Patient Experience of Care is an Indicator of Quality of Care

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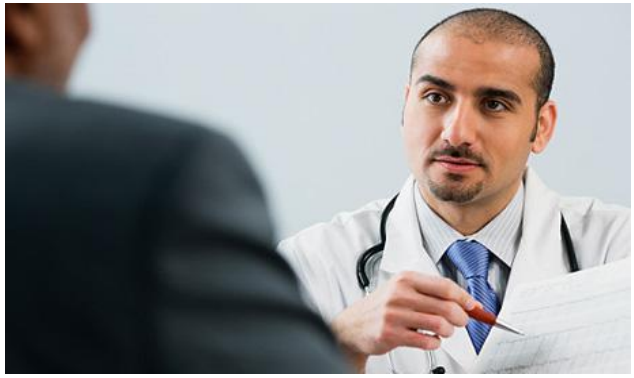
September 26, 2016 (12:00-1:30pm)

University of New Mexico

Department of Internal Medicine

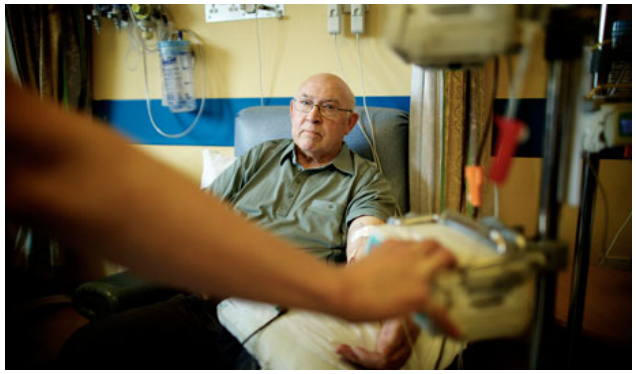
Division of Nephrology

We Measure Quality of Care to Improve It



Providers → **Find out how well they are doing**

Government/ Private Insurers → **Identify best/worst healthcare providers**



Patients → **Choose best health care for themselves**

How Do We Measure Quality of Care?

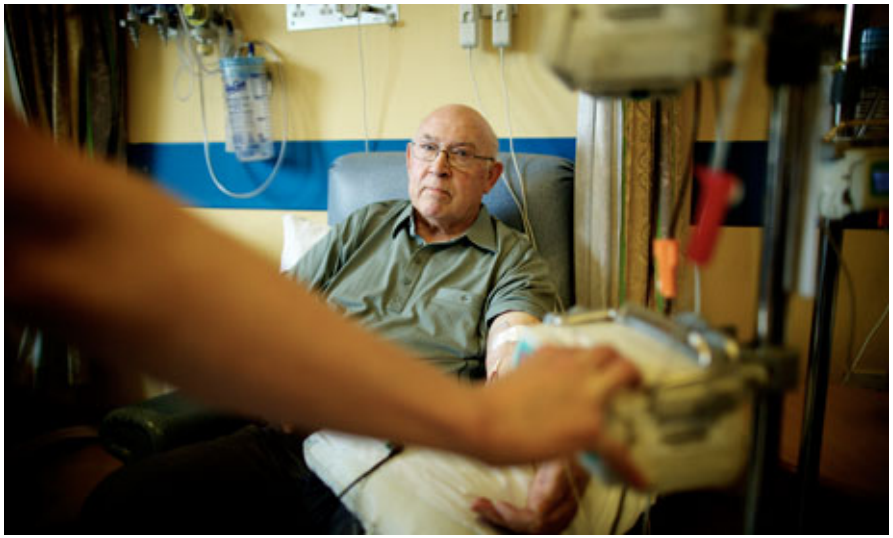
- Focus has been on expert consensus about clinical process.
- Variant of RAND Delphi Method

- **If diabetic, bare feet should be examined at least once every 15 months.**
  - **American Diabetes Association (1998)**

How Do We Measure Quality of Care?

