

- Track: Improving Patient s' Experience With Care
- Session: Improving Care Using the CAHPS Clinician & Group Survey
- Date & Time: April 21, 2010, 9:30 am
- Track Number: T2-S5-1

Practice Redesign & Patient Access: A Local CAHPS Experience

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Outline

- IMA and MGH PC practice redesign efforts
- Highlight challenges/opportunities for practice improvement at IMA
- CAHPS as a QI evaluation tool
- Where we are heading



MGH Primary Care

- 16 adult primary care practices:
 - 5 community health centers, 6 community-based practices, and 5 hospital-based practices
 - 220 MD PCPs (Internists, Pediatricians, Med/Peds, and Family Care PCPs) and 400 support staff serve these practices
 - Practices are located on the main campus in Boston, and in the surrounding communities
 - Collectively, these practices care for about 200,000 patients



Internal Medicine Associates

- 48 MDs
 - 67 residents MDs
 - 6 NPs
 - 20 RNs
 - serving 37,000 patients
-
- Pilot Team: 4MDs, 2 RNs, 2 MAs, 1 NP, 4 patient service coordinators serving ~ 5,000 patients



Internal Medicine Associates

- The PROBLEM: PATIENT ACCESS
 - Trouble getting appointments
 - Multiple ED/MWIC visits
 - Patients wait too long for info/answers
 - Staff and Patients: Who's in control?



Approach to Work Redesign

- Identify practice challenges/opportunities
- Perform small, easy-to-implement, inexpensive experiments which move us toward a patient centered medical home model – ongoing efforts
- Share approaches that work, pod by pod



Challenges / Opportunities

1. Improved Team Alignment

- Triage process can be especially difficult, for RN & MD
- RN care for pts often limited by (to) phone/clerical work
- *How can team organization improve patient access?*

2. Urgent Care access / ED /MWIC use

- 19 pts/day seen in ED ; 185 ED visits/1,000 pts per year in FY08.
- Many pts seen in MWIC
- *How can we see our own patients when they need to be seen?*

3. Opportunities to improve coordination of care

- Post-discharge f/u, outpatient care services
- vigilance of individual MDs >> management systems
- CRICO audit showed room for improvement
- *How can coordination of care improve access for patients?*



