
Learning from Experience

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The true memoir of surgeon Ed Rosenbaum, entitled “*A Taste of My Own Medicine*,” tells the story of a doctor who learns that there’s more to medicine than his skill in the operating room. After being diagnosed with cancer, Dr. Rosenbaum is forced to become a patient and experience first-hand the health care process that patients are routinely subjected to. In the end, the doctor learns a life-altering lesson from his experience as a patient—knowledge that he takes with him in his treatment of others in his practice and life. This story illustrates the power of experience and how without real-life experiences, we do not have a true perspective of the reality of what being a patient really means. Prior to his illness, Dr. Rosenbaum callously believed that all his patients wanted and expected of him was his skill in the operating room. However, when the tables were turned, he came to realize that his patients desired and expected much more.

How often do we develop processes in health care facilities without surveying the experiences of the people directly affected? Staff and patients who are on the receiving end of these processes are often left out of the planning cycle. The next time you walk into a building and its design makes you feel confused or uncomfortable, in most cases, it probably means that the planning process did not include the experiences and opinions of the end-users. While this can be a costly mistake, fortunately it can be avoided if the proper work is done up front.

Positive Experiences

Personally, I’ve had the opportunity to experience first-hand many positive experiences that have helped shape my view of the ideal health care system. I use these experiences in developing strategic plans that lead to the development of health care processes. My background of knowledge has been shaped by my ongoing experiences as a practicing physician—learning directly from my patients what’s important as they work to achieve a return to health. From my past experiences as a Health Policy Scholar for the Centers for Medicare and Medicaid (CMS)

and as a Medical Director of an HMO, I have learned to appreciate the political and administrative processes required to develop truly effective health care systems.

Positive experiences can be gained by following several paths—from formal education to internships and scholars’ programs. While many of these experiences often are difficult to find, by working with professional associations, such as the American Geriatric Society, a course can be more easily laid out for one to gain these valuable experiences. Due to advanced technology, educational experiences are available via the

Internet. This affords busy professionals the opportunity to take classes with little disruption to their normal schedule. Many degree and continuing medical education programs are available via the Internet, providing accessibility for interested individuals.

Negative Experiences

Of course, valuable knowledge can also be gained from even negative experiences. Recently, I found myself subjected to a very negative experience, which undoubtedly will help evolve my previous perspective of the ideal health care system. My oldest son was suddenly diagnosed with metastatic bone cancer. Nothing changes one’s perspective on things as much as a personal experience, especially one with such potentially serious consequences. Going through this process, I am learning first-hand what it’s like for an anxious caregiver to attempt to navigate the confusion of the health care system. Consumer-driven health care, which I had once intellectualized as being a viable system of health care delivery, has suddenly lost favor in my mind. Distraught caregivers, no matter how well educated, are in no position to make rational decisions—they desperately need a guide. Similarly, with regards to Medicare Part D, it is completely unrealistic to expect seniors to decide on their own which of the 75 prescription drug plans is the best for them.

During my current situation, I’ve also gained an increased

appreciation for the team approach. The team approach has always been embraced in geriatric care, but is often missing in general medical practices. Having a coordinated team of expertise makes the journey through a difficult illness such as cancer or Alzheimer's disease much easier, with improved outcomes for all involved.

Second-hand Knowledge

While first-hand knowledge has the most impact, it is not always possible (thankfully so in some cases). In such cases, second-hand knowledge directly from the person utilizing the health care system is an alternative means of gaining experience. This person can be the actual patient or a "planted" user who is placed in a situation to gain information that is reported back to the facility's staff to help improve future users' experiences.

There are several companies that harness the research power of "mystery shopping" to evaluate service performance in health care organizations. By identifying and monitoring barriers to good service and marketing opportunities, companies such as Devon Hill Associates help hospitals, clinics, assisted living facilities, and nursing homes increase business and patient satisfaction. Documenting the patient's experience goes beyond noting whether the nurse remembered to smile or the physician's bedside manner was pleasant. Fictitious patients—who are supplied with false medical charts and outpatient orders by hospital physicians—are able to document issues as simple as a bed's guardrails not being raised

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after a patient complained of dizziness, or as complex as appropriate triage care.

Less-involved learning opportunities can be gained by performing patient surveys. In December 2005, the National Quality Forum endorsed a 27-question survey that attempts to measure patients' health care experiences. Funded and administered by the Agency for Healthcare Research and Quality (AHRQ), which works closely with a consortium of public and private organizations, the Consumer Assessment of Healthcare Providers and Systems (CAHPS), program develops and supports the use of a comprehensive and evolving family of standardized surveys that ask consumers and patients to report on and evaluate their experiences with the health care system.