- Focus has been on expert consensus about clinical process; variant of RAND Delphi Method
  - e.g., If diabetic, bare feet should be examined at least once every 15-months

- **But how patients perceive their care also important**
- **CAHPS® project measures patient experiences.**



Cavanaugh, 2016, Patient experience assessment is a requisite for quality evaluation: A discussion of the In-Center Hemodialysis CAHPS survey. Seminars in Dialysis.

Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Approach

Complements information from clinical process measures

- Focus on what patients want to know about AND can accurately report about
  - Communication with health care provider
  - Access to care
  - Office staff courtesy and respect
  - Customer service

Quality of Care Indicators

- Process of care
  - Clinical indicators (expert consensus)
  - Patient reports (CAHPS®, 1995)
- Health
  - Clinical indicators
  - Patient reports (PROMIS®, 2004)

Rather than Assessing Patient Satisfaction, CAHPS Relies on Reports About Care

19. In the last 12 months, how often did this provider explain things in a way that was easy to understand?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

- Doctor Communication (4 items)
  - How often did your personal doctor explain things in a way that was easy to understand?
  - How often did your personal doctor listen carefully to you?
  - How often did your personal doctor show respect for what you had to say?
  - How often did your personal doctor spend enough time with you?
- Access to care (6 items)
  - When you needed care right away, how often did you get care as soon as you thought you needed?
  - Not counting times you needed health care right away, how often did you get an appointment for your health care at a doctor's office or clinic as soon as you thought you needed?
  - How often did you see the person you came to see within 15 min of your appointment time?
  - How often was it easy to get appointments with specialists?
  - How often was it easy to get the care, tests, or treatment you thought you needed through your health plan?
  - How often was it easy to use your prescription drug plan to get the medicines your doctors prescribed?
- Health plan customer service (2 items)
  - How often did your health plan's customer service give you the information or help you needed?
  - How often did your plan's customer service staff treat you with courtesy and respect?

In-Center Hemodialysis Items

Nephrologists' Communication and Caring

#	Composite	Response Categories
Q3.	For the questions that follow, your kidney doctors means the doctor or doctors most involved in your dialysis care now. This could include kidney doctors that you see inside and outside the center. In the last 3 months, how often did your kidney doctors listen carefully to you?	Never, Sometimes, Usually, Always
Q4.	In the last 3 months, how often did your kidney doctors explain things in a way that was easy for you to understand?	Never, Sometimes, Usually, Always
Q5.	In the last 3 months, how often did your kidney doctors show respect for what you had to say?	Never, Sometimes, Usually, Always
Q6.	In the last 3 months, how often did your kidney doctors spend enough time with you?	Never, Sometimes, Usually, Always
Q7.	In the last 3 months, how often did you feel your kidney doctors really cared about you as a person?	Never, Sometimes, Usually, Always
Q9.	Do your kidney doctors seem informed and up-to-date about the health care you receive from other doctors?	Yes, No

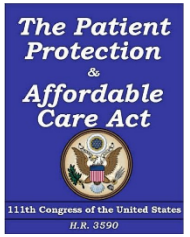
CAHPS Survey Implementation

- Develop surveys
  - Stakeholder input
- Train and oversee survey vendors
- Analyze and report plan-level data
  - Casemix adjustment
- Report to plans/providers for quality improvement

Public reporting of CAHPS Data

- Centers for Medicare & Medicaid Services (CMS) reports MCAHPS data by plan and state
  - Mails booklets
  - Online tool
- Helps beneficiaries choose coverage
- Makes plan performance transparent

CAHPS Tipping Point was its Widespread Adoption



. . . and its link to payment through ACA

Use of and importance of patient experience surveys has grown…

CAHPS Hospital Survey (HCAHPS) data accounted for 30% of hospitals' Total Performance Score in Value-Based Purchasing Program in FY2014

