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Becoming Patient-Centered: Approaches and Challenges

Sally K. Holmes, MBA; Irene E. Cramer, PhD; Martin P. Charns, DBA

One of the specific recommendations of the 2001 Institute of Medicine (IOM) Report, *Crossing the Quality Chasm*, is that health care should be safe, effective, patient-centered, timely, efficient, and equitable – dimensions known as the "Six Aims." The report defines patient-centered care as bringing together "compassion, empathy and responsiveness to the needs, values and expressed preferences of individual patients." [*Crossing the Quality Chasm*, p. 49]

HSR&D's Management Decision and Research Center (MDRC), together with Boston University's Schools of Public Health and Management is currently studying approaches used by a variety of healthcare organizations to be more patient-centered. This is part of an evaluation of *Pursuing Perfection: Raising the Bar for Health Care Performance*, a three-year, $20.9 million initiative of the Robert Wood Johnson Foundation. As implied, *Pursuing Perfection* grants are intended to help physician organizations and hospitals dramatically improve patient outcomes by pursuing perfection in all of their major processes.

Through interviews with healthcare executives, quality improvement experts, physicians, nurses, and frontline staff at twelve sites, MDRC has learned about approaches to becoming more patient-centered. While it is still too early to draw conclusions about factors that ultimately will define success, preliminary research shows a range of models being used to become patient-centered as well as significant challenges to attaining the levels envisioned by the IOM.

Approaches to Becoming Patient-Centered

Many of the organizations studied are explicitly committed to being patient-centered, but translate that commitment differently. At one end of the spectrum are organizations that believe they are being patient-centered by providing excellent care, with excellence defined primarily by clinical staff. At the other extreme are organizations redefining how care is delivered by giving patients and families a powerful voice in quality improvement activities. These organizations solicit patient input and feedback, invite them to be members of process improvement teams, and actively seek ways to involve families in treatment decisions and ongoing care. Activities observed in this latter group include:

- A children's hospital is redesigning how patient care is delivered, addressing tradeoffs between clinical control and family engagement. Their cystic fibrosis and juvenile rheumatoid arthritis programs are structured around patient and family involvement. Family members not only provide suggestions but also participate in rounds and pre-clinic assessments. Patients actively manage their own scheduling so that medical treatments can be woven around other activities.
- Two organizations have created entire new structures that reflect how patients experience medical care. In one, the organizational focus is designed around four key functions that reflect patient-centered care: access, assessment, treatment, and maintenance. Permanent process management teams are in place for each function with Vice President and physician champions on each team. The second organization reorganized their clinics around "prepared practice teams" that use the planned care model to give patients more care options (such as communicating with physicians by e-mail), to provide access according to patients' wishes, and to coordinate care across the silos traditionally found in medical care.
- Several organizations are implementing planned care programs to better serve patients with chronic illness. One approach uses advanced practice nurses to coordinate between patients and multiple care providers. Some organizations are experimenting with group visits to improve communication and teach patients self-management skills. Tools to enhance planned care include a document (i.e., single medication list or a shared care plan) that the patient carries that summarizes their conditions and treatments, making it easy for all of the patient's providers to have accurate information.

Organizations use a variety of tactics to solicit input from patients, including surveys, focus

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groups, and advisory groups. Some organizations use the Internet to exchange ideas with patients and families.

Challenges to Becoming Patient-Centered

Trying to be wholly patient-centered has been challenging for many organizations, since healthcare has been traditionally organized around a scientific model that emphasizes clinical expertise over patient and family preferences. Challenges include:

- Sometimes the treatments patients want and evidence-based care are not the same. For example, patients sometimes demand antibiotics when use is not indicated. Alternatively, some patients refuse treatments based on religious or cultural beliefs.
- Entrenched cultures are difficult to change for both clinicians and patients. Clinical staff often would prefer that patient involvement be indirect or contained. Patients sometimes are accustomed to having physicians make decisions for them and are not prepared to be more active participants.
- Having a dialogue with patients that makes care more transparent may engender fear about criticism, potential litigation, or about simply not being able to meet expectations. Nurses have disclosed that they are sometimes reluctant to solicit patients' needs because they may not be able to meet them. Administrators and senior organization leaders have discussed not knowing how to approach and talk to patients. Clinicians are particularly fearful about transparency and patient involvement when it comes to medication safety issues.
- Recent privacy legislation (e.g. HIPAA) has complicated creating patient access to their own records (electronic or paper) and other medical information that might help them become more active in their own care.
- Actively involving patients accelerates pressures for organizations to change.