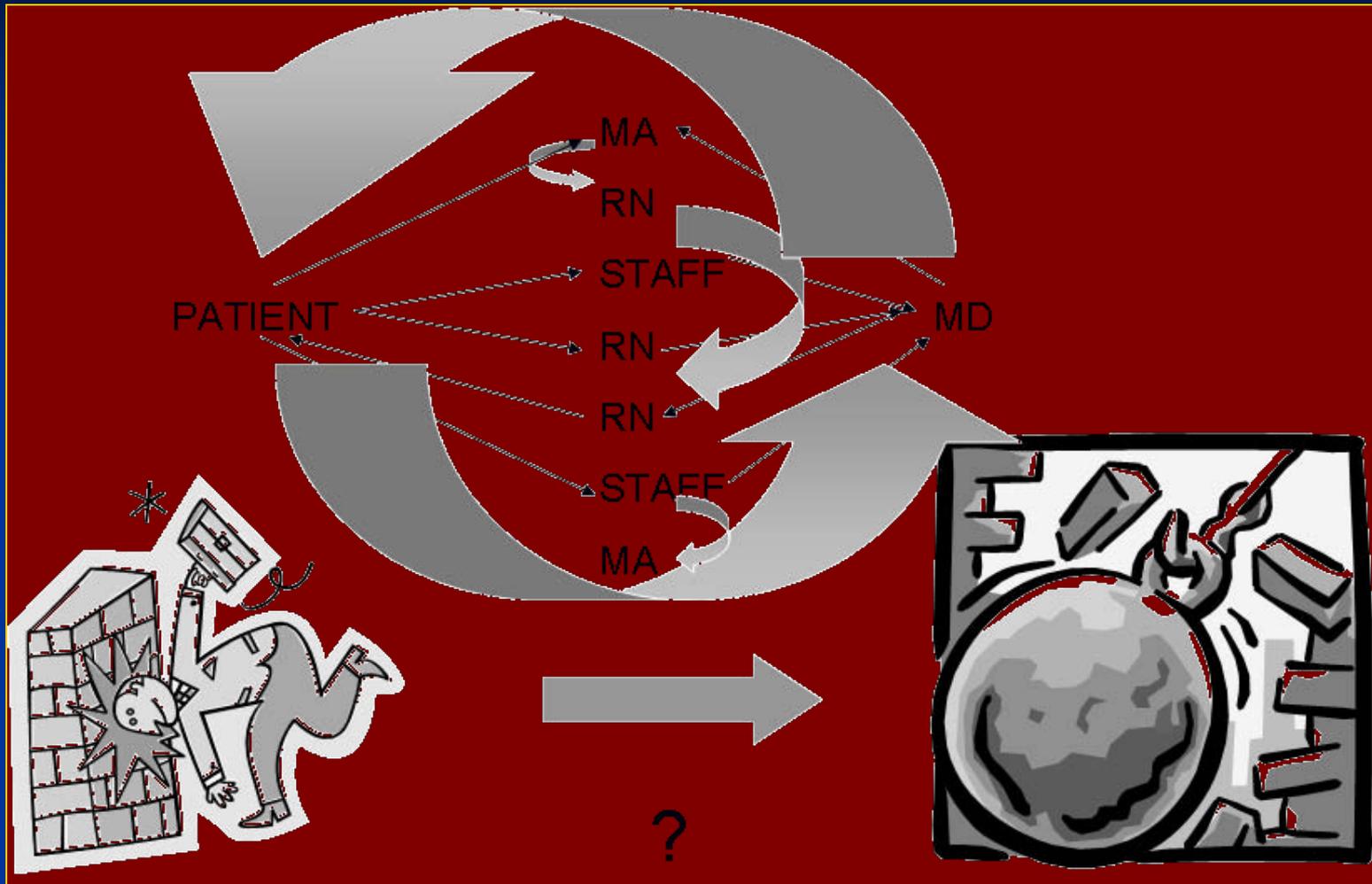
#1: Team Structure and Pt Access

OBSERVE / IDENTIFY ROOT CAUSES

- Triage process can be ambiguous and difficult
 - Pts don't know which RN/MA called and ? to call
 - MDs don't know which RN is handling what
 - RNs unsure what to do because each MD wants something different (hard to anticipate how to help)
 - RNs/MAs have many questions for busy MDs
 - Messages routed in many ways (phone/email/mailbox/in person), making them easy to loose and hard to find/track
 - Created uneven workload among RNs/MAs
 - Part time schedule of MDs/RNs contribute to confusion and re-work



