Safety Net Medical Home Initiative:
Transforming Practices into Medical Homes

Patient-Centered Interactions
Webinar Series

Patient-centeredness should be:
• Interpersonal – patients and family members must feel like respected partners in care
• Organizational – the practice has a structure set of processes and systems in place to facilitate great patient interactions
• Cultural – physicians, staff, patients and caregivers understand that the patient is the real expert on their health and wellness; thus, patients have an expanded role in decision-making and are encouraged and supported to manage their own illness through assistance in problem-solving and decision-making

Change Concept: Patient-Centered Interactions:
• Respect patient and family values and expressed needs.
• Encourage patients to expand their role in decision-making, health-related behaviors, and self-management.
• Communicate with their patients in a culturally appropriate manner, in a language and at a level that the patient understands.
• Provide self-management support at every visit through goal setting and action planning.

The “big ASK”: routinely asking patients about their experience of care to guide teams in the improvement and redesign aspects of achieving patient-centered medical home-ness

Methods to capture our patients’ experiences
• Regularly host focus groups
• Have patient representatives on the improvement team
• Informally ask patients about their ideas
• Routinely conduct patient surveys and review the results immediately
Eliciting Patient Experiences in Diverse Populations

Leo S. Morales, MD, PhD

Group Health Research Institute
Agenda

Selecting an instrument
Translation
Health literacy and survey readability
Mode of administration
Sampling
Response rates
Measurement bias
Focus Groups*
Terminology

Instrument = survey

Items = survey questions

Domain = composite = construct

Psychometrics = quantitative measures of survey performance
Choosing an Instrument: Two Common Situations

Develop a new instrument

• Identify concepts

• Write items

Use existing instrument (off-the-self)

• If measure can be modified/adapted

• If measure cannot be modified
Common Reasons for Developing a New Instrument

New instrument needed

• No existing instrument

• Variant construct

Existing instruments are not acceptable

• Poor psychometric properties

• Unacceptable in target populations
I. Identify Concepts & Develop Conceptual Framework
• Identify concepts and domains.
• Identify intended population and research application
• Hypothesize expected relationships among concepts

II. Create Instrument
• Generate items
• Choose administrative method
• Select recall period
• Choose response options
• Draft instructions
• Identify scoring procedures
• Format instrument
• Evaluate patient understanding
• Pilot test draft instrument
• Refine instrument & procedures

III. Assess Measurement Properties
• Evaluate reliability, validity, and ability to detect change
• Evaluate administrative and respondent burden
• Add, delete, or revise items.
• Identify meaningful differences in scores.
• Finalize instrument formats, scoring, procedures, & training manuals

IV. Modify Instrument
• Change concepts measured
• Change research application
• Change mode of administration
• Adapt for culture or language
• Other modifications
So normative comparisons can be made (benchmarking)

To replicate or maintain continuity with previous studies

Existing measure is state-of-the-art

The time and expense of developing new measure is prohibitive
Examples of Existing Patient Surveys

CAHPS (consumer assessments of health plans survey)
- http://www.cahps.ahrq.gov

PCAT (primary care assessment tool)

ACES (ambulatory care experience survey)

IPC (interpersonal processes of care):
- Stewart et al., Health Serv Res. 2007 June; 42(3 Pt 1): 1235–1256.
Satisfaction

• How satisfied were you with your care? Very Satisfied, Somewhat Satisfied, Not Satisfied

Experience

• How often did your doctor listen carefully? Never, Sometimes, Usually, Always

Ratings

• How would you rate your care? Excellent, Fair, Poor

• How would you rate your care where 0 is worst possible care and 10 is best possible care?
Structure of Patient Surveys

Global Rating

Item 1
Item 2
Item 3

Item 1
Item 2
Item 3
CAHPS Domains

Core Domains

- Getting appointments and health care when needed (5 items)
- How well doctors communicate (6 items)
- Courteous and helpful office staff (2 items)
- Overall ratings (1 item)

Supplemental Domains

- Cultural competence (in development)
- Health literacy (30 items)
COMMUNICATION
- General clarity (5 items)
- Elicitation of and responsiveness to patient problems, concerns, and expectations (11 items)
- Explanations of condition and progress (6 items)
- Explanations of processes of care (7 items)
- Explanations of self-care (6 items)

DECISION MAKING
- Responsiveness to patient preferences (4 items)
- Consideration of patients' ability to comply with treatment (4 items)

INTERPERSONAL STYLE
- Friendliness, courteousness (4 items)
- Respectfulness (4 items)
- Discrimination (8 items)
- Cultural sensitivity (6 items)
- Emotional support, reassurance (8 items)
- Empowerment (6 items)
- Friendliness, courteousness of office staff (2 items)
- Respectfulness of office staff (4 items)
Selecting Domains: Universal versus Specific Domains

