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

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# Where Are We Going Today?

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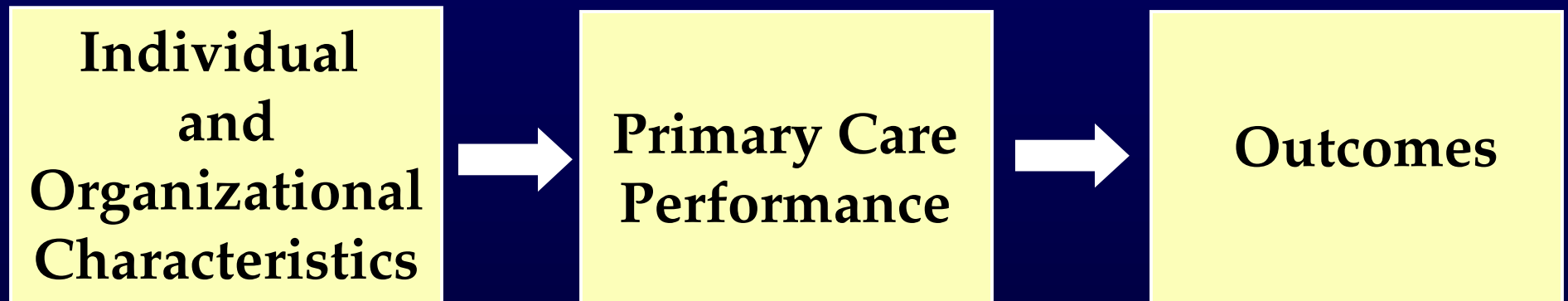
- u Measuring patient care experiences and linking to outcomes
- u Moving measures from an “idea” to “high-stakes implementation”
- u Measure readiness for “high stakes” uses
- u What do we know about improvement on these domains

# Patient Experience Measures & Links to Outcomes

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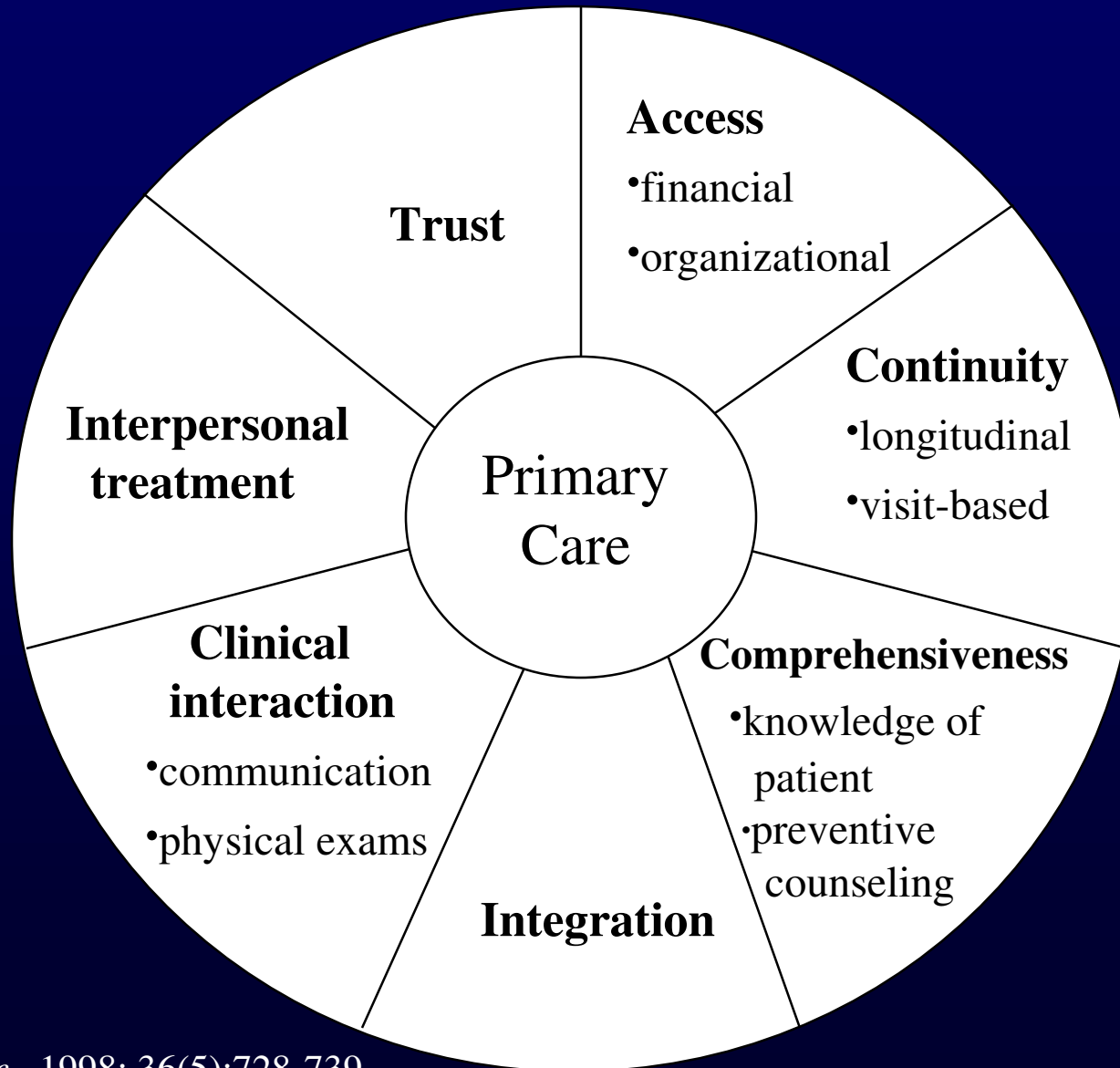
# Research Model

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# Essential Attributes of Primary Care Measured by the Primary Care Assessment Survey (PCAS)

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# Outcomes for Which Links to Clinical Relationship Quality Are Established