As part of the 2006 Patient Assessment Survey (PAS), several quality improvement organizations now offer groups the opportunity to measure patient experiences at the individual physician level. The "Physician Survey" provides information at the physician level that can help support medical group quality improvement activities under the pay-for-performance system, as well as in physician recognition and reward programs.

The Physician Survey also measures the quality of the patient-practitioner relationship from the perspective of the patient. It is comprised of 3 distinct surveys designed to evaluate the care provided by primary care practitioners, specialists, and pediatricians, respectively. Physician groups can field 1, 2, or all 3 surveys, as desired. During 2005, over 50,000 patients served by more than 1,700 physicians across 18 physician groups completed the survey. During 2006, all medical groups with eligible physicians have been encouraged to participate.

The Physician Survey relies primarily on A-CAHPS, or the Ambulatory CAHPS Survey, which was also developed under the auspices of the AHRQ.

The performance concepts assessed in the survey are:

- Patient access to care
- Patient and doctor communication
- Doctor knowledge of the patient
- Patient trust in the doctor
- Caring for a chronic condition
- Coordination of care
- Health promotion
- Overall patient rating of the doctor

Three sets of Physician Survey results are provided only to the physician group for internal use and benchmarking. These results are reported at the individual physician and group levels and are organized into 4 physician categories: adult primary care, pediatrics, Ob/Gyn, and specialists. The first deliverable, a physician group-wide report, compares the group's results with the scores from other participating groups. This report also includes results for all physicians participating in

the group. The second report is an Excel®-based electronic deliverable that enables the group to organize and analyze its results dynamically. This electronic report contains the results for each physician in the group, and provides several predefined report templates to organize the results by practice site, specialty, and other factors. The third deliverable is a set of individual physician reports for each of the group's participating physicians. These reports are formatted in an Adobe® Acrobat® PDF file for each doctor and include:

- All-project norms (mean and 90th percentile) by physician category (ie, adult primary care, pediatrics, Ob/Gyn, and specialists)
- Within-physician group norms by physician category
- Medical group-wide scores for the 4 to 5 quality domains and individual questions
- Physician-specific scores for the 4 to 5 quality domains and individual questions
- Patient demographics
- Physician group-specific key drivers of overall satisfaction with physicians by physician category

Each physician group designates those physicians it wishes to include in the survey. Eligible physicians must have a minimum of 100 patients who visited with them during the most recent 12 months. Commercially insured patients, regardless of the type of insurance (eg, HMO, PPO, etc), are eligible. Medicare patient populations can be included, although there are no Medicare-specific benchmarks at this time.

The physician groups are responsible for preparing a data file

Take-Away Message

- Past experience is a vital component when developing or redesigning any process so that the end user's perspective is fully captured.
- There are several opportunities to acquire experience, including internships and scholarship programs, as well as degree programs that are accessible on the Internet.
- Second-hand experience is available through "secret" patient or end-user surveys.

ROI

- Demand for one's services is based on patient satisfaction. Without real-life experiences, we do not have a true perspective of the reality of what patient satisfaction really means.
- As the medical payment market moves toward pay-for-performance, a clear understanding of the experiences of the end-users is essential to improve existing health care systems and maximize outcomes.

using the project's patient case-finding rules. Physician groups provide a single file for the PAS group-level project and the Physician Survey Project. A format for the data files is sent to each physician group to guide them in assembling this eligible population file.

The survey vendor draws a patient sample for each participating doctor. When a patient has an ambulatory visit with 2 or more participating doctors, the algorithm assigns the patient to the primary care physician if 1 of the visits is with a designated primary care physician. Otherwise, the patient is assigned to the physician who the patient has seen most recently.

The patient has the choice of completing and returning the survey by mail or online. The initial mailing to the patient includes a copy of the survey and an invitation to complete the survey online. For nonrespondents, a second mailing is sent with another copy of the survey and the invitation to participate online. Spanish, Chinese, and Vietnamese language versions are available online or can be mailed to patients upon request.

The Result

Obviously, first-hand experience is best. However, when that is impossible, second-hand experience can be very helpful. The sources of second-hand knowledge can range from a "secret patient" project to patient surveys. In the end, we should not miss any opportunity to learn from our own experiences or those of our patients so that we can improve existing health care systems to maximize outcomes for all involved.

As practices are forced to focus increased attention on outcomes, gaining this knowledge will become increasingly valuable. Pay-for-performance programs, public reporting of quality data, and the move toward market-driven practices will require practitioners to deliver what patients expect and want. Indeed, unless practitioners know what these things are, they will be impossible to deliver.

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