SHORT FORM PATIENT EXPERIENCE SURVEY – **RESEARCH FINDINGS**

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California Healthcare Performance Information System

Final findings report covering the bicoastal short form patient experience survey pilot conducted jointly by

Massachusetts Health Quality Partners (MHQP)

and

California Healthcare Performance Information System (CHPI)



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EXECUTIVE SUMMARY

For over a decade Massachusetts Health Quality Partners (MHQP) and California Healthcare Performance Initiative (CHPI) have measured and publicly reported about patients' experiences of care in the ambulatory care setting. Our initial efforts were groundbreaking. Over the past ten years, the drive toward patient-centered models of care and value based reimbursement have made patient experience measurement even more important and valuable for patients, providers and payers. During this same time, advances in communication technology have dramatically and profoundly changed our culture and these changes now challenge our earlier protocols for collecting information from patients. In order to maintain high response rates in a cost effective manner, we believe that traditional survey methods, such as mail and computer-assisted telephone interviews, will not be sufficient.

In an effort to spur innovation in this area, the Center for Healthcare Transparency (CHT) generously supported the implementation of a pilot study in our organizations' respective markets. The objective of the pilot was to evaluate new methods of surveying that make valid and reliable information about patient experience more widely available.

PROJECT DESCRIPTION

The overarching purpose of the Short Form Patient Experience Survey Project was to develop and evaluate new methodological approaches to make high value performance information available to the public. We also hoped to find ways to make patient experience surveys less expensive and reduce the burden of response for respondents without sacrificing the scientific rigor behind reported results. In the long term, if expenses can be significantly lowered it should be more feasible for organizations like ours to collect information about individual doctors. This level of information would be most helpful for consumers trying to make choices about care and for providers who are trying to improve patient experience.

MHQP and CHPI fielded their annual statewide patient experience measurement projects using a long form survey in early 2015 and tested a short form electronic and mail survey in parallel to these efforts. We used results and analytic work from our past surveys to support the evaluation of the pilot.

PROJECT OBJECTIVES

Our test of shorter and electronic versions of a survey was designed to answer these questions:

1) Will a short form survey provide comparable answers and rank providers similarly when compared with existing long form statewide surveys?

2) Will email approaches result in sufficient response rates and rank providers in a comparable way to the mailed short form?

These objectives are slightly different from our original intent to show that email short forms would produce results similar to that of mailed long forms. Despite a robust effort, our organizations could not generate enough email addresses from participants to address this broader and more desirable objective. The lack of widespread and systematic collection of patient emails is a major barrier. In addition, provider organizations are sensitive to the need for patient privacy and expressed concerns about using collected information to contact patients outside of their offices. These facts led, in a sense, to one of our most important findings: despite significant advances in communication technology, we must still rely on adding mail and phone survey modes to achieve sufficient response because provider organizations are not yet collecting and maintaining valid email addresses in a systematic way.

STUDY DESIGN

MHQP and CHPI recruited a subset of practices (in MA) and medical groups (in CA) who were willing to provide email addresses and invite their patients to participate in the survey. In CA, medical groups had traditionally been identified as the sponsor of the survey, however, in MA, the sponsors of the statewide effort have been MHQP and MA health plans and provider organizations.

In total, 57,683 patients seen by 1,862 individual physicians from 48 physician organizations in the two states received surveys as part of the pilot. The pilot sample frame included adult patients seen by PCPs at participating organizations during each state's measurement period. In California, 4,813 patients received the short form survey via email and 16,852 by mail. In Massachusetts, a total of 12,303 received the short form by email and 23,715 by mail. Patients who received email surveys had the option of also responding to open-ended questions at the end of their survey.

Both states fielded a parallel long form survey. In California, using the long form Patient Assessment Survey (PAS), 51,173 patients were surveyed originally by email and over 167,893 by paper. In Massachusetts, 177,685 patients received the long form Patient Experience Survey (PES) by mail; no Massachusetts patients received the long form by email.

Sample design was multi-layered to maximize usefulness of the available sample. The first layer was at the provider level to answer questions about doctors because information about doctors is of most interest to consumers and providers and because we see the largest differences in performance among providers. The second layer was at the practice (MA) or medical group (CA) level, and it was designed to allow for similar comparisons at those levels, reflecting the focus of current statewide surveys.