Universal (etic) domains

• Culturally neutral
• Comparative studies

Group-specific (emic) domains

• Culturally specific
• In-depth studies
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Translation

Before using an existing translation

• Find history of translation

• Find purpose of translation

• Test translation in target population using cognitive interviews

If you need to translate

• Find an experienced professional translator

• Follow a translation protocol

• Multiple independent translations

• Test translations in the target group using cognitive interviews

• Good translations are expensive and time consuming to obtain

Translation Methods: http://www.cahps.ahrq.gov/content/resources/CrossCultural/RES_CC_GuidelinesForTranslating.asp?p=103&s=34

Translator Qualifications

- Highest educational degree obtained in the target language
- At least five years living in the U.S. as an adult
- Familiarity with the U.S. health system
- Professional/technical degree in a health-related discipline or experience in the health field
- Professional work experience in the country of the target language
- Prior professional experience as a translator in any substantive area, preferably health-related
- Familiarity with regional variations in usage of the target language in the U.S.
- Certified as a professional translator
General Literacy, United States, 2003

National Assessment of Adult Literacy, 2003
Disparities in General Literacy
United States, 2003

Document Literacy

National Assessment of Adult Literacy, 2003
Disparities in Health Literacy
United States, 2003

National Assessment of Adult Literacy, 2003
Common approaches to assessing readability:

- Comprehension tests
- Cognitive interviews and focus groups
- Expert review
- Readability analysis

No standard approach for assessing survey readability

Few applications for non-English languages
Goal: To predict the reading level required to comprehend a passage.

Reading Level = a + b (word measure) + c (sentence measure).

Parameters a, b, and c from regression of the word and sentence measures on a criterion passage.

Available in MS WORD (tools -> options -> spelling and grammar -> readability statistics)

Readability toolkit:
http://www.grouphealthresearch.org/capabilities/readability/readability_home.html
Limitations of Readability Formulas

Language (jargon)

Formatting (font size and layout)

Knowledge (health system familiarity)

Experiences and judgment
Mean 6.4
Median 4.8

Modes of Administration

Personal (face-to-face)

Phone

Mail

Internet

Mixed modes

• mail followed by phone

• Internet followed by phone
## Comparison of Data Collection Modes

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<td>High</td>
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<td>Moderate</td>
<td>Low</td>
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<td>Length of Questionnaire</td>
<td>Short</td>
<td>Moderate</td>
<td>Long</td>
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<td>Sensitive questions</td>
<td>Best</td>
<td>Moderate</td>
<td>Poor</td>
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<td>Lengthy answer choices</td>
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<td>Moderate</td>
<td>Best</td>
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<td>Open-ended responses</td>
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<td>Best</td>
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<td>Complexity of Questionnaire</td>
<td>Poor</td>
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<tr>
<td>Possibility of interviewer bias</td>
<td>None</td>
<td>Moderate</td>
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Internet Surveys

**Advantages**

- Low cost
- Ease of survey programming
- Ease of data entry
- Large sample sizes

**Disadvantages**

- Computer ownership
- Internet access
- Computer literacy
Digital Divide among Whites, Blacks and Hispanics (2006)
Sampling

**Probability samples**

- Representative
- Results generalize
- More difficult and costly to collect
- Might exclude small groups (<5% of population)
- Example: randomly select patients from comprehensive list

**Non-probability samples**

- Easier to collect but not representative
- Results may not generalize
- Examples: patients from a waiting room; people exiting a hospital; 20 people from a list; a focus group
Response Rates

High response rate (>60%) ensure representativeness

Low response rates (<40%) do not ensure representativeness

Getting to 60% or more

- Updated contact information
- Provide modest incentives ($2 to $10) or entry into a lottery
- Mail multiple languages upfront
- Dealing with mistrust
  - Advance letter from trusted source
  - Ensure confidentiality
- Work the sample (multiple attempts over time)
- Keep the survey brief
Self-Reported Vision by Racial/Ethnic Group Among Persons
Visual Acuity of 20/25 or Better
Conceptual equivalence **of constructs and items** is achieved when the constructs exist, are relevant and are acceptable in all cultures.

Semantic equivalence **is obtained** when the words used to express the items mean the same thing **to people from different groups** in both the source and target languages.

Operational equivalence **is achieved** when standardized methods of survey administration are **appropriate** in both the source and target culture.

Psychometric equivalence **is achieved** when comparable psychometric properties are observed in the **source and target measures**.