THE "BRICK WALL": Impaired Access



MD/RN Support

■ CHANGES MADE

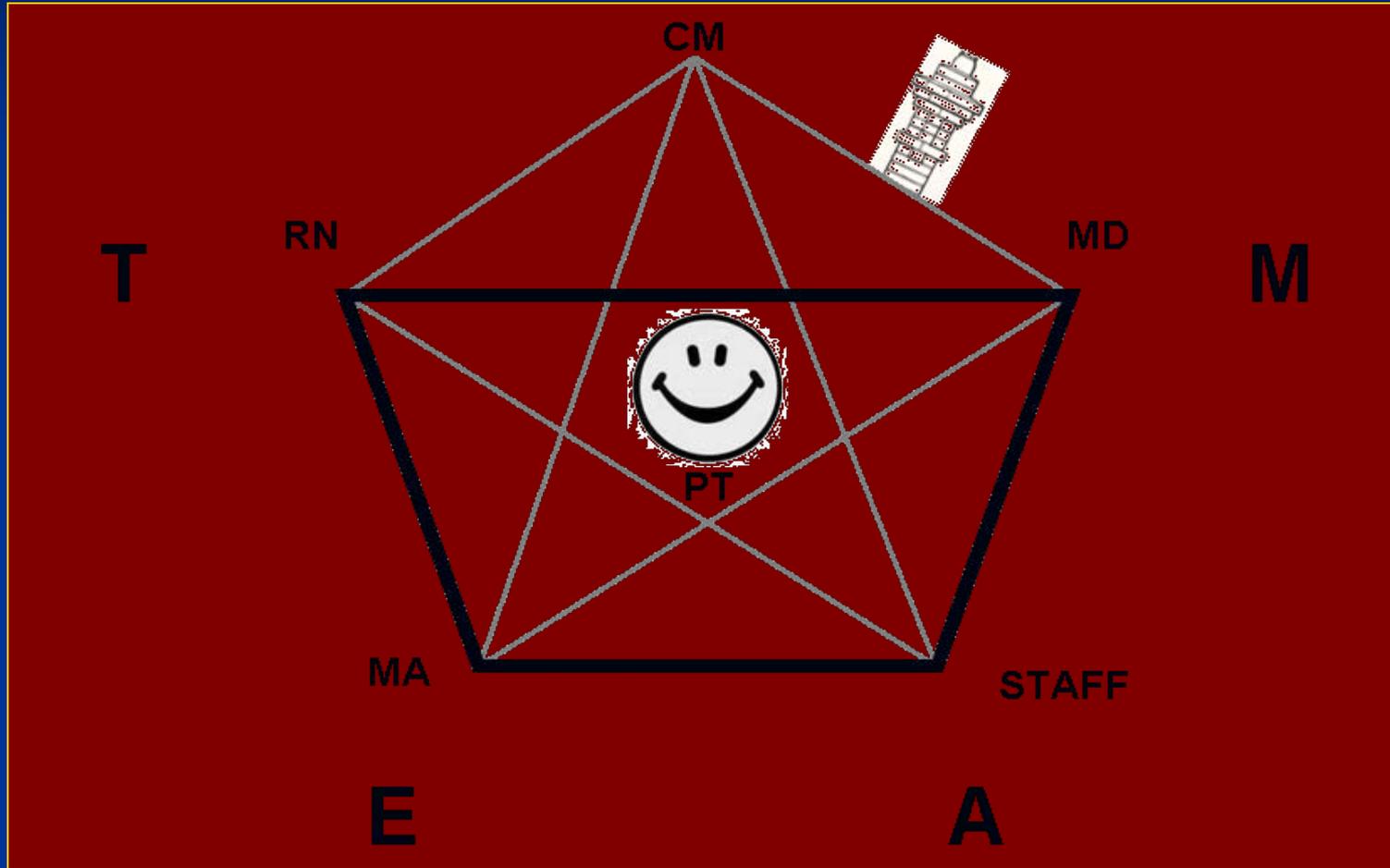
- Created cohesive MD/RN/MA “microteams” (1:1 FTE), moving toward pt coordinator inclusion
- MDs/RNs share office visits – “piggyback”
- NPs: shared patient panels for RHM/chronic disease care
- MDs see patients when they are sick
- Implemented team huddles before clinic
- Specify workflow - less ambiguity and re-work

■ RESULTS

- Streamlined communication for staff
- Patients know who they are talking to!
- MDs, RNs, MAs are better supported by each other
- RNs more satisfied – work evenly distributed, less wasted effort (searching, questions, rework), getting to know pts better and vice versa
- More time for “new” work w/o adding new staff



CLOSER TO HOME? IMPROVED TEAM STRUCTURE



New Team Structure Improves:

- Intra-communication (team)
- Work accountability/ownership
- Inter-communication (pt/team)
- Efficiency
- *Access and service*
- Care
- Satisfaction (pts and team)
- Transforms practice culture



2: UC Access / ED & MWIC Use

OBSERVE / IDENTIFY ROOT CAUSES

- Chart review of IMA patients seen in ED
 - low acuity ED visits, 50% seen between 9a-5p
 - majority did not call PCP or practice first
 - 90% of pts had been seen by PCP in prior 6 months
- Telephone survey of patients: why didn't you call us?
 - “My doctor's not in on Wednesdays.”
 - “I can never get an appointment when I need it.”
 - “I always have to talk to the nurse first.”



