

Advancing the Ambulatory Patient Experience Measurement and Reporting Agenda

Supported by the Center for Healthcare Transparency

One of the many challenges and opportunities facing the U.S. health care system is to make care more patient-centered. In order to do that, the nation needs to more effectively advance efforts to capture and report about how patients experience their care.

Knowing how patients perceive and experience their care is essential to designing a health care system that engages patients and meets their needs. While there is a national program in place to report the inpatient care experience, capturing and reporting comparable data for ambulatory care lags behind. This white paper has been prepared to help stimulate a discussion about how industry leaders can come together to advance this important work. This is an important and timely conversation, driven by many factors including the growing expectation among Americans that information about the care experience should be readily available to them.

This paper will:

- Define what is meant by ambulatory patient experience measurement and why it is an important element of improving the U.S. health care system;
- Present the current landscape for measuring and publicly reporting ambulatory patient experiences of care and lay out some current challenges of these efforts;
- Explore how attention to customer experience has played a key role in other segments of the U.S. economy and consider what the health care industry can learn from industries that have embraced public reporting about customer experience; and
- Identify barriers that must be addressed to successfully advance ambulatory patient experience measurement and public reporting to achieve the vision of providing all Americans with access to valid and useful ambulatory patient experience information.

What is Ambulatory Patient Experience Measurement?

The California Health Care Foundation defines ambulatory patient experience as “the sum of a patient’s interactions when accessing the health care system. The patient experience reflects the dimensions of care that are most important to patients, including personal interactions and communications, access to care, and care coordination.” (1)

In general, there are four types of ambulatory performance measurement data that may be gathered and published, as summarized in the below table:

Patient Experience	Asks patients questions that focus on what <i>actually happened</i> during a care episode
Patient Satisfaction	Asks patients questions that measure their <i>perceptions</i> of care
Patient Reported Outcomes	Asks patients questions about their state of well-being and how well they are able to function
Clinical Indicators	Provide clinical outcomes measures using sources such as medical records and claims data

Patient experience measurement is designed to focus on those aspects of care that patients tell us matter most to them. To advance patient experience measurement and reporting, it is important to distinguish patient experience from patient satisfaction. While patient satisfaction focuses on the patient’s perception of the services received, patient experience measurement is anchored in assessing what patients tell us actually happens when they receive care. Experiences include interpersonal actions and communications between patient and health care providers relating to how easy it is to access care, and how care is coordinated. Patient experience surveys are designed to ask questions about aspects of care where the patient is the best and only source of information. These fundamental principles are behind the ongoing efforts to design and advance Consumer Assessment of Healthcare Providers and Systems (CAHPS) family surveys, widely recognized as the national standard for patient experience measurement in a variety of ambulatory and inpatient settings.

Patient Reported Outcome Measures (PROMs) are different from patient experience measures in that they focus on specific conditions and ask patients themselves to evaluate their health and functional status. Through this area of measurement patients tell caregivers how well treatments are working.

Clinical indicators focus on clinical processes and outcomes for specific conditions and rely on methodologies with highly technical specifications. Depending on the measures that are made available for reporting, patients may not be able to find information that is relevant to them.

Why Reporting About Ambulatory Patient Experience is Important

Measuring and reporting about ambulatory patient experience on a national scale will require a significant amount of human and financial capital. However, such an effort has a number of significant values that justify this investment, including:

- Good experience of care matters to patients and their families and is an essential element of health care quality and an important outcome unto itself.
- Capturing the patient voice is fundamental to transforming our health care system into a more patient-centered system.
- An established body of evidence indicates that the quality of the patient-physician interaction has direct impact on improved clinical outcomes.
- Public reporting of patient experience survey results is increasingly important as the health care system transitions to be more driven by consumer choices. Patients must have access to quality information, as well as cost information, to truly assess value in purchasing.

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- Patient experience survey results support value-based health care purchasing. A growing number of private and public payers now link reimbursement to the quality of physician-patient communication and other patient experience measures.