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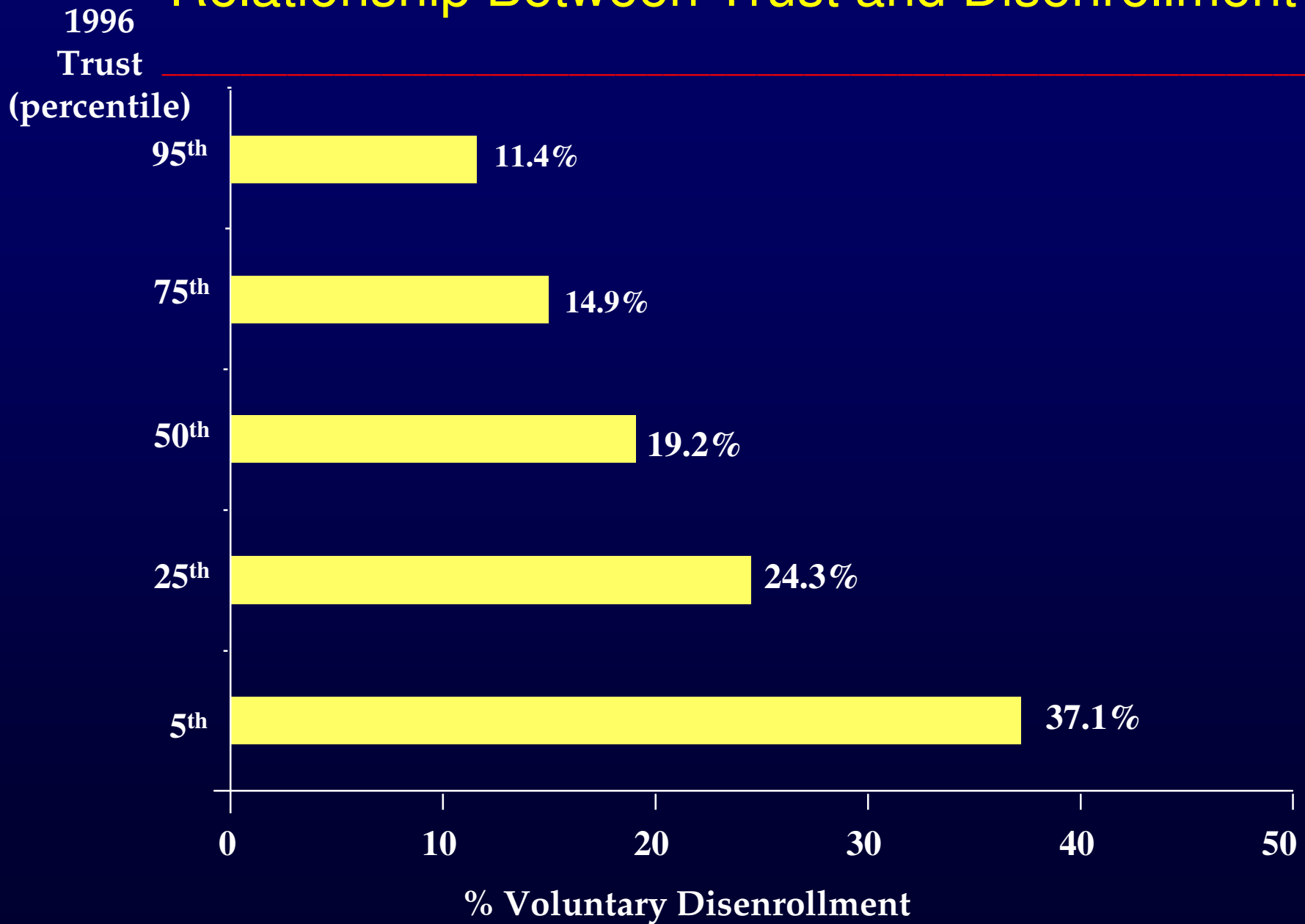
## u **“Business” Outcomes**

- ∇ Loyalty to the practice (voluntary disenrollment)
- ∇ Malpractice Risk
- ∇ Recommending the practice

## u **Health Outcomes**

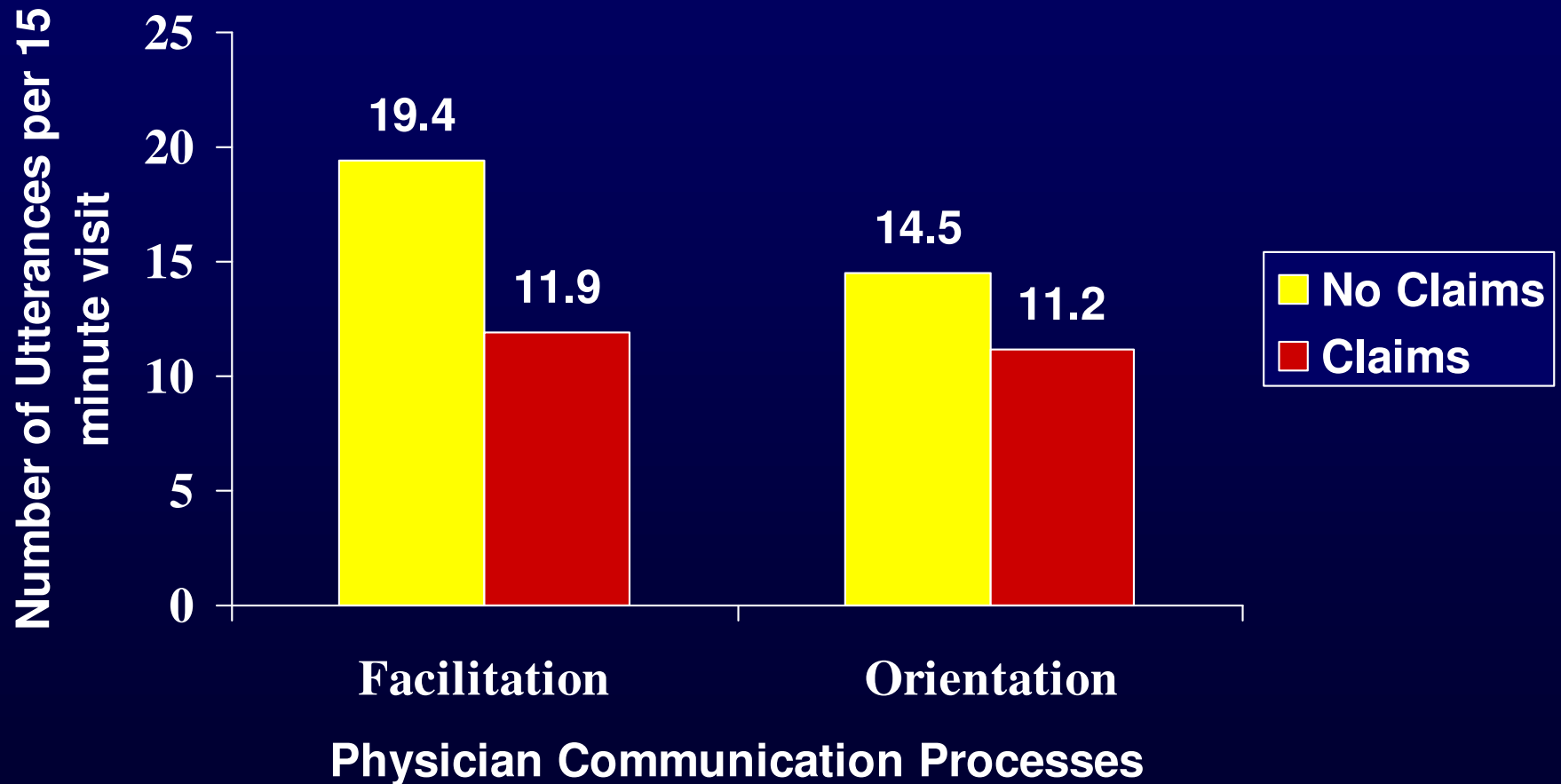
- ∇ Adherence to Clinical Advice
- ∇ Symptom Resolution
- ∇ Improved Clinical Indicators

# Relationship Between Trust and Disenrollment



Source: Safran et al. *JFP* 2001; 50:130-136.