Item equivalence **is observed** when a) items are not differentially more difficult (e.g. biased) in the target culture than in the original, b) item weights reflect comparative importance of items in all groups and c) the meaning of and distance between response choices is similar across cultures.

Criterion equivalence **is obtained** when the interpretation of scores is the same across groups, and when compared with norms for each group.
High Plains Medical Home

Home on the Range
Looking Back

• Patient Satisfaction Surveys since 1995

• Consistently Very Good

• Paid Less and Less Attention to Them
Medical Home Journey

• Patient Visit Redesign started in 2002 instituted many of the principles
• Our Team struggled a bit with where to start
• Decided to start with an assessment of our patient satisfaction survey – what better way to get a read as to whether we are patient focused or not
Out with the Old

• Old Satisfaction Survey did not capture all we needed to know
• Explored what others using
• Centered on the Consumer Assessment of Healthcare Providers and Systems (CAPHS) survey instrument to work from
  • Assess patient-centered care
  • Compare and report on services
  • Improve quality of care
• Began the process of adapting it to High Plains
Making It Fit

• Reviewed the core questions
  – Made minor changes in wording

• Reviewed supplemental questions
  – Identified supplemental questions most appropriate for our clinic

• PDSA to determine method for administration
  – Mail, Telephone, Lobby
Making It Fit

• Mail:
  – Gave survey to pt with stamped envelope to return.
  – 20 distributed with 8 returned in 2 weeks
• Telephone:
  – 20 calls made in 2 hours with 7 contacts
• Lobby:
  – 20 surveys completed in ½ day
Attention to Details

• Staff Buy-In:
  – All staff training
  – Reviewed purpose
  – Addressed concerns/questions

• Road-Blocks:
  – Time
  – Big Job
  – Consistency
  – Staff Buy-In

• Positives:
  – Giving our patients a voice
  – Helps identify next steps
  – Provides feedback to clinic staff and providers
Next Steps

• Analyze Data
• Identify our strengths and weaknesses
• Present and discuss results with ALL staff
• Use the CAHPS results as a starting point:
  – May need to use other surveys, focus groups, assessment tools to identify specific problems, their underlying causes, and actions for improvement.
• Develop Goals and Action Plans for improvement
Using a Patient/Client Centered Approach to Improved Health Outcomes

REAL Life Self-Management

Community Health Partners, Inc.
Laurie Francis, CEO
francisl@chphealth.org
Community Health Partners, Inc

- Three medical sites, two dental, and full literacy, adult ed., early childhood education and GED.
- Unwavering commitment to outstanding services – right people on the bus, expect great things, tools and training, feedback, data and visual management everywhere, measure leverage areas!
- Supervisory learning – self-analysis, education, feedback, facilitative Leadership training, examining data.............what does it mean?
- Can’t seem to truly improve health until we recognize and remember who the EXPERTS are!!

Every Single Staff Member, Every Single Patient, Every Single Time
The Mission

To Enhance Community Health and Wellbeing

- Innovative programming
- Strong partnerships
- Improved Outcomes

VISION
100% Access, 0% Disparity
Creating Excellence through Full Alignment

VISION
100% Access, 0% Disparity

MISSION
Enhance Community Health and Well-being

BALANCED SCORECARD
PILLARS of Excellence

Root Causes
Measures
Access
Engagement
Resources

TEAM GOALS/ACTIVITIES
PDSAs to improve PROCESS
Traditional Conceptual Frameworks

Patient Ill

EXPERT Diagnosis

EXPERT - tells Pt. What to do

Health Improves?

Enlightened Traditional

Patient Ill

EXPERT Diagnosis

EXPERT – Offers pt. Info. at Appropriate Literacy level
White space
Teach back

Health Improves?
Conceptual Framework for Improved outcomes in All Populations -

EXCELLENT CARE – Every Patient, EVERY time
- Timely access to provider team
- Clear Communication
- Motivational Interviewing
- Patient Priorities
- Data/evidence available to clinician and patient –
  Individual and panel management
  - Follow up
  - Constant patient-centered system improvement

Activated Provider/Support TEAM

Self-Management (Patient – Centered, Provider Supported)

Activated Patient/Client

Improved Health Outcomes

Impact of SOCIETY
- Poverty
- Education
- Social equity
Activation – who and how?