Evidence of how consumers view the value and impact of patient experience

Studies show that patients value patient-centered care. For example, a 2014 study found that 59 percent of patients rated doctor-patient relationships and physician characteristics as the most important aspects of high quality care.(2) In another study, patients ranked how well their physician listens to them as the number one factor that makes a high-quality doctor. That same study found that failure to listen or be attentive was the highest ranking factor in a poor-quality doctor.(3)

Evidence of how patient experience impacts clinical care

Research gathered over more than three decades documents the connection between patient experience and improved clinical outcomes. Studies dating back to the late 1980s and early 1990s have found that physician-patient interactions have an impact on clinical outcomes and patient adherence to their doctors' recommendations. (4), (5), (6) One study found that adherence with treatment recommendations was 2.6 times greater for primary care patients whose providers had full knowledge of their medical history and status compared to providers who did not have that information.(7) Several studies provide further evidence that patients with better experiences have better health outcomes, including improved outcomes for blood sugar control in diabetic patients(8) and improved results for patients hospitalized for acute myocardial infarction(AMI).(9)

The business case for gathering and reporting patient experience data

The business case for measuring and reporting ambulatory patient experience is also growing. In 2012, the United States expended 47.5 percent of all health care dollars in ambulatory settings.(10) Because of the body of evidence supporting its impact on clinical outcomes and its inherent value in assessing the quality of care, patient experience results are increasingly being tied to financial incentives. Both public and private payers now place increased emphasis on measuring how effectively physicians interact with patients and are linking those results to provider reimbursement and recognition. Leading examples include Blue Cross and Blue Shield of Massachusetts through its Alternative Quality Contract compensation

model(11) and the Integrated Healthcare Association in California (IHA). IHA also operates a private sector driven pay for performance program that incorporates patient experience survey scores.(12)

The public sector is also embracing this concept with the Centers for Medicare & Medicaid Services (CMS) including patient experience results as part of its evolving pay-for-performance and public reporting agenda.(13) Accountable Care Organizations (ACOs) are required to measure and report about patient experience and CMS has introduced its Physician Quality Reporting System (PQRS), which incents provider organizations to report about patient experience. Beyond the growing connection between provider reimbursement and ambulatory patient experience, many policymakers want to advance a national and local agenda through various mandates and government funded efforts. For example, a 2008 law enacted in Minnesota requires the state to develop a standard set of measures to be publicly reported including ambulatory patient experience.(14)

The business case for measuring and reporting ambulatory patient experience is also growing.

What Can Be Learned From Other Industries That Report About Customer Experience?

Numerous industries currently measure customer experience, including retail and e-commerce, government, consumer products, telecommunication and utilities, media entertainment, insurance and financial services, and the travel and hospitality industries.

Studies document the link between business results and measuring and reporting customer experience. One study found that customer service was the number one factor in building trust with a company. That same research found that 55 percent of consumers would be willing to pay more for a better customer experience, and that 89 percent of all consumers have stopped doing business with a company due to a bad customer experience.(15)

Proprietary firms support many of these efforts, with some making results publicly available to create a direct connection between consumer data gathered for quality improvement, as well as public accountability uses. For example, one firm examined feedback from 10,000 U.S. consumers describing their experiences with and their loyalty to 268 companies. The analysis showed a strong correlation between customer experience and loyalty factors such as repurchasing, trying new offerings, forgiving mistakes, and recommending the company to friends and colleagues.(16) Another firm has published results from its customer experience data showing how various companies compare in 14 industries. (17)

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Publishers who collect and share information to help customers make comparisons that support informed purchasing decisions have demonstrated that there is public interest in gaining access to this kind of information. Consumer Reports was founded in 1936 and has a 75-year track record of providing unbiased information to inform consumer decisions. It has over seven million subscribers to its magazine and website and generated more than \$33 million in operating revenue in 2013.(18) The Good Housekeeping Research Institute was established in 1910 and has been publishing product information for consumers since that time.

These efforts created the foundation for the 21st century information culture of “radical transparency” that we now live in. Today, the information industry is growing and expanding through the internet and social media. This further demonstrates the public appetite for information to help make informed consumer choices. Consumers continue to show their interest in both providing feedback and hearing from other consumers about their experiences. Presenting this information publicly has become an integral part of the service industry and has promoted transparency as a value. For example, Trip Advisor was established in 2000 and claims

to have as many as 280 million unique monthly visits to its website.(19) Amazon has also incorporated ratings and reviews to help market its diverse offerings and Yelp uses this model to support its business as an information provider. The growing predominance of the consumer-driven ratings and review model has substantially changed public expectations about what information should be available.

In the health care sector, Healthgrades was established in 1998 and provides ratings of health care providers. According to an independent source, Healthgrades received approximately 17 million unique visitors a month in January 2014.(20) It is likely that consumer demand for health information provided by vendors like HealthGrades will continue to grow, driven in large part by the continuing expansion of consumer directed coverage design and the desire for information to support decisions about care.