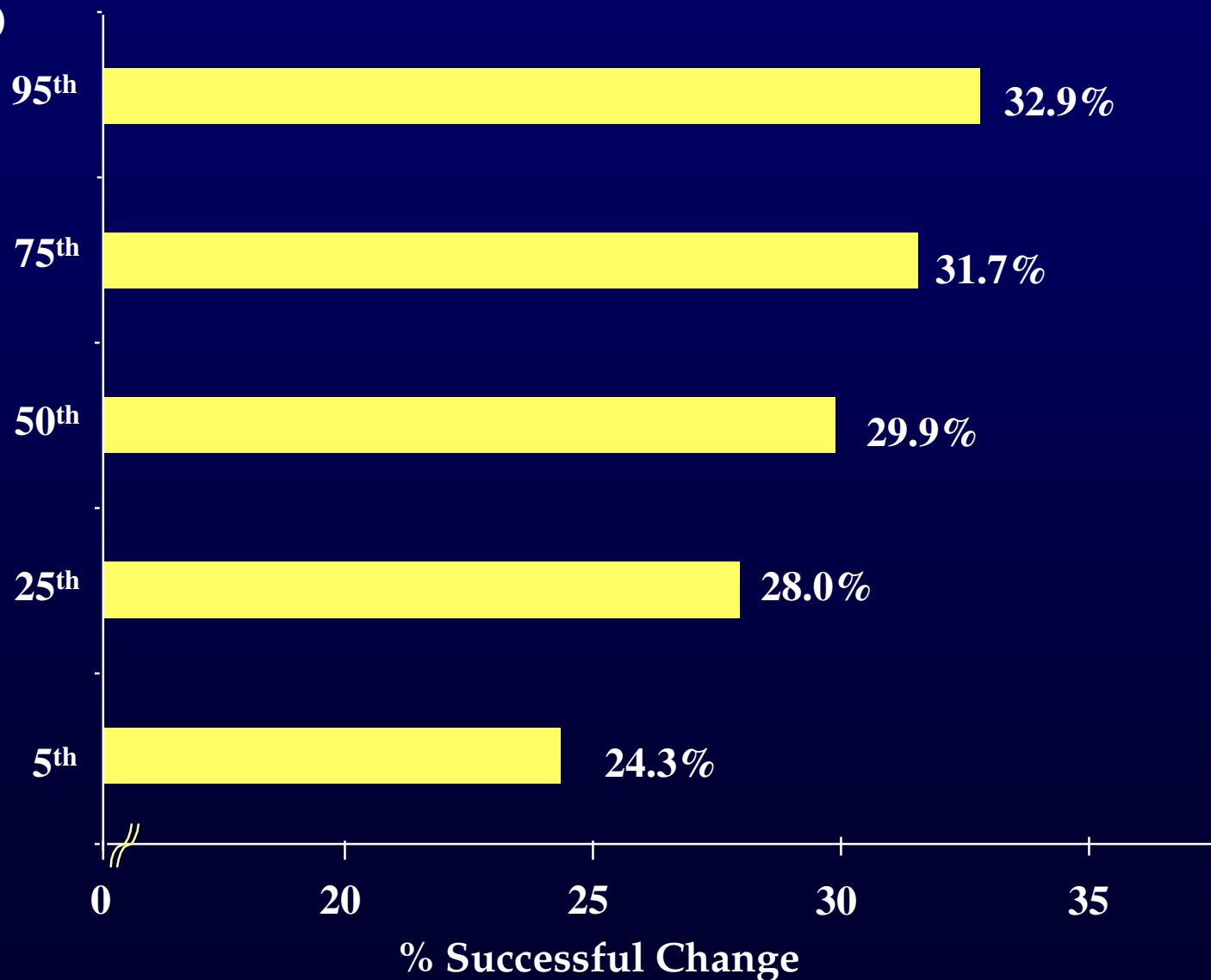
# Relationship Between Physician Communication and Medical Malpractice Risk



Source: Levinson et al. JAMA 1997; 277:553-559.

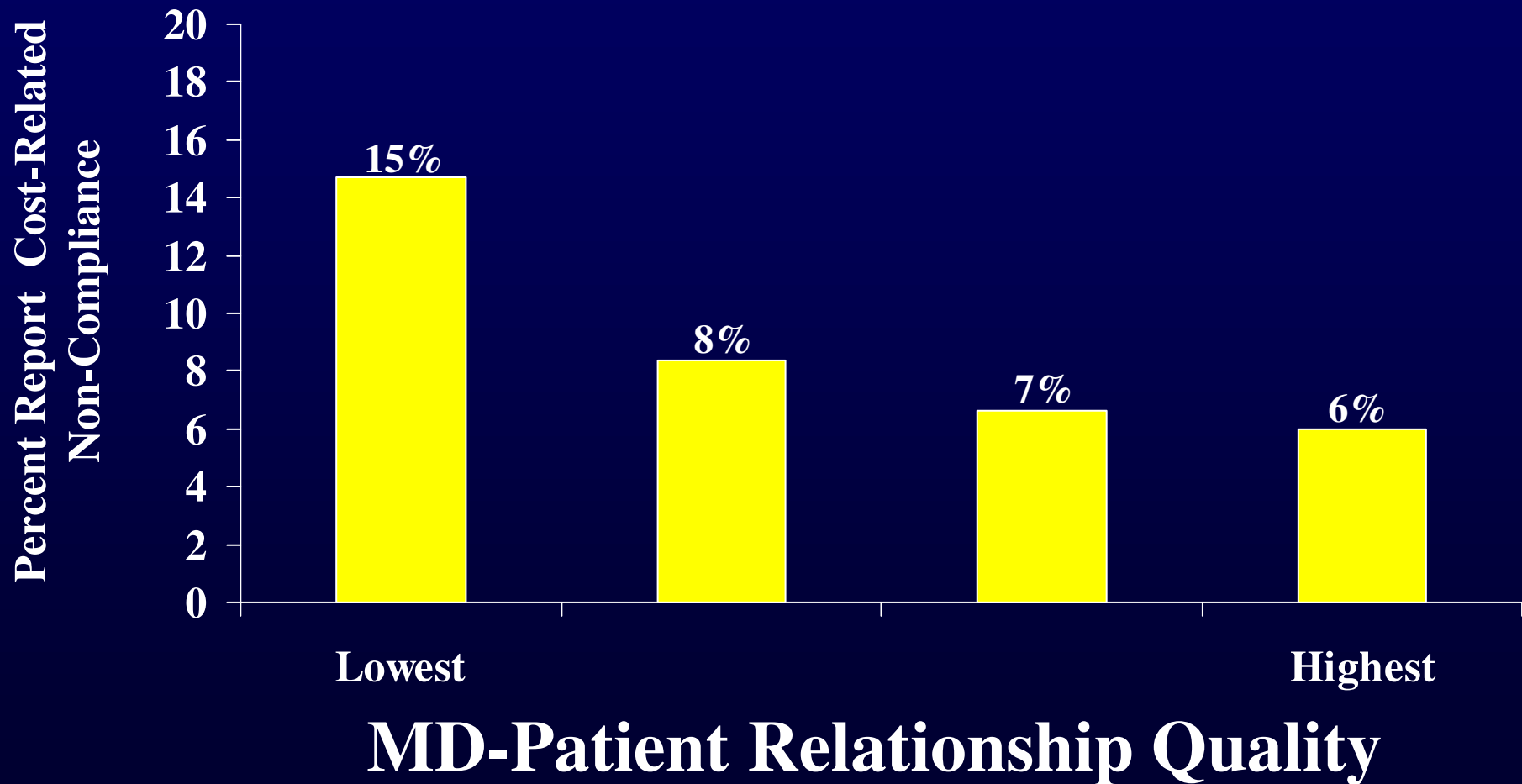
# Patient Trust as a Predictor of Adherence: Successful Behavior Change