UC Access / ED & MWIC Use

- 1-day experiment: offer an appointment instead of nurse triage (“Would you like to be seen?”)
 - 50% of “sick” pts said they wanted to be seen
 - of these, 90% determined medically appropriate by MDs (10% could have waited)
- **What we learned was surprising!**
- Pts who want to be seen will be seen (no matter what!)
ED/MWIC doesn't have to be more convenient than IMA RN triage added little value for most pts who wanted to be seen



UC Access / ED & MWIC Use

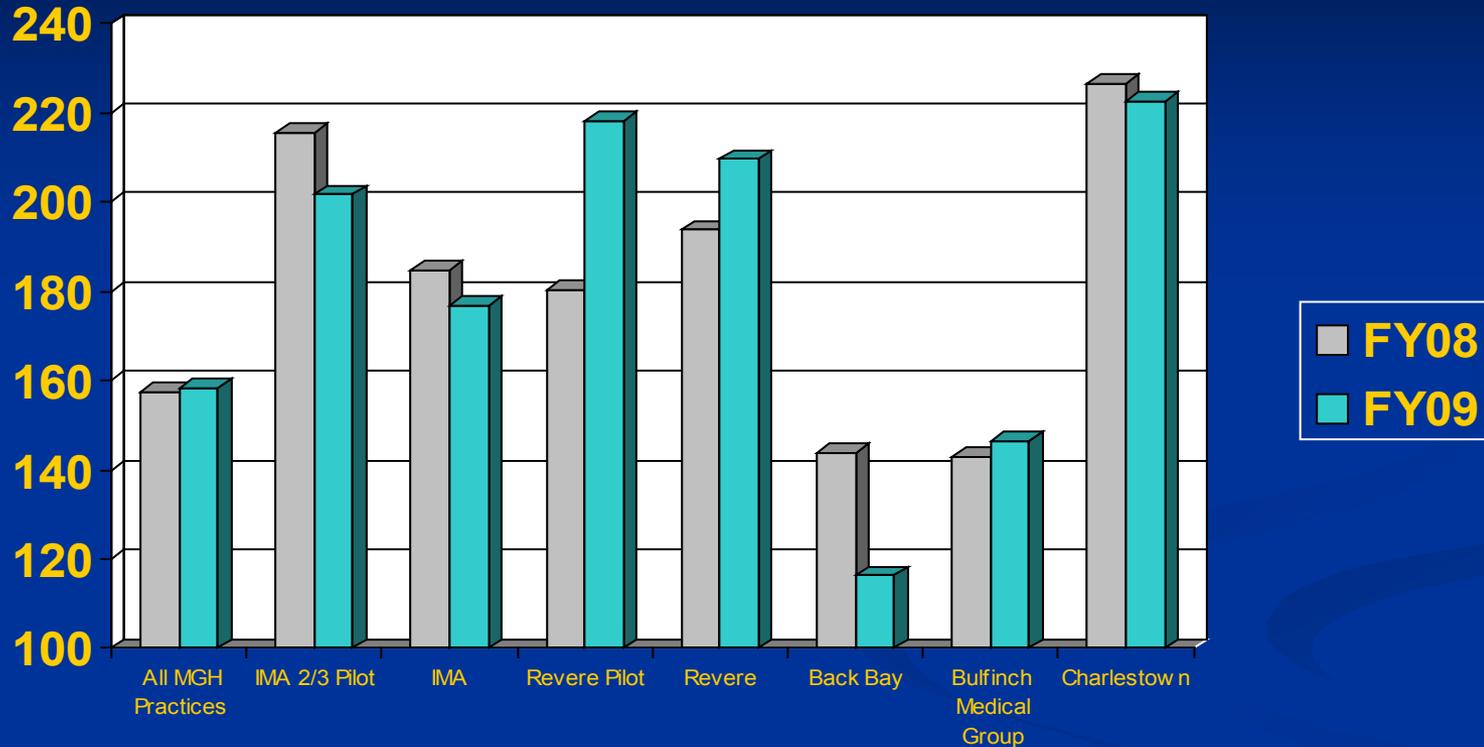
CHANGES MADE

- Held appointments for urgent care in each MD's schedule
- Created back-up urgent care capacity within IMA
- Educated pts (brochure) and staff – ED vs UC use
- Eliminated most RN triage for pts who want to be seen
- Advanced office capabilities – IVF's/IV/IM Abx to help eliminate unnecessary ED use