STUDY ANALYSIS AND FINDINGS

A primary aim of the pilot study was to test a shorter survey to determine if it gives comparable answers and ranks providers in a comparable way to existing statewide surveys. The demographic characteristics of the two regions differed significantly and substantially. California's sample was more racially and ethnically diverse, less educated and had more females than the MA study population. Differences in demographics were controlled for within each state's analysis so that comparisons could be made.

SHORT FORM ANALYSES

Our hypotheses were: 1) the short form will have better response rates than long forms within each state; 2) the short form and long form will produce comparable distribution of responses in both California and Massachusetts at the provider level; and 3) the short form and long form will rank doctors (in both states), practices (in MA) and medical groups (in CA) in a similar way.

| Short Forms | Massachusetts | California |
|----------------------|---|---|
| Response rate | Short form higher than long form (same time in field) (26.9% v.24.5%) | Short form same response as long form (responses arrived quicker but short form was fielded a shorter time than long form (25.4% v. 26.3%) |
| Results | Overall findings same for short and long forms with small exceptions at the item level* | Overall findings same for short and long forms with small exceptions at the item level* |
| Ranking of providers | Same for short and long form at the item level* | Same for short and long form at the item level* |

Table 1: Massachusetts and California Short Form Results

* This study did not test comparability of results or ranking at the composite level.

In addition to the high level results in the table above, the data provides several interesting findings:

• In Massachusetts, where the short and long forms were kept in the field for a similar amount of time, mail response rates were substantially higher for the short form. In California, short form responses were returned more quickly than the long form, however, the total response rates were the same. It should be noted that the fielding time was little more than half that of the long form, and therefore, it is possible that had the short form been in the field longer, California's response rates would have been higher for the short form than the long form.

• In general, in both states responses were comparable at the provider level regardless of survey length although there were some small differences according to the mode of response, particularly with regard to talking about stress in MA where mean scores were higher with the short form web responses.

• Doctors, practices (MA), and medical groups (CA) were almost universally ranked similarly in both states. All of the convergences (agreement of "true" answers) in both states were high, and in fact higher than in other pilots of this type.

EMAIL ANALYSES

Our hypotheses for this arm of the pilot were: 1) short form email response rates will be better than long form email response rates; 2) emailed short forms will give comparable responses to emailed long forms and mailed short forms; 3) emailed forms will rank providers in a comparable way to mailed forms that have similar content; and 4) patients in the sample frame who have emails will have different demographics than patients who do not have emails.

Table 2: Massachusetts and Californian Email Results

| Email results | Massachusetts | California |
|---|--|--|
| Response rate (RR) emailed vs. mailed short form only | Short form email RR was not as high as short form mail (21.5% vs. 29.7%) | Short form email with mixed mode follow-up RR was higher than short form mail (33.6% vs. 24.1%) |
| Response rates emailed short vs. emailed long form | Not tested in MA | No significant difference |
| Comparability of results | Comparable to both long and short form mail survey | Comparable to both long and short form mail survey |
| Email population demographics vs. mailed population | Slightly older and female | Slightly older and female |

Email results in the table above were interesting to us for the following reasons:

• In MA, email yield rates (usable response/surveys attempted) were higher than expected (21.5%) but not as high as mail yield rates (29.7%). They also were not as high as the total mixed mode yield in CA which was 33.6%. This is comprised of a yield of 9.8% for email responses, 21.2% for follow up with mailed paper surveys, and 2.4% for web responses using the link from the paper survey.

• There was not an appreciable increase in email yield rates associated with the short form in CA where a comparison to long form email could be made.

• Email short forms did provide comparable results to both long and short form mail surveys in both states.

• In both states, the demographics of those with email have shifted from what they have been in previous studies. Patients with email now tend to be slightly older and more female, whereas in earlier email studies they were younger and overwhelmingly male.

In addition to testing the hypotheses related to our key questions, we used the data collected through this pilot to do additional analyses and these results are included in our detailed results. Based on adjusted results, we looked at the relationship of responses by survey approach (long form vs. short form and email vs. mail) and response mode (mail vs. online). Differences found at this level were small. However, for organizations in MA and CA that are sensitive to small changes that could affect financial incentives, these pilot results could be used to adjust for trending.

We also considered different ways to summarize results of the short form survey through question groups or composites. Grouped communication questions and grouped questions about providers engaging with patients in talking about care showed high internal consistency among the items and fit together well. Two questions related to care coordination and two questions related to access did not perform as well when grouped together as composite measures. Additional questions could improve the access composite but the care coordination questions are best kept separate.

