Barriers to Safety-net Transparency with Providers about Patient Experiences in Healthcare

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Introduction

Due to rising healthcare costs and differential quality of care, major health insurers in the U.S. such as the Centers for Medicare and Medicaid Services (CMS) invested in performance measurement to assess healthcare quality provided by health plans and healthcare delivery systems (health plans/delivery systems). Historically, the poorest quality of care is linked to indigent communities from vulnerable sectors of society (the elderly, poor, homeless, immigrants, refugees and race/ethnic minorities). These communities have the highest prevalence of chronic diseases, relatively poor health, and depend on safety-net healthcare delivery systems such as Federally Qualified Health Centers and municipal public hospitals for their care.

A key underpinning of assessing healthcare quality is the standardization of performance measurement. This was spearheaded by the Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys. Sponsored by the Agency for Healthcare & Research Quality (AHRQ) in 1995 CAHPS surveys were designed and developed to assess various aspects of healthcare quality from the patient's perspective. For example, CAHPS surveys have been developed to assess patient experiences with outpatient care (e.g., health plan, physician group, and individual physicians) and health care systems (e.g., hospitals, nursing homes, and dialysis centers). Importantly, CAHPS surveys compliment measures of technical care quality by generating information about aspects of care quality for which patients are the best or only source. CAHPS surveys are used by over 90% of health plan/delivery systems.

How Do CAHPS Surveys Measure Patient Experiences with Healthcare?

Contrary to widespread belief CAHPS surveys do not measure patient satisfaction with healthcare. Rather, when a patient completes a CAHPS survey they are reporting and rating their healthcare experiences. To ensure that patient experience is actionable for health care providers and meaningful to consumers and patients, CAHPS surveys ask about specific care experiences, such as whether nurses and doctors listened carefully, test results were discussed, appointments were timely, and the degree to which care is respectful and responsive to patient needs (Martino et al, 2016).

All CAHPS surveys are developed by rigorous processes that include stakeholder input, focus groups, cognitive interviews, and field testing of draft surveys with patients. Survey content and procedures on how to implement a study are designed to allow comparisons across a range of patients; privately insured, fee-for-service, managed care organizations, and publically insured (Medicaid, Child Health Insurance Programs and Medicare).

How Are CAHPS Scores Used to Improve Quality of Care?

CAHPS data are translated into quality of care scores that can guide changes to institutional and practice behaviors that influence healthcare quality. There is growing evidence that health care providers are responsive to publicly reported information about patient experiences with their care using CAHPS surveys and as a result patient experiences are improving. Moreover, better patient care experiences are associated with higher levels of adherence to recommended prevention and treatment processes and better clinical outcomes. (Rodriguez, von Glahn, Elliott, Rogers, & Safran, 2009).

In addition to guiding individual plan/delivery systems quality of care improvement, CAHPS scores permit comparative performance ratings (CPR) across plans/delivery systems. These comparisons are publicized to lend transparency to plans/delivery systems care quality and promote informed decision-making by policy makers, health plan purchasers, and consumers about which plans/delivery systems best meet their administrative, budgetary, and healthcare needs. CMS requires

all health plans/delivery systems they remunerate for health care services to provide annual reports based on CAHPS survey data. In addition, they are required to submit their data to the Agency for Healthcare Research Quality (AHRQ) for inclusion in its database for secondary data analysis and public reporting.

Publicly reporting patient experiences with their healthcare has been demonstrated to promote policy and management decisions that improve patient experiences with care. For example, in California patient experiences with their physicians significantly improved following statewide measurement and public reporting of the quality of care provided by plans/delivery systems. Along with other measures of healthcare quality these outcomes were tied to information about patient experiences with healthcare measured by CAHPS. Moreover, CAHPS scores are used by healthcare insurers to determine health services remuneration (i.e., CMS) and quality of care oversight agencies (i.e., National Committee on Quality Assurance-NCQA) to establish benchmarks and assess compliance with accreditation standards.

Are CAHPS Surveys Useful for Healthcare Safety Nets?