Measurement can help bridge aspirations to becoming patient-centered and impediments to getting there. Most organizations in the study use patient feedback, particularly patient satisfaction measurement, to assess how well they are meeting patients' expectations and to identify ways to improve care. Patient surveys are being overhauled to be more patient-friendly, relevant, and useful. In addition, organizations are learning how to analyze and present data so that staff at all levels can use the data to plan and learn.

Next Steps

While being patient-centered is a goal expressed by many of the organizations studied, building a culture of patient-centeredness requires major changes, including learning how to talk and listen to patients, adopting new ways of providing care, and overcoming fears or learned behaviors. The organizations are finding the work to be difficult and time-consuming, but ultimately rewarding. Many of these organizations believe that all of the Six Aims can be most effectively achieved by being fully patient-centered. In fact, one of the study organizations reported that patient-centeredness is the "lens" through which to view the remainder of the Aims.

Within the next several years, the evaluation team will administer a survey to measure the extent to which organizations are accomplishing Pursuing Perfection objectives such as becoming more patient-centered. In addition, the team will assess the extent to which the approaches result in care that is better – both clinically and from the perspective of patients and families.

Transition Watch is a quarterly publication of the Office of Research and Development's Health Services Research and Development Service. Its goal is to provide timely, accessible health care change information and resources to aid VHA managers in their planning and decision making. Summaries and analysis of ongoing survey and management studies within VHA will be included, as well as organizational change resources from within and outside VA. For more information or to provide us with your questions or suggestions, please contact:

Geraldine Mcglynn, Editor
Information Dissemination Program
Management Decision And Research Center (152-M)
VA Boston Healthcare System
150 South Huntington Avenue, Boston, Ma 02130-4893
Phone: (617) 278-4433
Fax: (617) 278-4438 Email: geraldine.mcglynn@med.va.gov

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The Importance of Organizational, Provider, and Patient Factors in Guideline Implementation

Bradley N. Doebbeling, MD, MSc

Successful application of new research findings to clinical practice requires effective implementation strategies. However, determining which strategies are most effective in clinical practice is challenging. Adherence to clinical practice guidelines (CPGs) is nested within facilities both structurally and as a set of processes, and is influenced by the implementation process, and by rewards and sanctions at the organizational level. Despite the growing number of available guidelines, there has been little systematic investigation concerning effective mechanisms for implementation into practice.

Our cross-cutting QUERI project is exploring the factors that affect adherence with CPGs at VA facilities nationwide. We are examining the relationship between facilities' organizational characteristics, implementation structures, and processes as potential determinants of effective guideline implementation. Further, we are investigating how these factors operate across several guidelines to explore how guideline characteristics affect implementation and adherence.

Development and Validation of Benchmarking Methodology

Our initial methodological work involved the development and validation of alternate benchmarking methods to identify hospitals with consistently high or consistently low adherence across multiple performance measures.[1] Delivery of recommended evidence-based clinical preventive services was assessed in a stratified national sample of approximately 40,000 ambulatory care patients seen at VAMCs in the 1998 Veterans Health Survey. We calculated the proportions of patients appropriately receiving each service within the recommended time interval and assigned percentile ranks for each service for each of the 138 acute care VAMCs. We compared two approaches for benchmarking performance. We found that VA facilities had considerable variation in their levels of delivery of these preventive services across multiple measures and can be distinguished on the basis of their consistently high or low levels of adherence. Thus, examining service delivery across multiple performance indicators can identify opportunities to improve clinical guideline implementation and the delivery of care.

Evaluation of the Importance of Organizational Factors in Performance

In a series of analyses, we have examined the importance of organizational and patient population characteristics on adherence to performance measures. Organizational characteristics likely to affect adherence with the CPGs were classified into five conceptual domains (clinical emphasis, operational capacity, patient population, professionalism, and urbanicity).[2] Specific organizational factors, including mission, capacity, professionalism, and patient population characteristics appear to influence guideline adherence in this large multi-institutional sample involving multiple provider practices. These factors will be important variables to consider as predictors of adherence in future studies.

Multisite Qualitative Investigation of Barriers and Facilitators to Guideline Implementation

We selected VAMCs nationally across a range of geographic, bed-size, teaching affiliation, performance level, and patient age, gender, and ethnic distributions for further investigation. Fifty focus groups of physicians, administrators, and other clinician groups were conducted in 19 VAMCs to identify important organizational barriers and facilitators to implementation. Thematic analyses of the focus group data demonstrated markedly different perceptions of the importance of various barriers and facilitators across stakeholder groups. Participants consistently identified computerized patient records, administrative commitment, reorganization of work, and audit and feedback as important facilitators to guideline adherence. The most important barriers included time, workload, lack of computer support, and lack of guideline credibility.[3] We also identified a number of important domains not considered in current theoretical models. We used this rich qualitative dataset to develop and refine our written surveys that investigate guideline implementation, quality improvement, and other factors important in translation of evidence into practice.