Applying these concepts to measuring patient experience in ambulatory care

To move forward with providing the American public with ambulatory patient experience information, significant emphasis will be needed in adopting best practices from other industries that currently gather and publish similar information in a more efficient, timely and consumer friendly fashion. For example, current efforts to gather and publish ambulatory customer experience information in the health care sector generally rely on somewhat costly and time-consuming methods to gather data, such as paper surveys and phone interviews. Other industries use more efficient methods to gather and report this data. Consumers are

asked to respond to short and concise survey instruments, often electronically. In many cases, results are available to the public nearly instantaneously.

Finally, it is noteworthy that health care consumers are already rapidly moving to new alternatives to find the information they need to support their care decisions. For example, a recent study published by PricewaterhouseCoopers found that the majority of consumers under age 44 prefer to obtain health care review information from social media over all other available sources.(21)

How Do We Successfully Advance a National Ambulatory Patient Experience Measurement and Reporting Agenda?

Non-profit, multi-stakeholder groups like California Healthcare Performance Information System, Massachusetts Health Quality Partners (MHQP), Minnesota Community Measurement, and other regional health improvement collaboratives have led advances in ambulatory patient experience measurement and reporting. These organizations have helped identify the key elements that are inherent in any successful efforts to measure and report ambulatory patient experience. Those attributes fall under several general categories including the survey instrument used, how the survey is administered, how results are publicly reported, funding model and governance.

Aligning survey design and administration

Survey design and administration encompass the technical aspects of how surveys are structured and conducted. Key considerations include which survey instrument is adopted, population(s) measured, unit of analysis, and data sources. Decisions around survey design and administration are not only important as they relate to the science of how patient experience is measured and reported, but also have a major bearing on the relative cost of doing so. Survey design and administration also pertains to the degree to which various national and regional efforts are aligned. There are currently separate patient experience survey requirements and programs for ACOs and patient-centered medical homes (PCMHs), and these programs are not currently aligned with leading regional statewide efforts to measure and report patient experience. Lack of survey alignment, leading to duplicative surveys efforts, can be confusing, contribute to “survey fatigue” among patients, and increase data collection burden on health care organizations.

Another aspect of survey administration has to do with data collection methods. While traditional methods of large scale survey measurement have relied upon mail and land-line telephones to reach respondents, organizations are utilizing mail services much less frequently. Organizations conducting surveys have seen a continued decrease in the number of surveys returned through mail which means larger and more expensive sample sizes will be needed to gather enough data to report statistically reliable information in the future.

With regard to landline telephones, a recent

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National Health Survey found that 38 percent of adults live in homes that have cellular phones only and the growing preference for cellular and smartphones over landlines means that the survey population is much less accessible.⁽²²⁾ Both of these trends also mean that it is significantly more difficult to assure that response data is representative of the population being surveyed.

Advances in communication technology have dramatically and profoundly changed our culture over the past decade and are challenging well-established protocols for collecting reliable information from patients. Technological advances now allow for patient experience surveys to be conducted through electronic means, which will significantly reduce the cost of survey administration and also make it easier to collect information across different populations by offering surveys in a variety of languages. However, although it is widely recognized that there is a need to move to electronic modes of survey, we must maintain the validity and reliability of current wide-scale efforts when using the results for high stakes

uses, such as public reporting and pay for performance. A significant barrier to transitioning to electronic surveying is that emails and other electronic addresses are more closely guarded by both consumers and health care organizations, and they are not readily available for wide-scale survey efforts.

Public reporting

Public reporting methodology informs how results are presented to the general public. Decisions must be made on how the results should be presented and what should be emphasized. For example there can be an emphasis on identifying good vs. best performers, on differences in performers, performers meeting local or national benchmarks, or performers showing the most improvement. How the data is displayed is also an important decision that stakeholders care about, with various alternatives, including ranked ordered mean score, percentile rank, and “top box” comparison to mean.

Governance and financing

One might argue that the most critical set of decisions that dictate the long-term success of any effort are its approach to governance and financing. Governance refers to the decision making process that is adopted. This would include issues such as who is invited to join the governing board and whether a simple majority or consensus is required to approve changes. As the case studies discussed later will illustrate, regional collaboratives have demonstrated a significant value proposition in addressing this and other critical factors impacting the success of local efforts to advance ambulatory patient experience data collection and reporting.