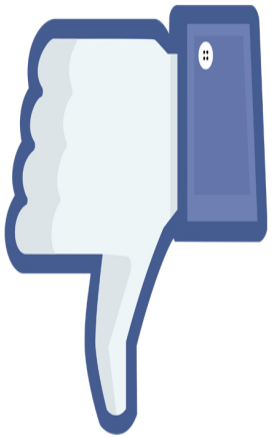
…greater scrutiny

Use of and importance of patient experience surveys has grown…

CAHPS Hospital Survey (HCAHPS) data accounted for 30% of hospitals' Total Performance Score in Value-Based Purchasing Program in FY2014

…greater scrutiny

..and more misinformation



Requiring CAHPS Team Response

Price, R. A. et al. (2014). Examining the role of patient experience surveys in measuring health care quality. Medical Care Research and Review, 71, 522-554.

Price, R. A. et al. (2015). Should health care providers be accountable for patients' care experiences? JGIM, 30, 253-256.

Xu, X., et al. (2014). Methodological considerations when studying the association between patient-reported care experiences and mortality. Health Services Research. 50(4), 1146-61.

Patient surveys are subjective and do not provide valid information

- Patient reports are "subjective" and providers have concerns about their scientific properties (Boyce et al., 2014, Implementation Science)

- Patient reports are as reliable (and valid) as clinical measures
  - Hahn, E. A. et al., (2007). Precision of health-related quality of life data compared with other clinical measures. Mayo Clinic Proceedings, 82 (10), 1244-1254.

Patient Reports are Weakly Related to Clinical Indicators

Patient Reports are Weakly Related to Clinical Indicators

- **Systematic review (55 studies)**
- **Wide range of disease areas, setting, designs, and outcome measures**

Consistent Positive Associations

- **Patient experience**
- **Patient safety**
- **Clinical effectiveness**

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Consistent Positive Associations

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- **Patient safety**
- **Clinical effectiveness**

Kemp, K. A., Santana, M. J., Southern, D. A., McCormack, B., & Quan, H. (2016). Association of inpatient hospital experience with patient safety indicators: A cross-sectional Canadian study. BMJ Open, 2016;6: e011242

Patient Reports are not actionable

- Patient surveys assess what is important to patients.
  - Patients want and need to know this information when choosing among providers.
- Patient reports used in quality improvement
  - Improves communication between patients and providers.

Patient-reported data cannot be fairly compared across providers

- My patients are different (e.g., sicker) than patients of other providers
- Patient reports are determined by factors outside the control of the provider

  -> Patient characteristics that are systematically related to patient reports and not indicative of care quality included in casemix adjustment.

  e.g., older age, lower education, better self-rated health

Because of low response rates, survey respondents are unrepresentative

- Maximize participation rates.
- Survey nonresponse does not necessarily lead to bias in comparisons.
- Casemix adjustment can compensate for nonresponse bias.

Collecting patient experience data is too burdensome and expensive

- Connie Anderson from Northwest Kidney Centers spoke in opposition to KDQOL-36 due to burden, saying I-CAHPS was more important on NQF renal committee call Friday.
- Patients are more burdened by invasive medical tests than responding to surveys.
- Survey data collection is not free but newer technologies can reduce costs.

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Bioethicists say patient-satisfaction surveys could lead to bad medicine

By Sabriya Rice | June 4, 2015

A new report by the Hastings Center suggests patient-satisfaction surveys that Medicare uses to assess healthcare providers are seriously flawed. The authors question whether the government should be relying on them in quality initiatives such as value-based purchasing.

"Good ratings depend more on manipulable patient perceptions than on good medicine," states the report, entitled Patient-Satisfaction Survey on a Scale of 0 to 10. "In fact, the pressure to get good ratings can lead to bad medicine.

The healthcare industry remains under pressure to boost transparency and

Providers motivated to fulfill patient desires, regardless of appropriateness

- "Pressure to get good ratings can lead to bad medicine."
  - Dr. Stuart Younger, Professor of Bioethics and Psychiatry at the Case Western Reserve University (Hastings Center Report)

Providers motivated to fulfill patient desires, regardless of appropriateness?