National Surveys of Organization, Guideline Implementation, and Quality Improvement (QI)

In subsequent phases, we used items from prior surveys, a systematic literature review, and our qualitative data to design and conduct two national surveys at all

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VAMCs, one of quality managers and primary care managers, and the second of providers. These surveys were developed to characterize the variation in approaches to and intensity of implementation across multiple guidelines, describe QI efforts, and identify organizational factors associated with consistent performance.

The Quality Manager Survey queried quality and primary care managers involved in primary care QI at 128 VAMCs. The survey examined organizational context, dissemination mechanisms, monitoring, feedback, provider knowledge, attitudes and compliance, barriers and facilitators to adoption, audit and feedback of performance, and institutional efforts to improve quality. Respondents rated interdisciplinary teamwork, the use of technology, and a structured implementation process as the most important factors in effective CPG implementation. Approaches to disseminating information regarding guidelines in VA vary markedly across facilities. In a series of ongoing analyses linking these data to national performance data, we have identified a variety of organizational factors, guideline implementation approaches, and efforts to improve quality of care that are associated with high levels of institutional performance.[4]

Our provider survey assessed provider and organizational factors influencing guideline adoption and adherence. It includes questions about provider attitudes, time, work organization, guideline-specific data (diabetes mellitus, congestive heart failure, chronic obstructive pulmonary disease, major depressive disorder), implementation approaches, adherence tools, impact of tools on care, availability of specific electronic tools, culture, support, audit/feedback, and other organizational dimensions, as well as demographics, and open-ended questions. We surveyed a sample of physicians, physician assistants, nurses, and nurse practitioners in primary care, ambulatory care, medical service, nursing service, and geriatrics at 139 VAMCs nationally. We found major facility-level differences in organizational context, wide variation in timing, approaches to and impact of implementation, and guideline-specific factors.

We found that cooperative culture and support, and the presence of a structured implementation plan predicted successful adherence to the diabetes provider performance measures. VISN influence, cooperation between physicians and senior administrators, work group deadlines, participation, and timing, as well as characteristics of the patient population, influenced institutional levels of adherence with diabetes patient outcome measures. In addition to a need for improved organizational systems for guideline implementation, a fit between the guideline and provider values regarding a given guideline impacts the extent to which organizational systems provide the capability to improve adherence. Multiple other analyses are ongoing.

Interviews of VA Facility Leadership

We are in the process of interviewing selected VAMC leadership to identify important organizational and system issues influencing the effectiveness of guideline implementation to determine what approaches have best worked in their facilities. Structured interviews include: (1) factors that lead to decisions to implement guidelines, (2) how a facility approached implementation, (3) successful approaches to implementation, and (4) problems to overcome regarding implementation. This qualitative investigation will enrich our understanding of effective approaches to implementation and help inform further analyses and subsequent investigation.

Summary

VA's efforts to adopt and disseminate clinical guidelines and measure performance related to key measures are effective in many ways. Clearly, guideline implementation, or translation of evidence into practice, is influenced by organizational, provider, and patient-level factors. Interdisciplinary teamwork, effective use of information technology, audit and feedback of performance, and benchmarking appear to be effective institutional-level and system-level interventions. However, implementation interventions, such as automated computer reminders, need to be tailored, refined, and adapted for the local environment and used wisely to not overwhelm or interfere with patient care. Further research is needed to identify the most effective combinations of implementation methods for different clinical settings, clinical problems, and institutions. We have only begun to learn how to incorporate patient preferences and participation in implementation research. Further work is also needed to determine how to sustain and improve consistent adherence over time.

1) Doebbeling BN, Vaughn TE, Woolson RF, Peloso P, Ward MM, et al. *Benchmarking Veterans Affairs Medical Centers in the Delivery of Preventive Health Services: Comparison of Methods.* Medical Care 2002;40:540-54.
2) Vaughn TE, McCoy K, BootsMiller BJ, Woolson RF, Sorofman B, et al. *Organizational Predictors of Adherence to Ambulatory Care Screening Guidelines.* Medical Care 2002;40(12):1172-85.
3) Lyons S, Tripp-Reimer T, Sorofman B, Dewitt J, BootsMiller BJ, et al. *Informatics technology for clinical guideline implementation: Perceptions of multiple stakeholders.* Journal of the American Medical Informatics Association 2003; In Revision.
4) Welke KF, BootsMiller BB, McCoy KD, Vaughn TE, Ward MM, et al. *What Factors Influence Provider Knowledge of a Congestive Heart Failure Guideline in a National Health Care System.* American Journal of Medical Quality 2003;18(3):122-27.