Finding an adequate and sustainable funding model is also essential. Key considerations such as who owns the data, and how providers are encouraged to participate in survey activities must also be addressed.

Table I in the appendix of this document provides a high-level summary of the various alternatives available to entities that are seeking to advance ambulatory patient experience measurement and reporting in their community. In the next section of the paper, we will examine the specifics of how many early efforts are addressing these key decisions.

Lessons From Early Adopters: An Examination of Industry Leading Efforts

Numerous efforts are underway to collect and report ambulatory patient experience data. Some of these initiatives have been reporting this information for more than a decade, while others have more recently begun local efforts. Information has been gathered from two sources to assess what can be learned from the experiences of these early adopters.

The Aligning Forces for Quality (AF4Q) program, funded through a multi-year grant from the Robert Wood Johnson Foundation (RWJF), has provided financial and technical support to 16 alliances working to advance implementation and use the CAHPS Clinician and Group Survey (CG-CAHPS). A paper prepared by Shaller Consulting Group summarizes key findings related to this

work.(23) Among the key findings cited in that document are:

- Various versions of CG-CAHPS are being adopted with both centralized and decentralized data collection methods.
- Most communities are reporting at the group practice or clinic site level, and have not generally addressed consumer demand for scores for individual providers.
- To date, most reporting has been done in silos: through single purpose websites or separate sections within a reporting website and have not been integrated with clinical quality, patient safety, and cost measurement to create a more integrated, comprehensive picture of performance.
- Most of the 16 communities did not have an existing effort underway, and the support from AF4Q has been instrumental in getting them started.

Further data were gathered for this white paper through a survey conducted by the Massachusetts Health Quality Partners. A detailed summary of the six communities that provided responses to this survey may be found in Table II in the appendix of this document. Several key conclusions may be drawn from those results:

- Five of six reporting communities are multi-stakeholder non-profit entities, which include all key stakeholders in their governance (consumers, employers, providers, health plans/carriers and, with one exception, public officials).

- All reporting communities used various versions of CG-CAHPS. All six communities measured patient experiences of adults, but only MHQP in Massachusetts also reported on children.
- All communities reported results based on commercially insured populations. Four also reported for Medicaid patients and three did so for Medicare beneficiaries.
- All six communities reported at the primary care medical group and primary care practices levels. Some have also begun reporting at the specialty care level.
- Provider and/or health plan support for patient experience surveying was cited as one of the most common contributors towards the success of the programs.
- Pay-for-performance initiatives were cited as another key factor for success. RWJF funding through AF4Q and alignment with national surveys also contributed to program successes. Creating a sustainable business model was a key concern for several.
- The cost and burden of existing data collection methods, declining response rates, and getting members to use a single standardized tool were also cited as challenges.
- Half of the collaboratives rely on grants to fund their work. Three employ membership fees and the majority also obtain financial support through provider and health plan/carrier contributions. Three reported receipt of government funds to support their efforts.

- The number of physician organizations measured and reported ranged from 172 to 651. Limited data was provided on the estimated cost of these efforts, and none of the respondents submitted data quantifying the cost per unit of analysis.

From this information, several key conclusions may be drawn:

- While great progress has been made, ambulatory patient experience measurement and reporting is still in a relatively early phase of its development and implementation.
- The Affordable Care Act, along with associated current actions by CMS and the Department of Health and Human Services (HHS) are helping to promote the expansion of this effort. State level mandates can also help advance this work. But government actions alone will not assure the successful implementation of an effective and sustainable effort.
- Sustainability is a key concern, driven in large part by the need to identify a long-term funding/business model to support these efforts.
- CG-CAHPS has emerged as the clear consensus instrument, but there are still multiple versions in play with some stakeholders continuing to use instruments that do not adopt these standards.

Conclusion: Key Issues That Must Be Addressed

There is a clear need to adopt new technology to improve the efficiency and consistency in how data are gathered, both to reduce costs and to avoid “survey fatigue” resulting from multiple, uncoordinated efforts.

Based on the current state of efforts to advance ambulatory patient experience measurement and reporting, we can draw the following conclusions:

- There is a clear case for aggressively advancing a national ambulatory patient experience measurement and reporting strategy. This is supported by a wide body of research that demonstrates that this information is valuable to patients in its own right, is often associated with improved clinical outcomes, and is also going to be linked more and more to provider reimbursement in the coming years. Providers will also benefit from having access to this information beyond any direct links to how they are paid, as it will help them assess and improve the care they deliver to patients.
- Consumers and providers are not yet fully engaged and efforts are needed to better inform them of the value of this information.