- Higher intensity care is not related to better outcomes

- Good communication is important in addressing unreasonable expectations

"Patient satisfaction can be maintained in the absence of request fulfillment if physicians address patient concerns in a patient-centered way." (Fenton et al. 2012)

Podcast Addressing Concerns about CAHPS Surveys

Can patients really report on the quality of the care they receive?

Do patients' expectations affect how they respond to CAHPS survey questions about their providers?

Is there a tradeoff between positive patient experiences and favorable clinical outcomes?

To help users of CAHPS surveys address these and other questions, the Agency for Healthcare Research and Quality (AHRQ) released a podcast: "CAHPS Surveys: Sorting Fact From Fiction," featuring Rebecca Anhang Price, PhD.

Listen to this podcast:
https://cahps.ahrq.gov/news-and-events/podcasts/cahps-surveys-podcast.html

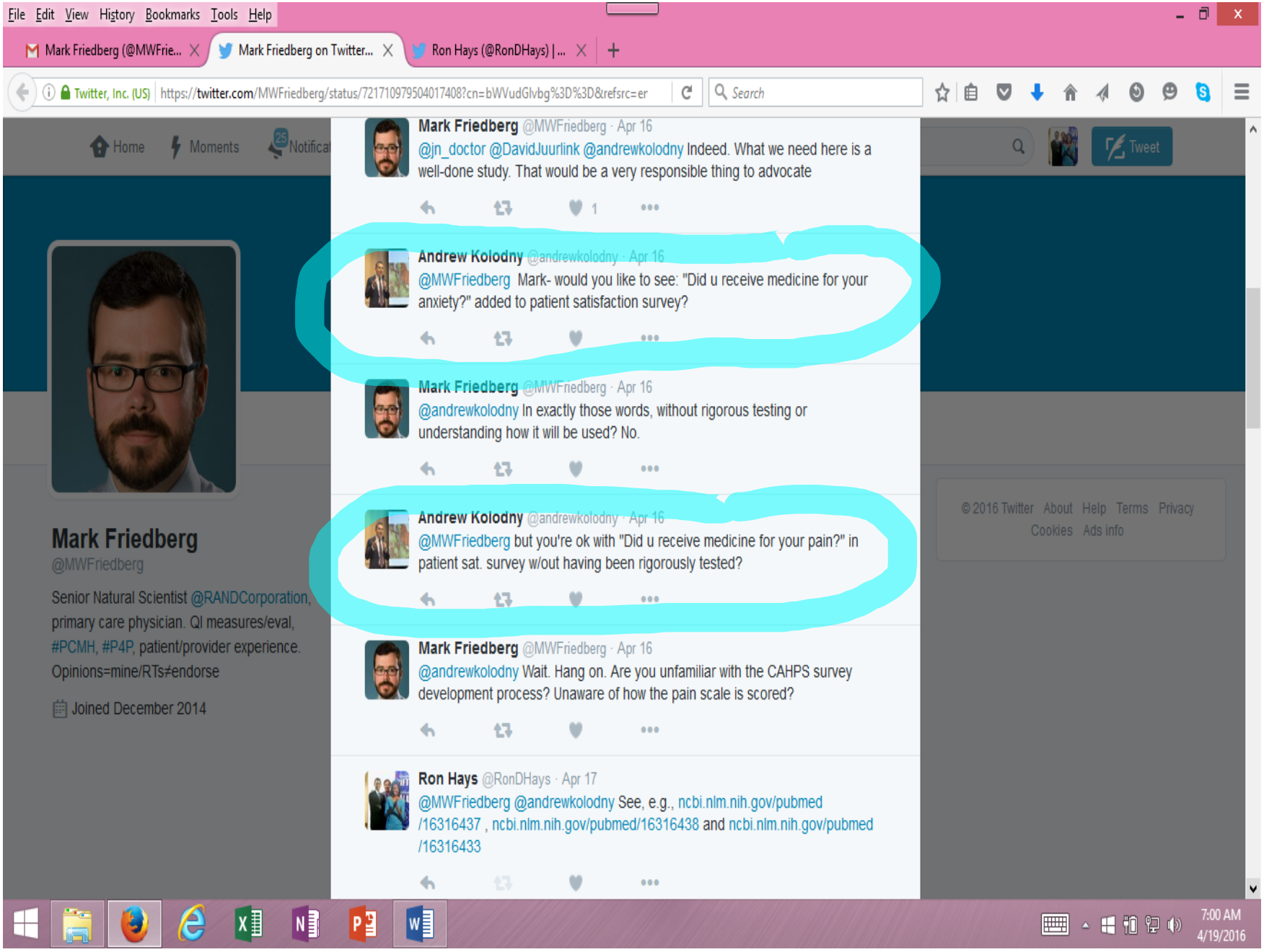
HCAHPS Survey, Pain Management, and Opioid Misuse: The CMS Perspective