Patient reports and ratings of their healthcare experiences are useful for assessing any plan/delivery system's quality of care. This is especially important for safety-nets serving fast growing and indigent race/ethnic minority communities that comprise a significant proportion of the U.S. general population This population has recently gained significantly greater access to publically funded health care insurance (Medicaid, CHIP).

The Robert Woods Johnson Foundation reported that more than 19 million people < 65 years of age gained health insurance between 2010 and 2015, spurred by ratification of the Affordable Care Act of 2012. Among these 6.2 million (32%) were Hispanic and 2.8 million (15%) were non-Hispanic black representing a percent change of uninsured for these populations of -37% and -45%, respectively. Of

note is that 87% of adults gaining coverage between 2010 and 2015 had less than college level education. Of these 6.2 million were non-Hispanic white and 7.9 million were nonwhite or Hispanic.

As such healthcare safety-nets, the main source of care for indigent race/ethnic minorities, must prepare for a surge of new patients. Moreover, this necessarily broadens the scope of performance measurement since more than ever the diverse socio-cultural and socio-cognitive characteristics of these sub-populations must be considered to be able to improve their experiences with care. However, survey non-response is a serious concern in use of surveys by healthcare safety-nets serving race/ethnic minority communities and transparency with providers.

Lack of Data from CAHPS Surveys a Barrier to Safety-net Quality of Care Assessment

Response rates to surveys in indigent communities served by healthcare safety-nets tend to be low. This has limited the robustness of data collected by healthcare safety-nets using CAHPS surveys. Since the time when CAHPS was inaugurated, survey response rates have declined. At its inception the CAHPS Medicare survey enjoyed a response rate of about 75% but they have fallen by about 30 percentage points. Of importance and concern are particularly low response rates to CAHPS surveys by Latino communities.

Latinos response rates of 30% (CAHPS Medicaid), 36% (CAHPS PPO Commercial) and 39% (CAHPS non-PPO) were reported in 2011 by the Myers Group; a prominent CAHPS vendor. A steep decline is evidenced by the 11% response rate to the CAHPS Clinician and Groups Survey 3.0 (CG CAHPS 3.0) in 2016 for a large safety-net plan/delivery system in Los Angeles County that has a patient population comprised of 80% Latinos (Personal Communication: A. Chen, September 1, 2017). The significance of non-response to CAHPS surveys was underscored when the NCQA concluded that the 38% response rate by Latinos to the 2015 CAHPS 5.0 H Medicaid Child survey was insufficient to conduct meaningful statistical testing. It may be concluded that healthcare policy and management decisions relevant to improving healthcare quality for Latinos is not sufficiently informed by Latino experiences

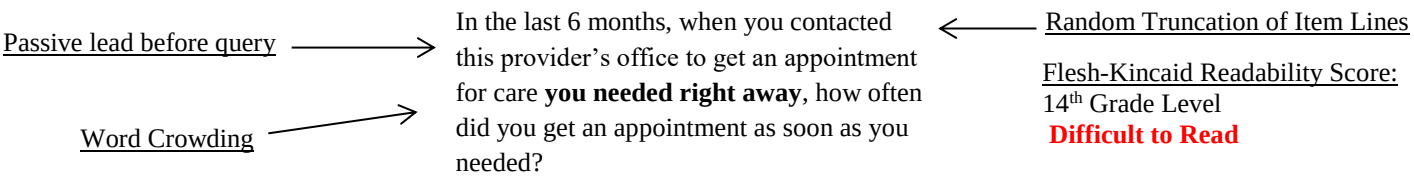
with healthcare and that may be the case for other indigent communities served by healthcare safety-nets.

Furthermore, this intimates that the reasons for non-response may be related to the cultural and/or linguistic appropriateness of the CAHPS survey's design (e.g., legibility, wording, readability, language) for indigent communities that tend to be limited in educational attainment and literacy skills, harbor ethno-medical beliefs and have poor health literacy. Without a closer examination of these factors, healthcare safety-nets cannot adequately measure experiences with healthcare for a significant proportion of their patients and consequently would lack the ability to be transparent with their providers about performance measurement based on patient experiences.

How will Patient Experiences with Safety Net Care Be Measured in Indigent Communities?