1996 Trust  
Scale  
(percentile)



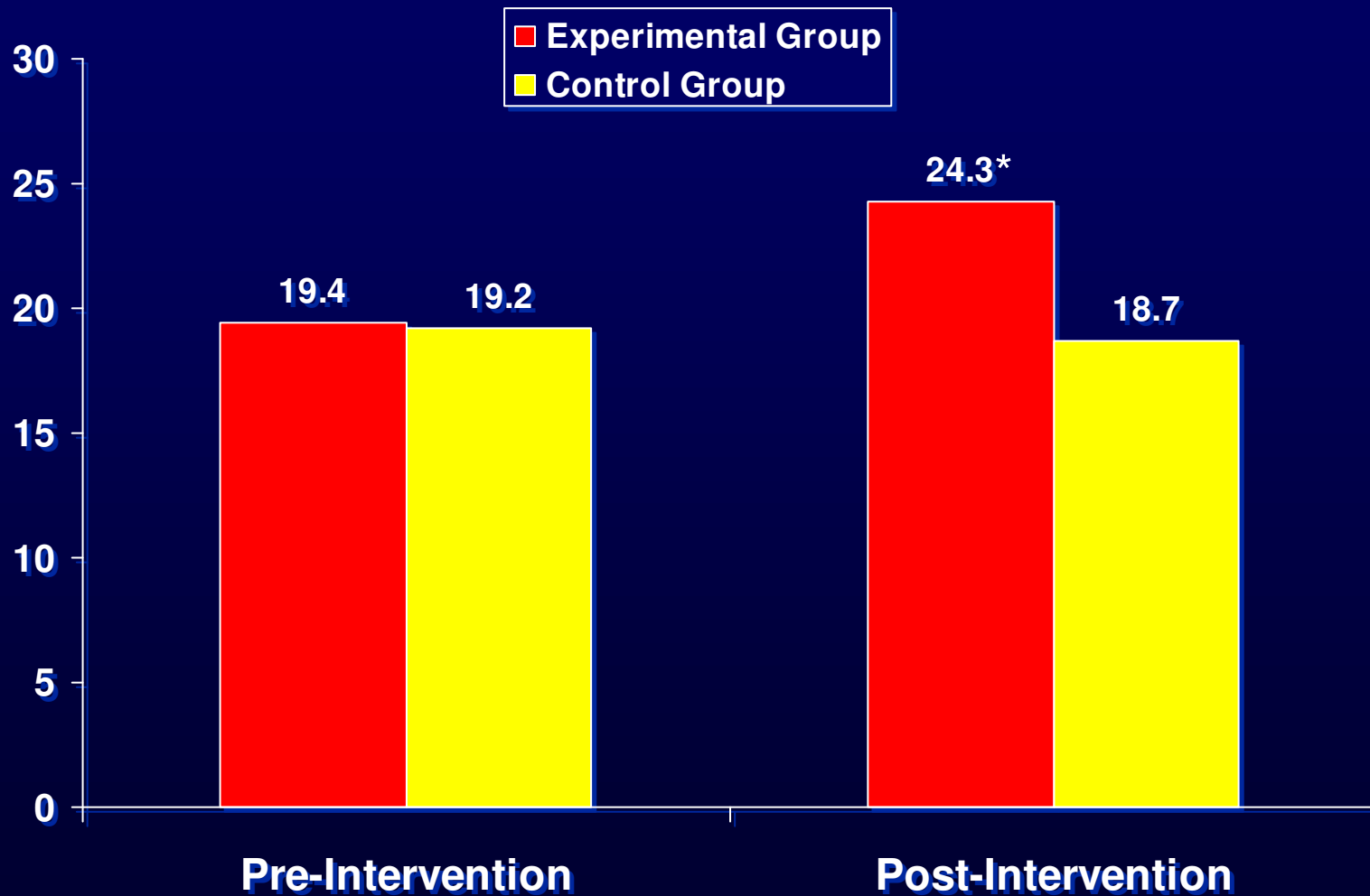
Source: Safran et al. *JGIM* 2000; 15 (supp):116.