Clarifying Facts, Myths, and Approaches

CMS believes that effective communication with patients about pain and treatment, including options other than prescription medicine when appropriate, is the preferred way to improve patient experience of care.

In the process of developing the HCAHPS Survey, we did not find that experience with pain dominated patients' overall assessment of the hospital experience.

http://www.qualityreportingcenter.com/wp-content/uploads/2016/02/IQR_20160126_QATranscript_vFINAL508.pdf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Ron Hays @RonDHays · Apr 17
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Some suggest patients can be "satisfied" to death.

http://www.ucdmc.ucdavis.edu/publish/news/newsroom/6223 — joshua fenton patient satisfacti... — Patient satisfaction linked t...

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Latest

Health System > Newsroom > Patient satisfaction linked to higher health-care expenses and ...

NEWS | February 13, 2012

Patient satisfaction linked to higher health-care expenses and mortality

Doctors may agree to patient requests for services to increase patient satisfaction

Editor's note: Read this press release [en español]

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(SACRAMENTO, Calif.) — A team of UC Davis researchers found that people who are the most satisfied with their doctors are more likely to be hospitalized, accumulate more health-care and drug expenditures, and have higher death rates than patients who are less satisfied with their care.

Published today in the *Archives of Internal Medicine*, the national study is believed to be the first to suggest that an overemphasis on patient satisfaction could have unanticipated adverse effects.

"Patient satisfaction is a widely emphasized indicator of health-care quality, but our study calls into question whether increased patient satisfaction, as currently measured and used, is a wise goal in and of itself," said Joshua Fenton, assistant professor in the UC Davis Department of Family and Community Medicine and lead author of the study.

Media contact(s)

Karen Finney
Send e-mail
Phone: 916-734-9064

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- Darrell Steinberg joins UC Davis Behavioral Health Center of Excellence
- UC Davis Children's Hospital listed in the nation's Best Children's

Fenton et al. (2012) Archives of Internal Medicine

- 2000-2005 Medical Expenditure Panel Survey cohorts
  - Nationally representative survey of U.S. civilian non-institutionalized population. Panels followed over 2 calendar years with 5 rounds of interviews (baseline, 6 months, 12 months, 18 months, 24 months).
  - n = 34,180
- Four CAHPS communication (last 12 months) and 0-10 rating of health care item from round 2 (round 4 not used)
  - Quartile from average of standardized scores for 5 items
- Results interpreted as indicating that acceding to patient demands results in expensive and dangerous treatment.

Five Concerns with Fenton et al.

1. Unmeasured variables. Adjusted for age, gender, race/ethnicity, education, income, metropolitan statistical area, census region, access to usual source of care, insurance coverage, smoking, number of chronic conditions, self-rated general health, SF-12 PCS and MCS, number of prescription meds, medical care expenditures, number of office visits, any ER visits, any inpatient admissions, and MEPS cohort … but associations still may be due to unmeasured variables (e.g., severity of illness).