UC Access / ED & MWIC Use

ED Visits per 1000 Patients

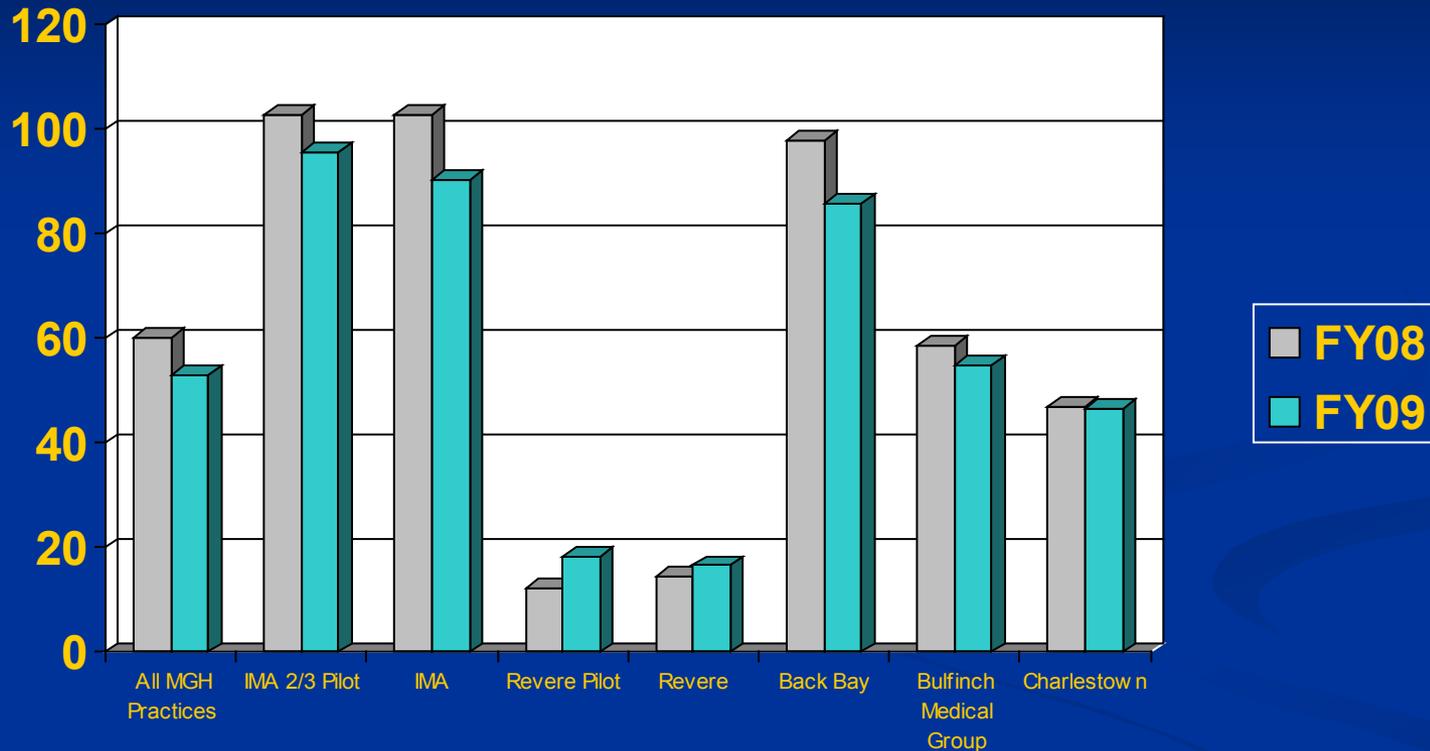


- The average across all MGH practices **increased** slightly – **0.4%** – from FY08 to FY09, with some practices increasing up to **21.1%**.
- The number of ED visits for the IMA 2/3 pilot group **decreased** by **6.5%**.
- The number of ED visits for the IMA as a whole **decreased** by **4.4%**.



UC Access / ED & MWIC Use

MWI Visits per 1000 Patients



- The average across all MGH practices **decreased** by 11.7% from FY08 to FY09.
- The number of MWIC visits for the IMA 2/3 pilot group **decreased** by 7.2%.
- The number of MWIC visits for the IMA as a whole **decreased** by 12.24%.



H1N1 Season: An Access Highlight

Issue:

- Initial Stage of Amb Emerg. Planning; MGH requested expanded PC access to minimize impact on MWIU and ED during H1N1 season.