- There is a clear need to adopt new technology to improve the efficiency and consistency in how data are gathered, both to reduce costs and to avoid “survey fatigue” resulting from multiple, uncoordinated efforts.
- There is also a clear need to continuously improve both data collection methods, and what is being measured and reported to maximize value to all stakeholders.
- Regional collaboratives and local efforts will play a key role in supporting the ultimate goal of providing consumers with access to ambulatory care patient experience information in all 50 states.
- There are important lessons that can be learned from other industries that successfully gather and report consumer feedback. These offer some valuable insights that can help inform this effort. Other industries have been driven to successfully advance agendas to measure and report customer experience, we need to do the same for ambulatory patient care.
- Over the past several years, great progress has been made through both national efforts such as CG-CAHPS, as well as leading regional programs that are working to advance ambulatory patient experience measurement and reporting. From these efforts, one can begin to identify certain consensus approaches that can be adopted as we move towards a national agenda. They also help us identify a number of potential alternative approaches that might be explored further as efforts to gather and report ambulatory patient experiences expand and mature. Given this progress, the industry is now at a critical stage as it seeks

to align these promising efforts in order to assure their growth and long-term success.

As industry leaders continue their work to achieve the shared vision of a sustainable national effort, there are a number of key issues and questions that should be addressed. Those include:

Engaging consumer and patients:

1. Capturing the patient voice is key to providing patient-centered care – what do we need to do to assure we will continue to engage patients in providing their feedback in patient experience surveys?
2. What are the best ways to report results to the public? Are there other industry leading examples that we should consider adopting?
3. Does the public distinguish between reliable and unreliable data about user reviews? Can we educate consumers to seek better information and engage them in using patient experience data?

Lessons from early adopters:

1. What key lessons can be learned from the experience of these industry leaders?
2. How important is it that a consistent approach is used to report results across markets?
3. How can we more effectively engage consumers, physicians, insurers, employers, policymakers, and regulators to collect, access and use ambulatory patient experience data to improve care? What actions are required to reach each of these unique audiences?

Learning from other industries:

1. What do our efforts to advance public reporting for ambulatory patient experience have in common with other industries? How are they different?
2. What can we learn from other industries that have developed and sustained efforts to gather and report information on consumer experience?
3. What can we learn from other industries about how to constantly improve our data collection and data reporting methods?
4. What can we learn from other industries about the value of the patient experience feedback to improve health care?

Aligning survey design and administration:

1. How important is it that a common instrument and approach be employed within and across markets? What is the process to do this?
2. What are the advantages and disadvantages of centralized versus decentralized data collection?
3. How do we as an industry stay aligned with the changing norms in consumer surveys (e.g. shorter forms, electronic administration) to counter declining response rates?
4. What can we do to align questions to avoid duplicating efforts?
5. What are the most effective models of government support for advancing this agenda? If government does not play a key role, what private sector entities can create

the greatest leverage?

Creating sustainable funding mechanisms:

1. What are the key lessons to be learned from how existing efforts are funded?
2. Is there a way to leverage different stakeholder interest in survey results into a multi-stakeholder funding model?
3. How can we pursue common funding sources across markets?
4. To what extent should the relative cost of various approaches impact our overall approach (i.e. sample size, data collection methodology, unit of analysis, etc.)?

Some of these issues will be easier to address than others. However, regardless of the challenge involved, given the progress to date and value of expanding current efforts to gather and report ambulatory patient experience data, it is incumbent on industry leaders to come together to seek consensus on addressing these topics.

Acknowledgements

This report was prepared by Massachusetts Health Quality Partners (MHQP) with funding support from the Center for Healthcare Transparency. We thank Steve Wetzell, Principal, Wetzell Health Care Strategies and Rose Judge, MHQP's director of Patient Experience Surveys for their role in developing this report. We would also like to acknowledge the Robert Wood Johnson Foundation for their support in bringing a national panel of experts together to drive effective measurement and reporting of the patient experience in health care.

About MHQP

Massachusetts Health Quality Partners (MHQP) is a non-profit, broad-based coalition established in 1995 that provides reliable information to help physicians improve the quality of care they provide their patients and help consumers take an active role in making informed decisions about their health care. MHQP's mission is to drive measureable improvements in health care quality, patients' experiences of care, and use of resources in Massachusetts through patient and public engagement and broad-based collaboration among health care stakeholders, including physicians, hospitals, health plans, purchasers, patient and public advocates, government agencies, and academics.