   - Sicker patients may need more information and clinicians may spend more time with them.

2. Estimated effect was implausibly large, suggesting good patient experience is more dangerous than having major chronic conditions.

Is Receiving Better Technical Quality of Care Bad for Health?

Change in SF-12 PCS regressed on process of care aggregate

Hypothesized positive effect, but regression coefficient was NOT SIGNIFICANT

unstandardized beta = -1.41, p =.188

Kahn et al. (2007), Health Services Research, Article of Year

Five Concerns with Fenton et al.

3. Only amenable deaths can be prevented by health care.

- Prognosis for those with end-stage pancreatic cancer is not modifiable by the type of care they receive.
- Only 21% of the 1,287 deaths in the study were amenable to health care.
  - Nolte, E. and C. M. McKee. 2008. Measuring the health of nations: updating an earlier analysis. *Health Aff (Millwood)* 27(1): 58-71.

4. Patient experiences with care vary over time.

- Used CAHPS data at MEPS round 2 to predict mortality 3 months to 6 years later.
- > half of deaths occurred more than 2 years later.
- Among those with best (quartile 4) experiences at round 2, > half had worse experiences 1 year later

5. Only looked at 5-item CAHPS aggregate

Reanalysis of Fenton et al. (Xu et al., 2014)

- Same data used by Fenton et al.
  (Note: Fenton would not share his computer code with us.)
  - 2000-2005 Medical Expenditure Panel Survey data
  - National Health Interview Survey and National Death Index
- Same statistical analysis
  - Cox proportional hazards models with mortality as the dependent variable and patient experience measures as independent variables
- But, unlike Fenton et al.
  - Separated non-amenable and amenable deaths
  - Considered consistency of patient experience and death
  - Looked at individual items to better understand the patient experience with mortality association

Patient Experiences and Mortality: *Non-Amenable vs. Amenable Deaths*

Patient Care Experience	Non-Amenable Mortality		Amenable Mortality	
	Hazard Ratio	p-value	Hazard Ratio	p-value
Quartile 1 (reference)	(1.00)		(1.00)	
Quartile 2	1.07	0.56	1.27	0.25
Quartile 3	0.96	0.70	1.28	0.25
Quartile 4 (most positive)	1.26	0.03	1.23	0.32
Overall p-value for patient care experience quartiles		0.03		0.59

Adjusted for age, gender, race/ethnicity, education, income, metropolitan statistical area, census region, access to usual source of care, insurance coverage, smoking status, number of chronic conditions, self-rated overall health, SF-12 PCS/MCS, number of drug prescriptions, medical care expenditures, number of office visits, any ER visits, any inpatient admissions, and MEPS cohort.

Patient Experiences and Mortality: *Consistency of Experiences Over Time*

Patient Care Experience (baseline : 1 year later)	All-Cause Mortality	
	Hazard Ratio	p-value
Quartile 1 : Quartile 1 (reference)	(1.00)	
Quartile 2 : Quartile 2	0.89	0.42
Quartile 3 : Quartile 3	1.13	0.57
Quartile 4 : Quartile 4	1.09	0.54
Different quartiles at baseline and 1 year later	0.88	0.35

