Studying the Doctor-Patient Relationship using Consumer Evaluations of Care

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May 3, 2007 (1-3pm) http://www.gim.med.ucla.edu/FacultyPages/Hays/

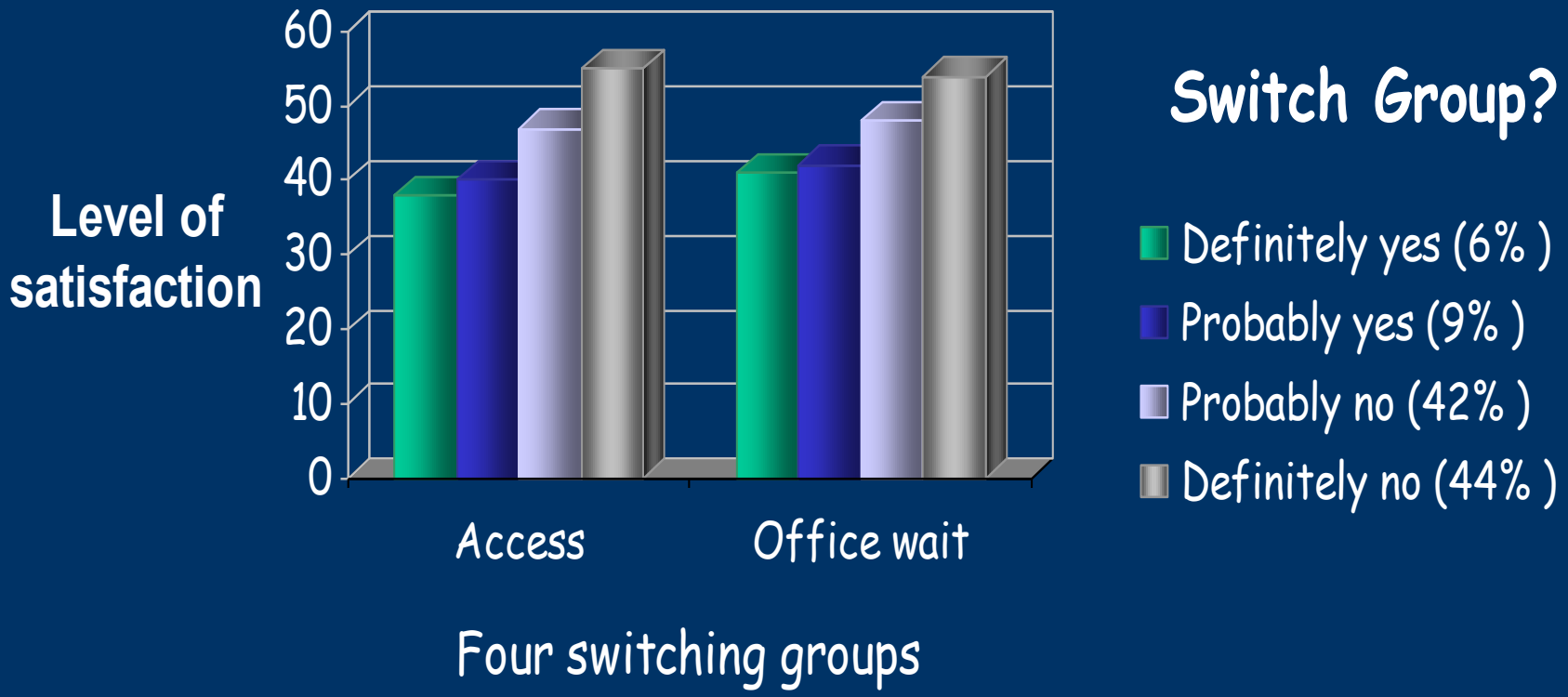
Would you put your trust in this doctor?