About CHT

The Center for Healthcare Transparency is working with organizations across the country to provide meaningful cost and quality information to 50% of the US by 2020. By leveraging the groundbreaking work done in regional data and analytics organizations, the Center brings the power of informed decision-making to every stakeholder in the healthcare puzzle – patients, providers, plans, employers and public purchasers. The Center for Healthcare Transparency (CHT) is a nonprofit initiative led by the Network for Regional Healthcare Improvement (NRHI) and the Pacific Business Group on Health (PBGH).

Appendix

TABLE I Elements Required to Support Ambulatory Patient Experience Measurement and Reporting		
General Category	Element	Alternatives
Survey Design and Administration	Survey Instrument	CG-CAHPS 12 month
		CG-CAHPS visit
		CG-CAHPS Patient-Centered Medical Home
		Other/customized/proprietary
	Population Measured	Adult
		Children
		Condition-specific
		Race
		Gender
		Socio-economic status
		Other
	Unit of Analysis	Primary care medical group (multiple sites)
		Multi-specialty medical group (multiple sites)
		Primary care practice (single site)
		Multi-specialty medical group (single site)
		Individual primary care provider
		Individual specialty care physician
	Method to Determine if Results are Reportable	Minimum number of completed surveys
		Statistical reliability
		Other
	Data Source	Single source (i.e. provider site or organization)
		Multiple source (i.e. providers, payers)
		Other
	Payers Included	Commercial
		Medicare
		Medicaid
	Data Collection Method	Paper mailed to participant's home
		Telephone interview
		Interactive voice recognition (IVR)
		Online with option of mailed survey
		Online by patient
		Paper at point of service
		Other
Data Collection Frequency	Continuous	
	Quarterly	
	Annually	
	Other	
Reporting Frequency	Quarterly	
	Semi-annually	
	Annually	

TABLE I (continued)

Public Reporting Methodology	Method Used to Communicate Results	Website
		Social media
		Printed results distributed by sponsoring organization
		Printed results distributed by health plans/carriers
		Printed results distributed by providers
		Printed results with government entities
		Printed results in partnership with private partners (i.e. Consumer Reports)
		Other
	Providers Can Review Pre-Published Results	Yes
		No
	Method Used to Portray Results	Rank ordered mean scores
		Performance categories based on percentile rank
		Statistical comparison to benchmark
		"Top box" comparison to mean
		Other
	Aggregate Versus Question Specific Scores	Report results for each question
		Report composite results
		Combination of these two approaches
	Publish Patient Comments	Yes
		No
Governance and Business Model	Entities On Governing Body	Consumers/patients
		Employers
		Providers
		Health plans/carriers
		Public officials
		Other
	Data Ownership	Sponsoring entity
		Participating providers
		Employers
		Health plans/carriers
		Government agency
		Other
	Method to Encourage Provider Participation	Government mandate
		Certification/recognition programs
		Financial incentives or penalties
		Condition of participation in insurance offerings
		Good faith cooperation
		Other
	Revenue Sources	Membership fees
		Consumer user fees
		Employer fees/contributions