In response to lower than desirable survey response rates, the CAHPS team critically evaluated CAHPS survey visual display (i.e., consistency and legibility) and cognitive design (i.e., word choices and readability). It found inconsistent item wording, poor legibility, random truncation of item sentences to fit a column format, and Flesch-Kincaid readability scores for most items that require college and graduate school level reading skills to comprehend. This is demonstated below by Item #6 of the CG CAHPS 3.0 survey below:

CG CAHPS 3.0 Item #6



These findings are consistent with a significant chasm between the socio-cognitive attributes of indigent communities and the cognitive demand of completing CAHPS surveys. Based on this information, the CAHPS team developed an easy-to-complete version of CG CAHPS 3.0. These CAHPS-E

versions use plain language principles mandated by CMS to create text that is understood by the general public. To lend objectivity to the process the CAHPS-E team developed two new methods based on the rules of grammar and the rules of poetry; **Grammatic Parsing and Stanzaic Versification**, respectively.

We coined the term *grammatic parsing* to describe the new method to differentiate it from the term '*parsing*' in the computer sciences. Based on a 19th century approach to teaching grammar, grammatic parsing is not unlike dismantling a large brick house (complex sentence) into its component bricks (grammatical components) then restructuring the bricks into several smaller units (simple sentences) that accommodate the same number of residents (retains meaning). Application of this method results in simple sentences conveying one idea. Occasionally, a complex item must be parsed into more than one item comprised of simple sentences.

Stanzaic versification is then applied to grammatically parsed survey items. Survey items comprised of simple sentences are divided into 2 or 3 shorter lines to create a survey stanza akin to stanzas in poetry. Each line of the survey stanza, usually a phrase or clause, represents a single idea. Unlike the unsystematic tru How often do you get care as soon as you needed? ext wrapping from word processing programs, in Stanzaic Versification line breaks are designed to represent a single idea that flows with minimal interruption into the next line to complete a thought. The resulting CAHPS-E survey consists of easy to read items as demonstrated by revision of CG CAHPS 3.0 item #6 (above) to the CG CAHPS-E 3.0 version (below).

CG CAHPS-E 3.0 Item #6

How often did you get care
as soon as you needed?

Stanzaic Versification of Item Lines

Flesh-Kincaid Readability Score:
3rd Grade Level
Very Easy to Read

We are preparing to test the efficacy of CAHPS-E at improving survey response rates among indigent communities served by healthcare safety nets. We hypothesized that this new approach will improve response rates, yield high quality data and foment a movement whereby healthcare safety nets may be

transparent with providers about patient experiences with care and in doing so contribute to improving the quality of care they receive.

Suggested Resources

Bowan G, Gangopadhyaya A. Who Gained Coverage under the ACA, and where do they Live? (2016) ACA Implementation, Monitoring and Tracking. Robert Wood Johnson Foundation https://www.urban.org/sites/default/files/publication/86761/2001041-who-gained-health-insurance-coverage-under-the-aca-and-where-do-they-live.pdf

Martino SC, Elliot MN, Hambarsoomian K, Weech-Maldonado R, Gaillot S, Haffer SC, Hays RD. Racial/Ethnic Disparities in Medicare Beneficiaries' Care Coordination Experiences Med Care 2016;54(8): 765-71

CAHPS Clinician and Group Survey Item Before and After Revision to CAHPS-E version

Using Grammatic Parsing, Plain Language Principals & Stanzaic Versification

CG CAHPS 3.0 Item #6

- Very complex sentence with 6 ideas
- Time frame, statement and question in same sentence
- Word crowding
- Font: Times New Roman

In the last 6 months, when you contacted this provider's office to get an appointment for care **you needed right away**, how often did you get an appointment as soon as you needed?

- Random truncation of sentence into lines
- Flesch-Kincaid Readability Score: 14th grade level
- Very difficult to read

CG CAHPS-E 3.0 Item #6

- Simple sentence with 2 ideas
- Time frame listed on top of survey column
- Unneeded statement removed
- Font: Garamond

How often did you get care as soon as you needed?

- Stanzaic Versification of lines
- Flesch-Kincaid Readability Score: 3rd grade level
- Very Easy to Read

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