Lastly, in response to the growing interest in patient narratives about services, we included open-ended questions that were fielded in both states' electronic short form pilots to test the feasibility of eliciting narrative responses from patients. We chose to test two different sets of open-ended questions with respondents randomly assigned to receive either a three-item elicitation or a five-item elicitation. Preliminary findings indicate that response rates were similar for both sets of questions. However, those receiving the five-question protocol gave longer responses than did those receiving the three-question protocol. There were differences in response rates by patient characteristics in both MA and CA samples, but none of these varied significantly between the two sets of questions. In general, non-respondents were younger, less educated, and more often Asian. There were no differences in length of narrative (i.e., word count) across patient characteristics within the CHPI data, but within the MHQP data, younger adults and women gave longer responses. Responses were largely positive and correlated with responses to the close-ended items.

CONCLUSIONS

The results of this pilot indicate that new and more innovative approaches to surveying are evolving and promising for our efforts to reduce survey costs and burden. A move in this direction will help make high value performance information available to the public. Along with the promise of new approaches, we encountered the reality of the current state of patient information systems and the limited experience many physician organizations have in engaging their patients in new ways. We found that full implementation of the email modes of survey is hindered by the lack of systematic collection, verification, and maintenance of patient emails. Email surveying is currently not a viable survey option by itself. However, the results in both states, including a response rate of almost 40% for phone responses to the PAS long form survey in California, suggest that multi-mode surveys that reach patients in numerous ways are the best option. Indeed, multi-mode surveys must be fielded to achieve results that are reliable enough for high stakes use. We do believe that if systematic collection of patient contact information is widely adopted, and the concerns about privacy protection are addressed for patients and providers, the ability to survey through electronic modes can improve substantially.

With the constraints noted, the generally positive results we achieved in testing our hypotheses through this pilot are strengthened by the fact that overall, similar results were found in two regions with significantly different health systems and patient characteristics. Contrary to prevailing wisdom, the Massachusetts response rates were better for a short form survey than they were for the longer 61-question survey, and California might have had higher response rates had the fielding period been longer. In addition, the short form survey instrument appears to be a viable alternative to longer form surveys with the finding that relative scores for doctors, practices, and groups to the same question are generally comparable for the short form based on convergence statistics with case mix control. Further, response to the email short form survey produced results that are comparable to long form surveys.

It will be important for organizations that are considering whether to use a short form to understand that the composite scores from the current long form and the new short form may or may not rank providers, practices or groups similarly depending on the items included in the composites. In this study, we were not able to test our composites to determine if they score and rank providers the same. However, as the items that comprise the composites rank providers the same, the new short form composite rankings will be valid. If results for some composites are used for high stakes purposes, it would be prudent to do one of the following:

- Keep the composites construction stable until other changes are made to the instrument;
- Remove items that are not in the short form composites from the previous year's long form survey composites and run an analysis to see if the composite results, now having identical items, are comparable (note that these should be comparable since the items from both years are convergent);
- Or complete a small pilot project using the old and new composites so that adjustments can be made if needed.

Our detailed analysis of adjusted results found small differences in responses by survey approach (long form vs. short form and email vs. mail) and response mode (mail vs. online) that can be adjusted for in CA and MA for provider organizations that might be sensitive to small changes as they relate to financial incentives. Other markets can use the same adjustments noted in this report as they are likely to follow the same pattern as in CA and MA. However, if stakes are sufficiently high in a given market, a small test with 2500 respondents using the new survey prospectively (to compare with a large fielding of the old survey) or the old survey restrospectively (to compare with a large fielding of the new shorter survey) would be suggested so that local adjustment factors can be determined.

With our short form pilot and the release of CG-CAHPS 3.0, we are headed toward broader use of shorter surveys that will be less expensive to mail and less burdensome to patients. If these shorter surveys are fielded with a scientific sampling frame and a full multi-modal survey approach including email, they will yield comparable information to current surveys with better response rates. Altogether, these steps should increase confidence in the ability to achieve reliable results at a lower price.

Finally given the numerous avenues consumers have to comment on a variety of products and services they receive, including health care services, it is important that a systematic way to elicit and analyze such comments be designed. The development of nationally recognized protocols for collecting and reporting narratives is necessary to increase provider acceptance and the likelihood of effective quality improvement efforts. The public reporting of such comments on health care quality websites has the potential to help consumers make more informed choices and increase their interest in engaging with their providers in conversations about care. The work we have done in this pilot is a first step in the direction of systematic collection and reporting. We hope to continue this work and advance the field further in the coming months and years.