- **Provider** – patient team (teacher – learner)
  - **Motivational Interviewing** training – education and ongoing reinforcement
  - **Pod** meetings – system improvement, communication, clear roles
  - **STANDING ORDERS** – empowering staff to act
  - **Tools** to support dialogue around patient/client goals, priorities
  - Good patient/client information pertinent to priorities (pt.’s, clients)
How to get the most out of your visit at CHP

- Ask for written materials
- Rate your understanding, confidence and commitment
- Bring a friend or family member to your appointments
- Reflect back what you heard your provider say
- Take notes while your provider talks
- Bring your medications in and go over them together
Newest Vital Signs CHP Patients' Test Scores

4 - 6 correct answers 46%
2 - 3 correct answers 32%
0 - 1 correct answers 22%
WE Care about YOU and Your PRIORITIES. WE are a TEAM!

What are your HEALTH GOALS in the future?

What do we know about staying healthy...

Combining your concerns and our expertise...

What are your plans?
Clinical Support Systems

- Use of EMR/Software/Staff to support care
  - Data collection
  - Using reminders
  - Whole team involved – front desk/back desk
  - Data in Balanced Score Card – org. goals

- Clinical Score Card – to improve practices

- Panel management and open access to care
Self Management Cue Sheet

- Tobacco
- Medication
- Exercise
### Smoking Cessation

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<th>May-08</th>
<th>Jun-08</th>
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<td>61%</td>
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<td>74%</td>
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<td>Avg.</td>
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<td>85%</td>
<td>78%</td>
<td>59%</td>
<td>70%</td>
<td>66%</td>
<td>76%</td>
<td>82%</td>
<td>89%</td>
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#### % of clients who had smoking addressed at their visit

- **Percentage**
  - 0% to 100%

- **Graph Legend**
  - CHP
  - GCC
  - Avg.
  - CHP-B

- **Smoking Cessation**
  - % of current smokers with whom cessation was advised in past month
  - Quarterly target: 50%
  - Optimal target: 100%
**Self Management Goals Set**

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<td>32%</td>
<td>42%</td>
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**Goal Setting**

*Patient Generated*

- Form completed and copy given to patient – % last month
- Quarterly target: 40%
- Optimal target: 75%

**Collaborative Goal Setting - Quality Allies**

- 90.0000
Take Home Messages

- Organizational Culture
  - Imbed everywhere

- Provider/Support Staff Education
  - Clear Communication – Listening as much as talking...
  - Health Literacy
  - Motivational Interviewing
  - Self-management – Patient Priorities

- Tools to Support Behavior Change
  - Self-management prompts
  - Room design/materials
  - Note paper in each room
  - Bulletin board in waiting area

- Tracking Health Outcomes
  - And Process – Patients feeling heard, priorities addressed, accomplishing goals?
  - Movement on Collaborative Goals?
CareSouth Carolina – Who Are We?

• Private, non-profit community health center with services that began in 1980. Began with one office, one doc, 4 staff members….. and me!

• Ten offices located in eight federally designated Medically Underserved Communities (MUAs) in rural South Carolina

• System of Care involving hospitals, nursing homes, private providers, numerous health and social agencies, schools, medical student training for USC; and many others

• 30 providers, 40,000+ patients, 290+ staff

• JCAHO accredited since 1999

• Integrated behavioral health system

• On a journey of quality improvement since 1999
Self-management Support Steps to Build Skills and Confidence

Basic Skills
- Goal Setting
- Action Planning
- Problem Solving

Advanced Skills & Techniques
- Motivational Interviewing
- Uncomplicated Depression
- Group Interactions
- Training others in Basics

Expert Skills & Techniques
- Necessary for special populations (Addictions, MH)
  - Ex: Cognitive Behavioral Therapy
  - Dialectical Behavioral Therapy

Adequate for majority of population

Source: Connie Davis. RNP
The CareSouth Carolina Elements of SMS in the Stepped Model

- Care Teams with roles and responsibilities for SMS throughout the team
- Care Managers for higher levels of need
- Standardization of group and individual learning needs
- Patient focus groups for re-design
CareSouth Carolina, Inc.
Patient Information - Chesterfield Site

goal = 90.00
CareSouth Carolina, Inc.
Patient - Confident Managing - Chesterfield Site

goal = 90.00

Month

%
Reliability Data for SMG Set

- Jan
- March
- May

% SMG Set
Does SMS Make a Difference?

- Depression: 64% of 1,410 patients in depression registry have a 50% reduction in severity

- Diabetic Control: 50% of 3,500 patients with diabetes are in control (HbA1c < 7.0)

- BP Control: 55% of 8,300 patients with diabetes and HTN have blood pressure in control

- Moving to 0% Disparity in chronic conditions that have as great as 300% disparity on our area.

- Patient Confidence: 84.6% of patients are very confident they can manage their health

- Continuity with Provider: 83.7% of all visits are with provider of patient’s choice