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: 4 MDs, 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 \textit{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
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%.
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 3/4ths 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.
### Primary Care Pilot Care Team Clinician/Group CAHPS Patient Experience Top-Box Percentages*

<table>
<thead>
<tr>
<th>Measure</th>
<th>IMA Pilot</th>
<th>Total IMA</th>
<th>Benchmarks</th>
<th>MGH PC Target**</th>
<th>MGH PC Avg***</th>
<th>Nati'l 90th %ile****</th>
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<tbody>
<tr>
<td>Got Urgent Care Appt.</td>
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<tr>
<td>N* %</td>
<td>48 68.8%</td>
<td>383 69.2%</td>
<td>313 73.8%</td>
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<tr>
<td>Got Routine Care Appt.</td>
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<tr>
<td>N* %</td>
<td>80 73.8%</td>
<td>736 70.2%</td>
<td>583 75.8%</td>
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<td>Got Ans. Reg. Hrs.</td>
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<tr>
<td>N* %</td>
<td>47 55.3%</td>
<td>426 61.5%</td>
<td>356 64.9%</td>
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<td>Wait Time 15 Min. Screener</td>
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<tr>
<td>N* %</td>
<td>92 43.5%</td>
<td>849 41.7%</td>
<td>685 46.0%</td>
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<tr>
<td>Informed of Wait Time</td>
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<tr>
<td>N* %</td>
<td>19 36.8%</td>
<td>278 37.8%</td>
<td>190 35.8%</td>
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<td>Dr Follow Up w/Results</td>
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<tr>
<td>N* %</td>
<td>84 81.0%</td>
<td>786 73.8%</td>
<td>640 75.0%</td>
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<tr>
<td>Helpful Staff</td>
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<tr>
<td>N* %</td>
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<td>818 67.5%</td>
<td>661 68.7%</td>
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<tr>
<td>Staff Courteous</td>
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<tr>
<td>N* %</td>
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<td>824 82.4%</td>
<td>665 83.0%</td>
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<td>Rating of Doctor</td>
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<tr>
<td>N* %</td>
<td>82 80.5%</td>
<td>803 88.7%</td>
<td>631 86.4%</td>
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*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 PCAvg ≥ 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
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