Intervention:

- RN/MA/staff schedules flexed to have zero budget impact
- 4:00pm to 7pm 1MD/1RN
- MD's sign up for 1 session – payment based on WRVU's
- ILI's and other urgent visits

Results:

- Began 11/16/09 → 1/9/10
- 132 patients seen (avg 5/session but frontloaded use in early part of week)
- Enabled EOD Tx (IVF's, nebs, lab w/u, etc.) to avoid ED visit
- Same day access – immense patient satisfaction
- Expanded model to long holidays (Thanksgiving Fri): 42 pts/3-4MDs
 - Only 1 patient admitted to hospital (97.6% savings in ED visits)



UC Access / ED & MWIC Use

Lessons Learned

- Easier to say YES than NO!
- RN time freed for other tasks
- Fewer wasted same day appointment slots
- Pts pleased with improved access
- Encouraging trends in ED utilization



#3: Coordination of Care – Transitions

OBSERVE / IDENTIFY ROOT CAUSES

- Nat'l Medicare 30 day readmit rate 19% (MGH 16%)
- Up to 3/4^{ths} preventable
- \$18 billion/year
- Inherently vulnerable population
- No standard post-discharge follow up policy
- MGH PC Practice Survey of Post-D/C F/U Policy
- Low # of pts = high level of coordinated outpt care
- Referral and f/u process can be cumbersome
- MDs/RN's/Staff often feel “on their own”
- Care coordination risks being side-lined for more acute responsibilities – becomes “end of day” work



Coordination of Care – Transitions

INTERVENTION: POST-DISCHARGE TFU CALL

- Use IT systems already in place to identify discharges
- RNs call ALL pts < 48hrs after d/c from unit or ED
 - Pt understanding of Dx and Tx
 - Symptom Assessment
 - Medication Reconciliation/Access
 - F/U Appt within 1 week
 - Assist with other appts, labs, tests, procedures
 - Home services/transportation/social services needs assessment
 - Disease and preventive education
- **F/U appts within 1 week, NP as pop-off access
- Increased collaboration with CMS case manager

EXPECTED RESULTS

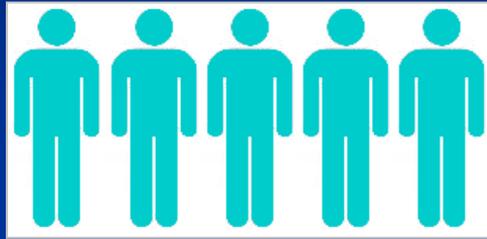
- Enhanced communication, overall improved pt experience (they can't say enough about it!)
- Improved adherence to/less deviation from treatment plans by our patients
- Fewer ED visits and re-admissions
- RN/MD satisfaction – less “catch up” later



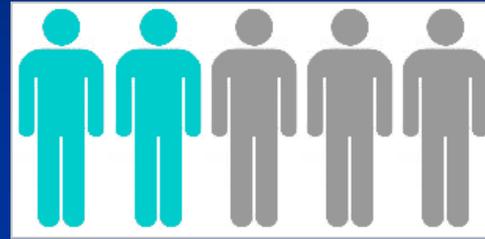
Coordination of Care – Transitions

■ RESULTS

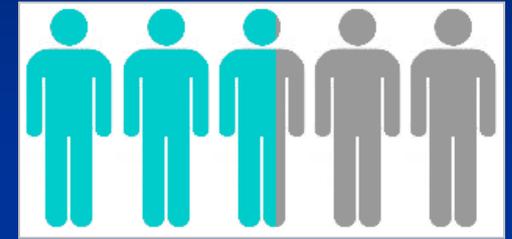
103 discharge summaries were collected JUN-DEC 2009. A random sampling of 20 summaries were looked at for our review.



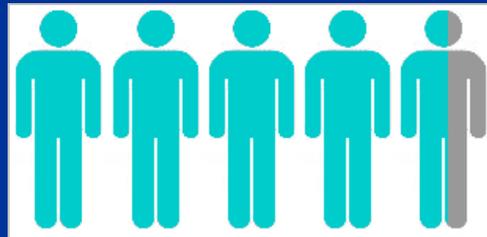
- 100% of the calls made within 48 hours of discharge.