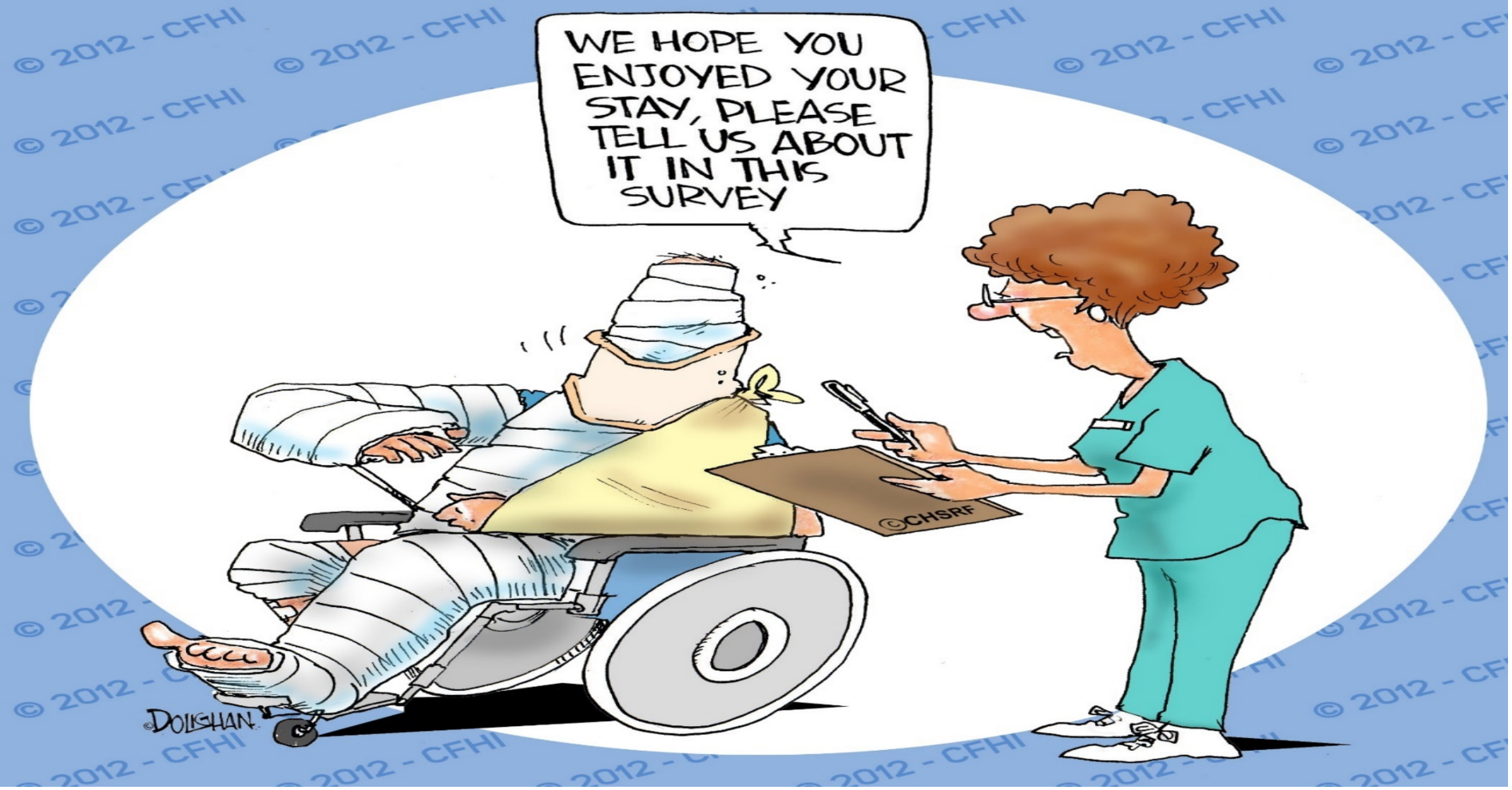
Patient Experiences and Mortality: *Significant for Only One Item*

Patient Care Experience Items	All-Cause Mortality	
	Hazard Ratio	p-value
Rating of healthcare 9-10 vs 0-8	1.10	0.15
Listen carefully to you †	0.98	0.76
Show respect for what you had to say †	1.05	0.44
Explain things in a way that is easy to understand †	1.09	0.17
Spend enough time with you †	1.17	0.03

† "Always" versus "Never"/"Sometimes"/"Usually"

Fenton et al. (2012)

"Patient-centered communication requires longer visits and may be challenging for many physicians to implement."



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Powerpoint file at:
http://gim.med.ucla.edu/FacultyPages/Hays/