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

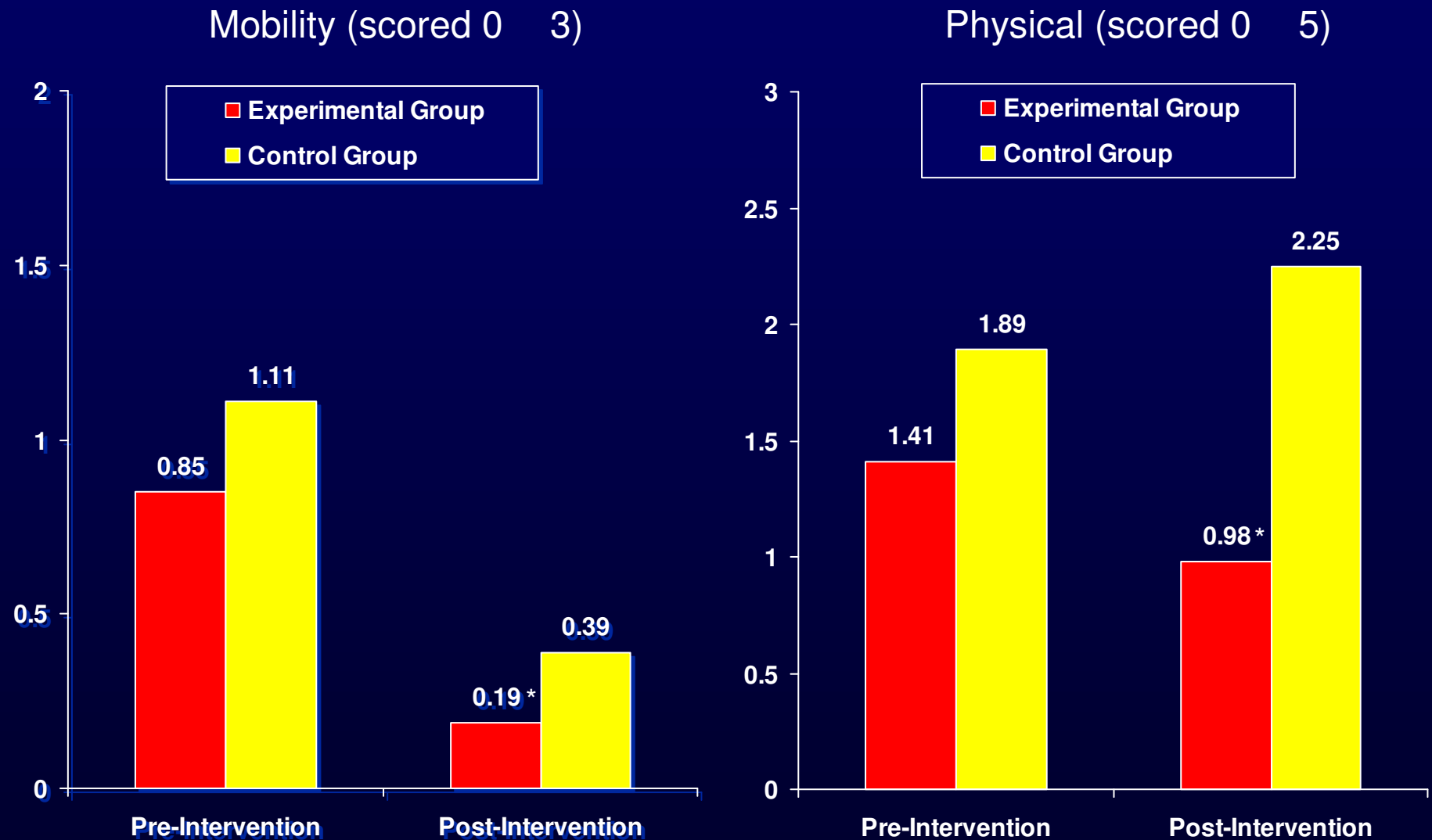


Source: Wilson et. al., JGIM 2005; 20 (8): 715-720

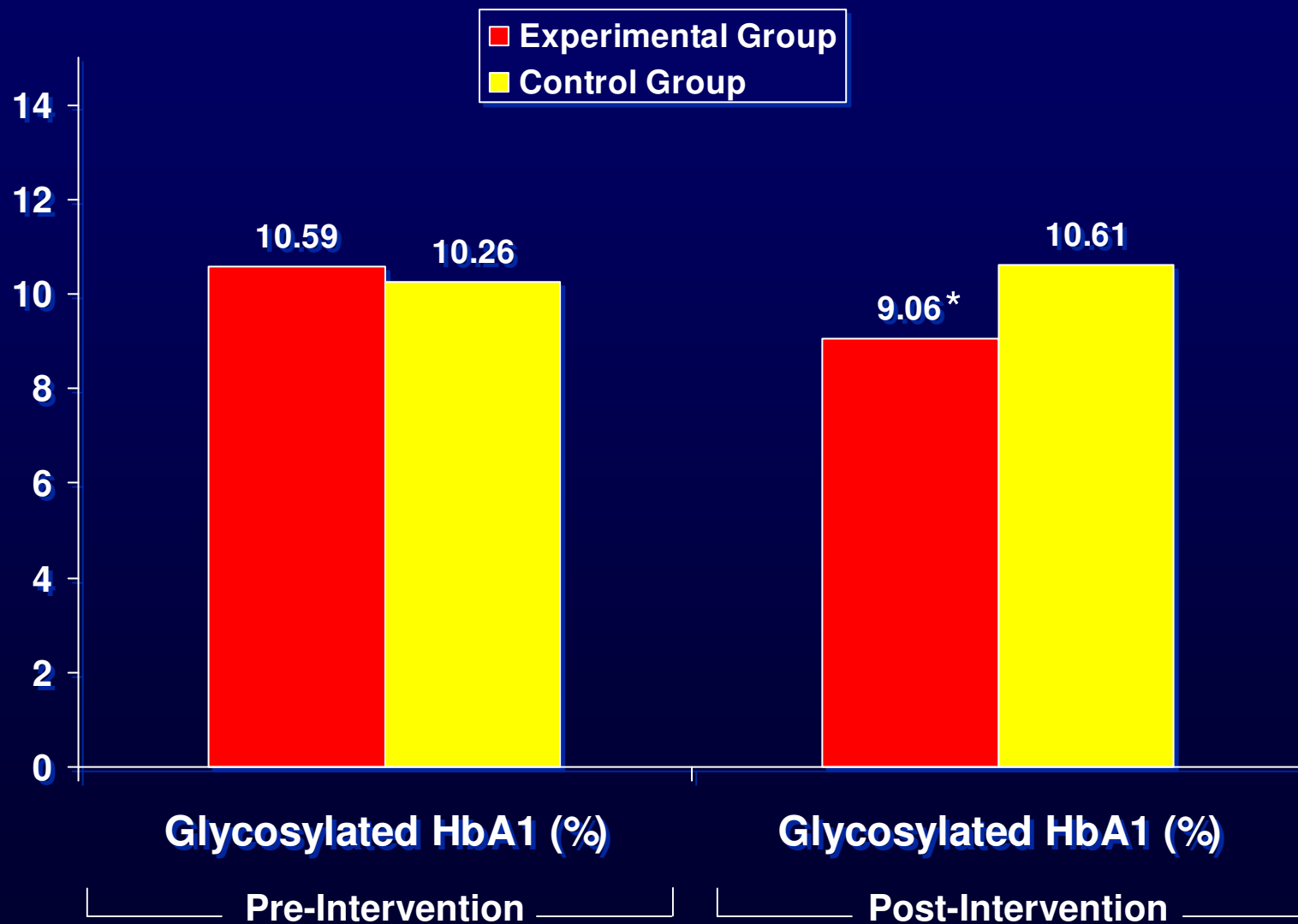
# Patient Preference for Active Involvement in Medical Decision-Making: Effect of a Patient Involvement Intervention



# Effects of an Intervention on Health-related Quality of Life: Functional Limitations



# Effect of a Patient Involvement Intervention on Diabetes Control



# Barriers to Adherence

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**Cognitive**

**Financial**



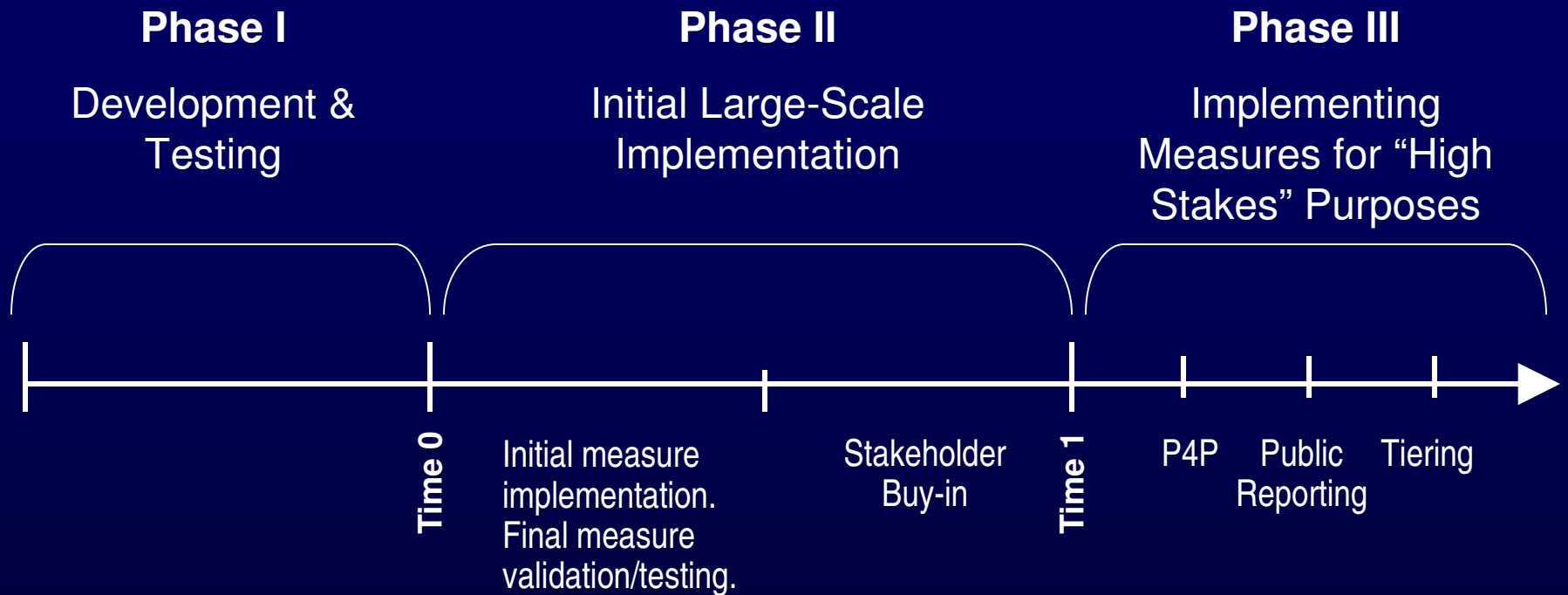
**Logistical**

**Motivational**

# **Moving from Research to Practice**

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# Staged Development & Use of Performance Measures