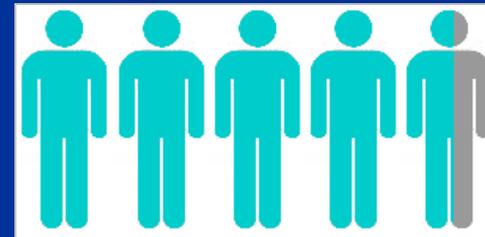
- An intervention was made for 40% of the patients (i.e., med reconciliation, MD involvement, appointments, etc.).



- 55% of patients were scheduled for a follow up appointment.



- 91% of patients scheduled seen within 1 week



- 91% of patients scheduled kept their f/u appointment.

CG CAHPS Survey Data

- IMA Pilot vs IMA
- Compare with benchmarks

Primary Care Pilot Care Team Clinician/Group CAHPS Patient Experience Top-Box Percentages*

Measure	IMA Pilot						Total IMA						Benchmarks		
	Q109		Q209		Q309		Q109		Q209		Q309		MGH PC Target**	MGH PC Avg***	Nati'l 90th %ile****
	N*	%	N	%	N*	%	N*	%	N	%	N*	%	%	%	%
Got Urgent Care Appt.	48	68.8%	44	72.7%	46	82.6%	383	69.2%	402	67.9%	313	73.8%	71.0%	66.2%	74.4%
Got Routine Care Appt.	80	73.8%	89	76.4%	74	78.4%	736	70.2%	767	72.8%	583	75.8%	72.4%	67.5%	66.3%
Got Ans. Reg. Hrs.	47	55.3%	47	61.7%	49	71.4%	426	61.5%	448	58.7%	356	64.9%	66.2%	62.8%	60.9%
Wait Time 15 Min. Screener	92	43.5%	103	51.5%	82	53.7%	849	41.7%	917	43.7%	685	46.0%	45.6%	40.1%	52.6%
Informed of Wait Time	19	36.8%	22	22.7%	19	47.4%	278	37.8%	270	43.3%	190	35.8%	35.9%	29.7%	N/A
Dr Follow Up w/Results	84	81.0%	95	81.1%	80	78.8%	786	73.8%	846	74.8%	640	75.0%	77.2%	74.1%	76.6%
Helpful Staff	88	69.3%	102	55.9%	82	68.3%	818	67.5%	872	66.9%	661	68.7%	66.7%	59.9%	59.6%
Staff Courteous	89	79.8%	101	83.2%	82	85.4%	824	82.4%	883	84.5%	665	83.0%	82.1%	76.1%	77.7%
Rating of Doctor	82	80.5%	96	87.5%	79	86.1%	803	88.7%	840	89.8%	631	86.4%	87.9%	81.6%	61.4%

*Results presented are top-box percentages-percentage responses in the most positive response option category

**MGH PC Target reflects MGH PC Avg (Q1Q209) + 5 percentage points, if MGH PC avg. < 90.0%. MGH PC Target reflects MGH PC Avg.(Q1Q209)+1 percentage point, if MGH PC Avg ≥ 90.0%

***MGH PC Avg reflects most recent quarter

****National comparison data source: Pilot data from national entities collecting C/G-CAHPS data on a voluntary basis from 2005 to 2008.

● Teal shading: performance > MGH PC Target



Quality outcome measures beginning to validate interventions



Where are we heading re: Access?

- Unloading RHM tasks from MDs → improved time w/ pts
 - (Pre-visit identification and teeing up of vaccinations, mammogram, colonoscopy, routine referrals)
- Integration of iHealthSpace (portal) and online referral systems
- Improve further team alignment (pt coordinators)
- Chronic disease management programs
- Expand pod management → more effective microteams
 - Staff capabilities – education (RN triaging, TFU evals/ RN/MA skills refresh)
 - Build leadership from ground up – seeing non MD positions stepping up



Key Learnings

- Step back.....observe.....experiment
- Think Globally, Act Locally
- Team Structure Drives Function/Efficiency
- Opportunity to re-focus on patients
- Proactive / pre-emptive care vs. reactive care
- CAHPS data as evaluation tool