TABLE II
Summary of Early Adopter Case Study Survey Results

	California Healthcare Performance Information System	Maine Quality Forum	Massachusetts Health Quality Partners	Minnesota Community Measurement	Washington Health Alliance	Wisconsin Collaborative for Healthcare Quality
<i>About the Organization</i>						
Market Served	California	Maine	Massachusetts	Minnesota & border communities	Five counties (King, Kitsap, Pierce, Snohomish, Thurston)	Data reported for about 60% of Wisconsin providers
Type of Organization	Multi-stakeholder non-profit	Government	Multi-stakeholder non-profit	Multi-stakeholder non-profit	Multi-stakeholder non-profit	Multi-stakeholder non-profit
Yrs. of public reporting	12	2	9	3	2	2
<i>Sustainability and Key Priorities</i>						
Most significant factors contributing to success	<ol style="list-style-type: none"> 1. Statewide P4P program 2. Provider support 3. Alignment with national surveys 4. Multi-stakeholder governance 	<ol style="list-style-type: none"> 5. Growing recognition of importance of assessing and improving pt experience (e.g. links to Medicare VBP) 6. Multi-stakeholder support for patient experience surveying 	<ul style="list-style-type: none"> • Insurer P4P program • Health plan and provider engagement and support • Alignment with national surveys 	<ul style="list-style-type: none"> • Use of measures by payers • Provider commitment and recognition of value • Government mandate 	<ul style="list-style-type: none"> • Provider support and cooperation • RWJF AF4Q funding • Health plan support and cooperation • Purchaser sees value • Good vendor support (CSS) 	<ul style="list-style-type: none"> • RWJ AF4Q grant
Greatest challenges so far	<ul style="list-style-type: none"> • Survey responses rates • Administrative costs • Ensuring relevant topics are included 	<ul style="list-style-type: none"> • Funding for repeated rounds of statewide surveying 	<ul style="list-style-type: none"> • Keeping consumers engaged – declining mail survey response rates • Sustainable business model (Fears that costs not fairly shared) • High costs of surveying • Barriers to embracing the value of consumer feedback, confusion about terminology (i.e.: pt. satisfaction vs. pt. experience) 	<ul style="list-style-type: none"> • Data collection burden using mailed or phone survey • Lack of alternative methods for safety net providers • Delay in reporting results 	<ul style="list-style-type: none"> • Sustainable business model • Broadening provider participation to support statewide implementation 	<ul style="list-style-type: none"> • Getting all members to use a single standardized tool (CG-CAHPS)
Highest priorities to meet greatest challenges	<ul style="list-style-type: none"> • Evaluating more cost effective methods • Stay abreast of the latest research • Maintaining alignment with national standards • Expanding test questions 	<ul style="list-style-type: none"> • Finding support/options for funding future rounds of surveying 	<ul style="list-style-type: none"> • Better use of technology to have greater flexibility in surveying and reduce survey costs • Developing a sustainable and fair business model • Survey alignment • Articulate value proposition to all key stakeholders 	<ul style="list-style-type: none"> • Increase use by all payers including Medicare • Tie to methods groups can use to improve results • Address data collection burden • Increase use by payers and the public - including Medicare - to incent data collection 	<ul style="list-style-type: none"> • Developing a sustainable business model 	<ul style="list-style-type: none"> • Demonstrate value of public reporting results • Create synergy to maximize value for internal provider CQI (integrate patient experience into other condition-specific improvement areas that is working on)

Table II (continued)
Survey Design and Administration

Survey instrument	CG-CAHPS 12 Month	CG-CAHPS Patient-Centered Medical Home	CG-CAHPS PCMH	CG-CAHPS Visit	CG-CAHPS 12 Month	CG-CAHPS Visit
Population(s) measured	Adults	Adults	Adults and children	Adult	Adult	Adult
Number of questions	53	52	61 adult, 68 pediatric	37	52	37
Unit of analysis	<ul style="list-style-type: none"> Primary care medical group (2 or more practices) Multispecialty medical group (2 or more practices) Individual primary care provider Individual specialty care physician 	<ul style="list-style-type: none"> Primary Care Practice Specialty Care Practice 	<ul style="list-style-type: none"> Primary care medical group (2 or more practices) Primary care practice Individual primary care provider 	<ul style="list-style-type: none"> Primary care medical group (2 or more practices) Multispecialty medical group (2 or more practices) Primary care practice Specialty care practice 	<ul style="list-style-type: none"> Primary care medical group (2 or more practices) Primary care practice 	<ul style="list-style-type: none"> Primary care medical group (2 or more practices) Primary care practice Specialty care practice
Criteria for publicly reporting results	<ul style="list-style-type: none"> Statistical reliability 	<ul style="list-style-type: none"> Minimum Number of Completed Surveys for Each Unit of Analysis 	<ul style="list-style-type: none"> Statistical reliability 	<ul style="list-style-type: none"> Minimum number of completed surveys 	<ul style="list-style-type: none"> Minimum number of completed surveys Statistical reliability 	<ul style="list-style-type: none"> Minimum number of completed surveys
Survey response rate	34.4%	Not reported	26%	35%	29%	Not reported
Data source for sampling	Single source (from provider sites or entities)	Centralized Data Aggregation from Multiple Sources	Centralized data base using multiple sources	Single source (from provider sites or entities)	Centralized data using patient sample from multiple health plans	Single source from providers using external vendors
Payer populations included	<ul style="list-style-type: none"> Commercial 	<ul style="list-style-type: none"> Commercial Medicare Medicaid 	<ul style="list-style-type: none"> Commercial 	<ul style="list-style-type: none"> Commercial Medicare Medicaid 	<ul style="list-style-type: none"> Commercial Medicaid 	<ul style="list-style-type: none"> Commercial Medicare Medicaid
Data collection method(s)	<ul style="list-style-type: none"> Paper mailed to home with online option Telephone interview Email invitation with online option 	<ul style="list-style-type: none"> Paper mailed to patient's home Telephone interview 	<ol style="list-style-type: none"> Paper mailed to home Online option with mailed survey 	<ol style="list-style-type: none"> Paper mailed to home with online option Telephone interview 	<ol style="list-style-type: none"> Paper mailed to home 	<ol style="list-style-type: none"> Paper mailed to home with online option Telephone interview
Data collection frequency	Annually	Annually	Annually	Annually	Bi-annually	Continuous
Public Reporting Methodology						
Method(s) used to communicate results	<ul style="list-style-type: none"> Website Printed insert in Consumer Reports 	<ul style="list-style-type: none"> Website Social Media 	<ul style="list-style-type: none"> Website Printed insert in Consumer Reports Social Media 	<ul style="list-style-type: none"> Website Social media Printed results by us Printed results by employers 	<ul style="list-style-type: none"> Website Social media Printed results by us Printed results by employers and providers 	<ul style="list-style-type: none"> Website