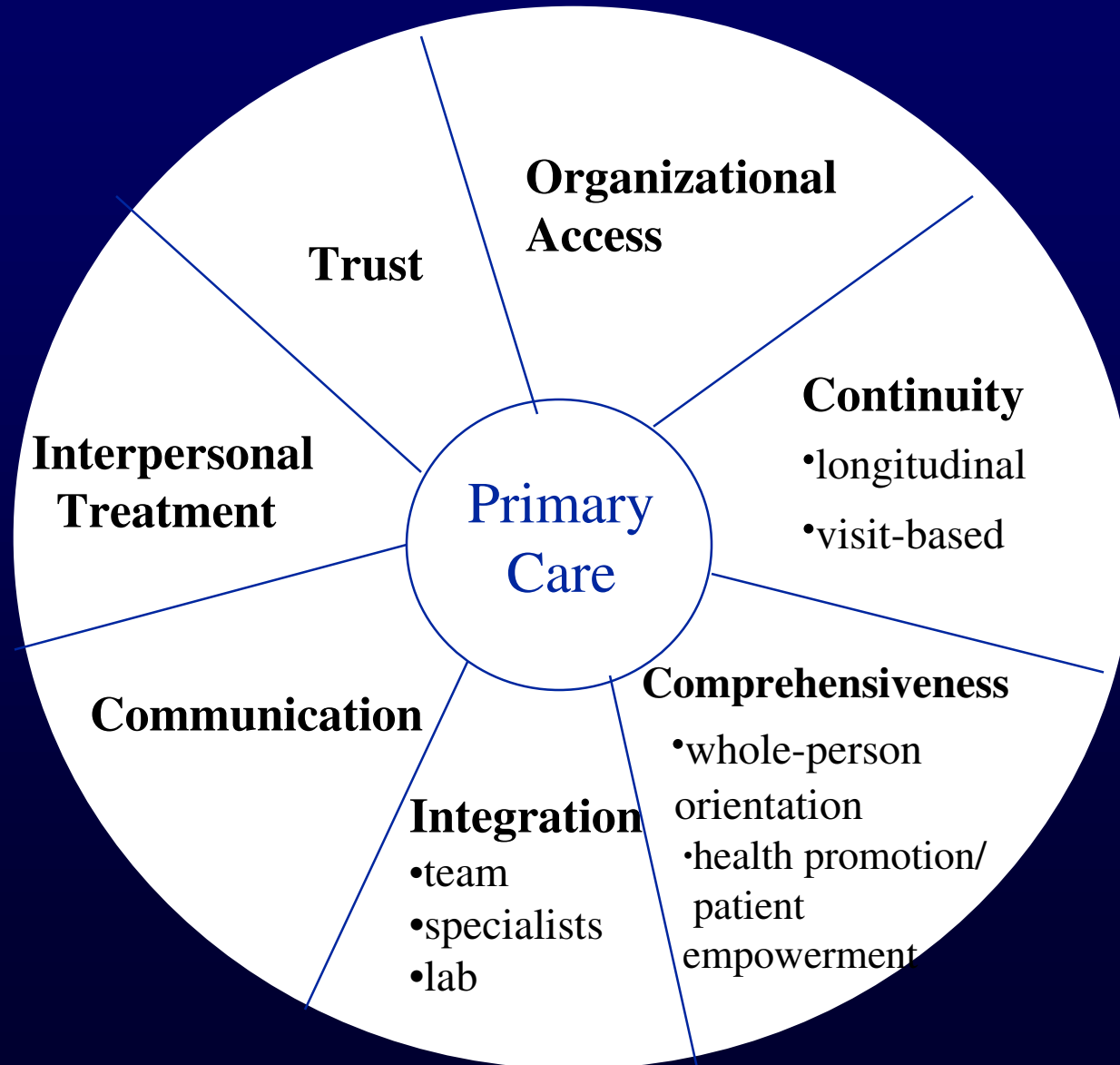


# “1<sup>st</sup> Generation” Questions: Moving MD-Level Measurement into Practice

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- u What sample size is needed for highly reliable estimate of patients’ experiences with a physician?
- u What is the risk of misclassification under varying reporting frameworks?
- u Is there enough performance variability to justify measurement?
- u How much of the measurement variance is accounted for by physicians as opposed to other elements of the system (practice site, network organization, plan)?

# Measures from the Ambulatory Care Experiences Survey (ACES), 2002



Source: Safran et al. *JGIM* 2006; 21(1):13-21

# Physician-Level Reliability: A Measure of Concordance Among Patients

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Source: Safran et al. *JGIM* 2006; 21(1):13-21

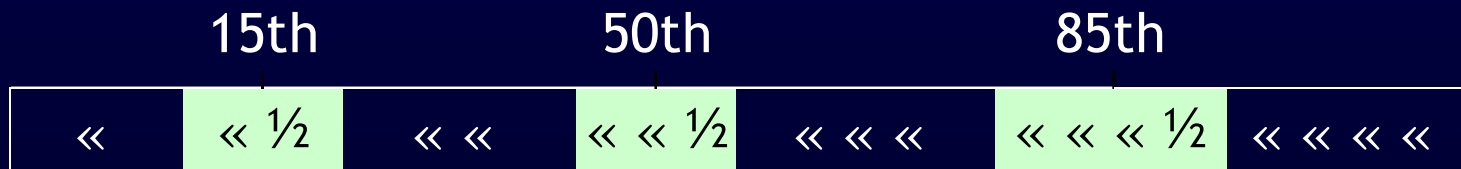
# Sample Size Requirements for Varying Physician-Level Reliability Thresholds

	Number of Responses per Physician Needed to Achieve Desired MD-Level Measurement Reliability		
	Reliability: 0.7	Reliability: 0.8	Reliability: 0.95
<b>ORGANIZATIONAL/STRUCTURAL FEATURES OF CARE</b>			
Organizational access	23	39	185
Visit-based continuity	13	22	103
Integration	39	66	315
<b>DOCTOR-PATIENT INTERACTIONS</b>			
Communication	43	73	347
Whole-person orientation	21	37	174
Health promotion	45	77	366
Interpersonal treatment	41	71	337
Patient trust	36	61	290

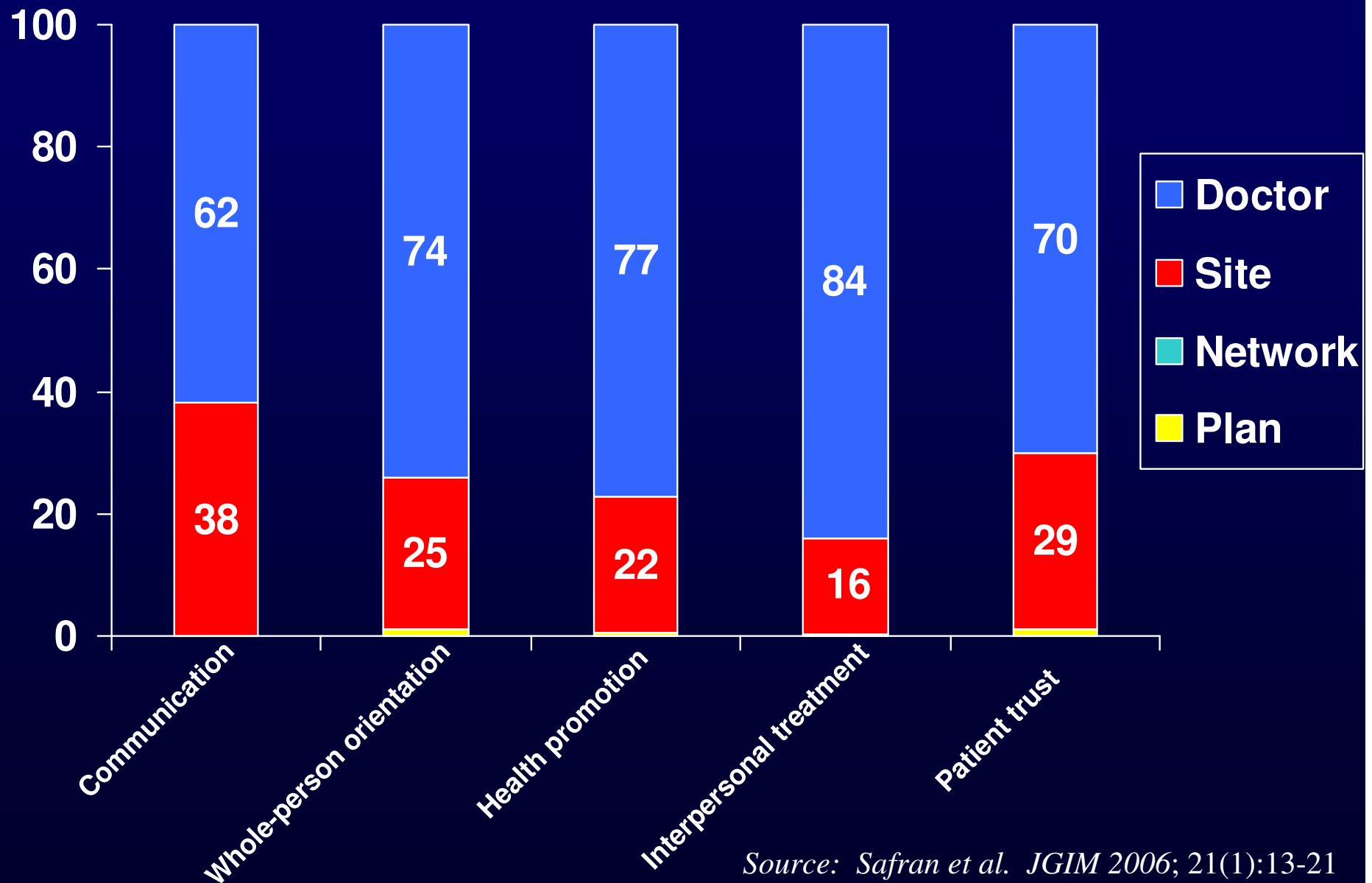
Source: Safran et al. *JGIM* 2006; 21(1):13-21

# 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

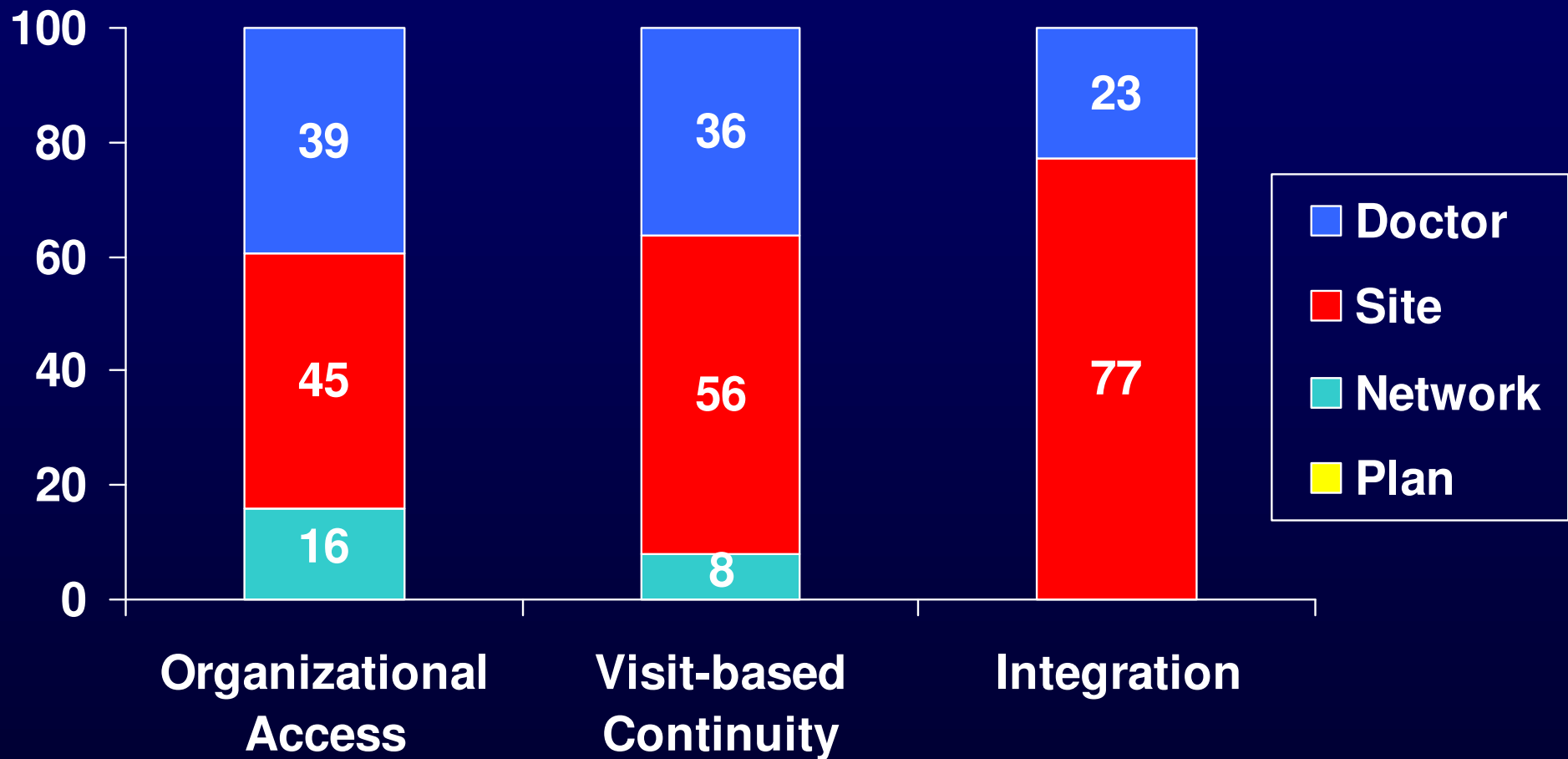


# Allocation of Explainable Variance: Doctor-Patient Interactions

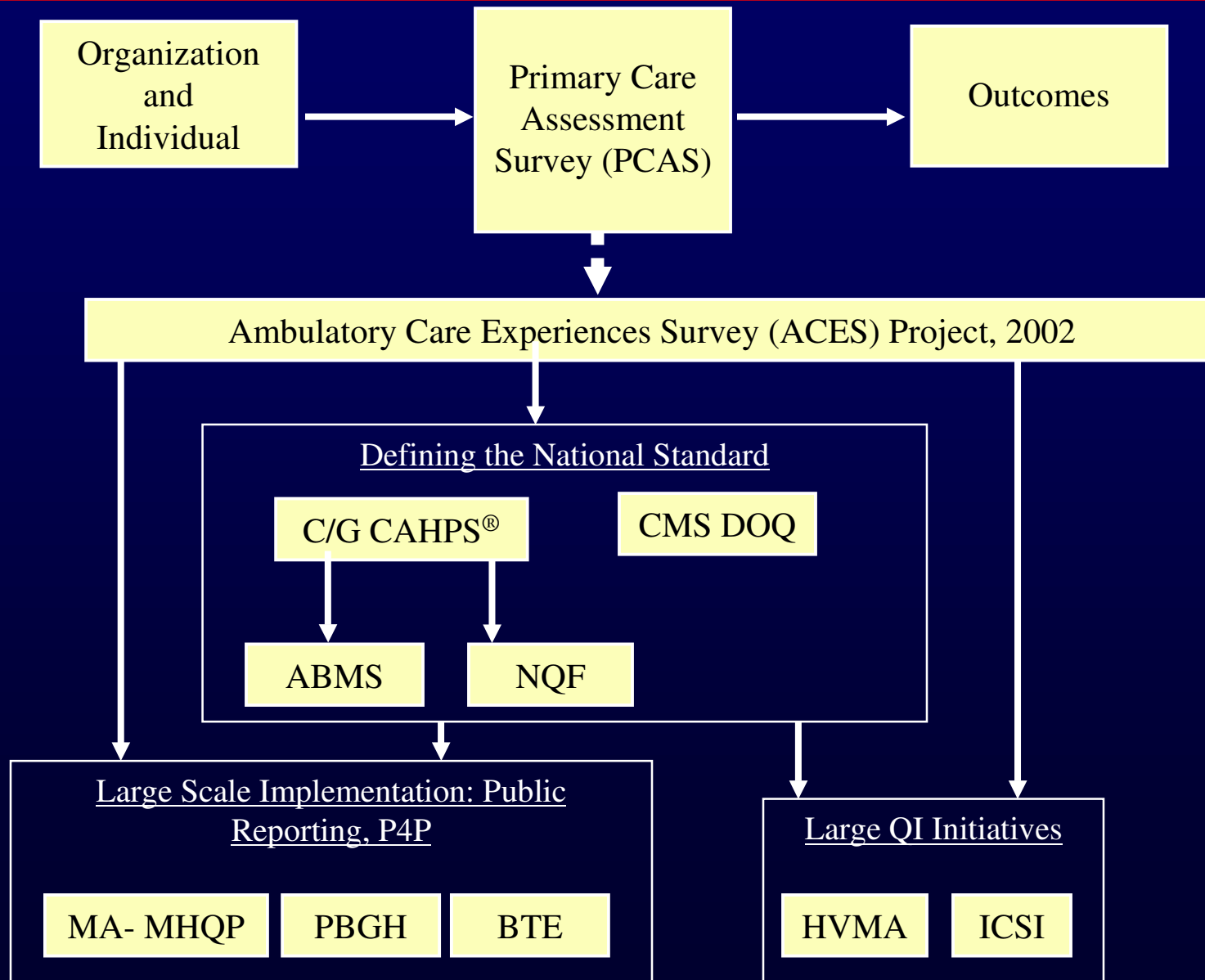


Source: Safran et al. *JGIM* 2006; 21(1):13-21

## Allocation of Explainable Variance: Organizational/Structural Features of Care



# Widespread Adoption of Physician-Level Survey Measures



# Measure Readiness for “High Stakes”

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# 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

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Cognitive

Financial



Logistical

Motivational

# **How ‘Improvable’ Are These Areas of Performance?**

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## Challenges of Achieving Improvements

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“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

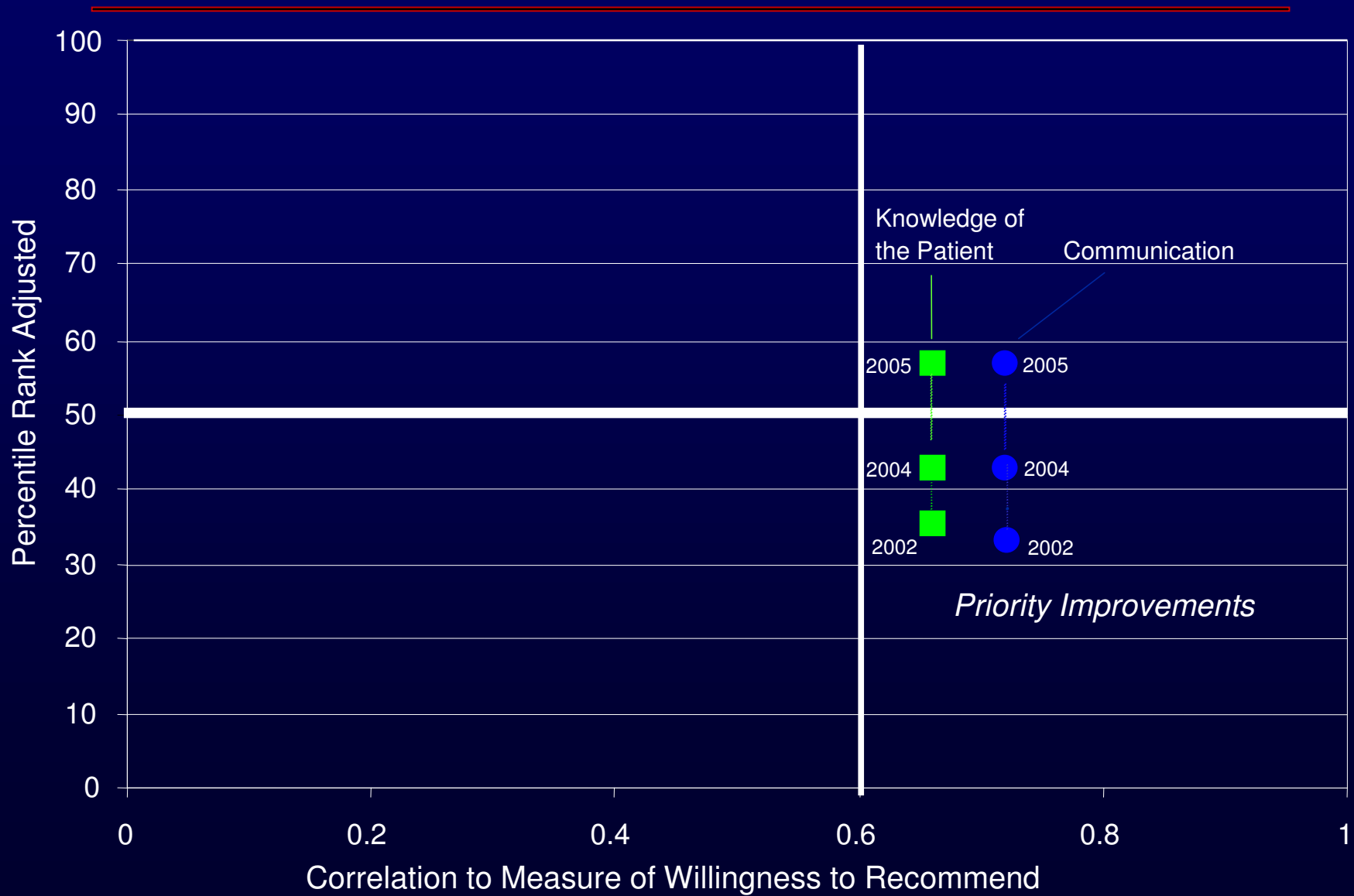
# MA Practice Improvement Initiative: A Success Story

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- u Intervention: A multi-site primary care practice (n=14 sites)
- u Senior leadership-initiated improvement
  - v Key motivator: Statewide survey results (2002)
  - v New business model
- u Likely contributors to success:
  - v Ongoing, visible priority of senior leadership and the board
  - v Cultural: Practice-wide “messaging”
  - v Informational: Ongoing data collection and reporting (Beginning January 2004)
  - v Structural: Increased continuity (Beginning 2003)
  - v Behavioral: Skills training (Beginning 2006)
- u Control Group: Affiliated practices (n=5)
  - v Identical data collection and reporting
  - v No focused intervention

# Improving Patients' Care Experiences: How Are We Doing?

## Changes in 2 Important Metrics: Jan 2002 - Jan 2005



# Summary

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- u Two decades of measure development and validation preceded the widespread uptake of patient care experience measures for “high-stakes” purposes
- u Substantial evidence links patient care experiences – particularly the quality of clinician-patient interactions –to important outcomes of care
- u 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)
- u 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
- u 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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Doctor and the Doll by Norman Rockwell

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