<p align="center">Table II (continued) Governance and Business Model</p>						
Entities represented on governing body	<ul style="list-style-type: none"> Consumers Employers Providers Health plans/carriers 	<ul style="list-style-type: none"> Consumers Employers Providers Health Plans/Carriers Public Officials 	<ul style="list-style-type: none"> Consumers Employers Providers Health plans/carriers Public officials 	<ul style="list-style-type: none"> Consumers Employers Providers Health plans/carriers Public officials 	<ul style="list-style-type: none"> Consumers Employers Providers Health plans/carriers Public officials Union trusts 	<ul style="list-style-type: none"> Consumers Employers Providers Health plans/carriers
Who owns the raw data??	<ul style="list-style-type: none"> Our organization Participating providers 	<ul style="list-style-type: none"> Our organization 	<ul style="list-style-type: none"> Our organization Participating providers Health plans/carriers Government agency 	<ul style="list-style-type: none"> Our organization (with limited license to raw data) Participating providers 	<ul style="list-style-type: none"> Our organization 	<ul style="list-style-type: none"> Participating providers
Methods used to encourage providers to participate	<ul style="list-style-type: none"> Financial incentives or penalties Results shared with physicians and plans 	<ul style="list-style-type: none"> Good faith cooperation Requirement for practices in Maine PCMH Pilot and Health Homes initiatives 	<ul style="list-style-type: none"> Certification/recognition requirements Financial incentives and penalties Condition of participation in insurance offerings 	<ul style="list-style-type: none"> Government mandates Financial incentive and penalties Condition of participation in insurance offerings Good faith cooperation 	<ul style="list-style-type: none"> We include all provider groups with three or more providers in the survey provided that we have an adequate sample size 	<ul style="list-style-type: none"> Good faith cooperation
Revenue sources	<ul style="list-style-type: none"> Provider fees/contributions Carrier/health plan fees/contributions 	<ul style="list-style-type: none"> Government funds 	<ul style="list-style-type: none"> Provider fees/contributions Carrier/health plan fees/contributions Government funds 	<ul style="list-style-type: none"> Membership fees Government funds Grants 	<ul style="list-style-type: none"> Membership fees Provider fees/contributions Grants 	<ul style="list-style-type: none"> Membership fees Grants
Estimated annual cost	\$2 million	\$1m	\$1m	Internal annual cost to aggregate and report results was about \$200,000, provider costs for data collection about \$1 million	\$250,000	\$20,000
Number of practice sites/medical groups measured and reported	173	267 practices	480	651	46 medical groups in 185 clinic locations	12 organizations; 86 clinic sites; 45 specialty practices

Many thanks to Oregon Health Care Quality Organization for information for this table even though they have not yet publicly reported their ambulatory patient experience survey results. Oregon Health Care Quality Organization is another non-profit, multi-stakeholder regional health improvement collaborative and will use the CG-CAHPS PCMH survey tool to report on adults and children for Commercial, Medicare and Medicaid populations for primary care medical groups and practice sites. The effort will be grant funded.

Endnotes

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