HS265

- Corita GRUDZEN
- Ihsanul HAQ
- Catherine RONGEY

Negative Perceptions of Access to Care and Office Wait Are Associated With Wanting to Leave Group

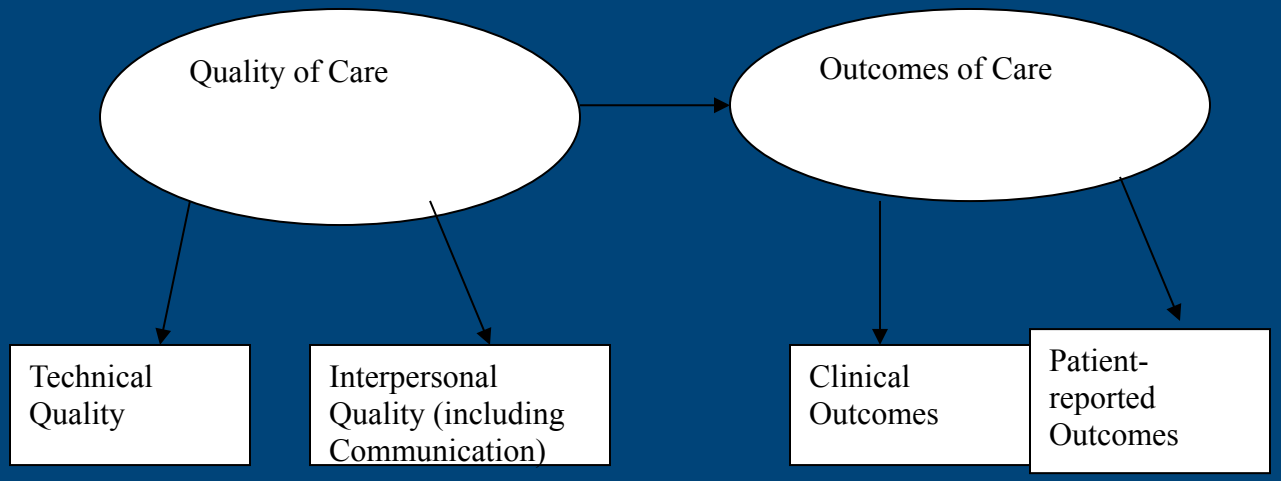
(Hays et al., Archives of Internal Medicine, 158, 785-790, 1998)



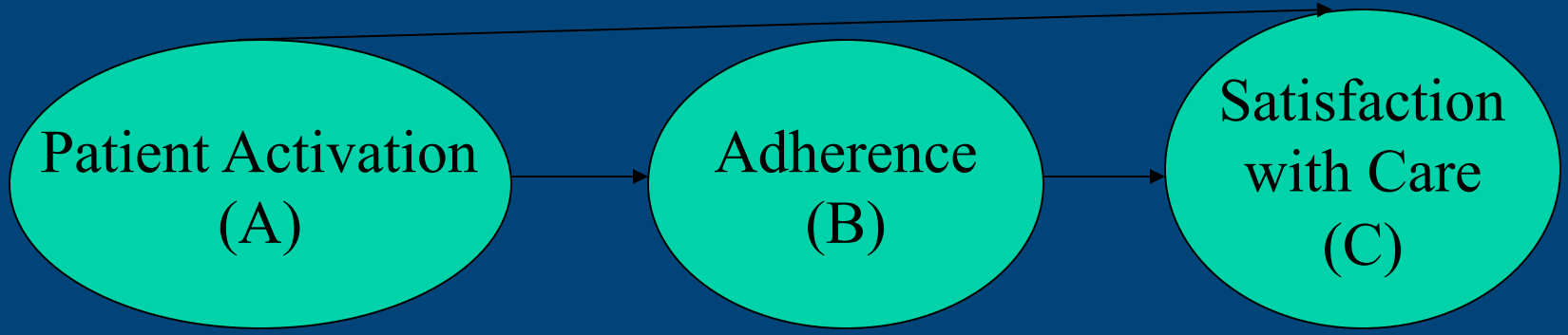
Patients Who Wanted to See a Specialist, But Did Not, were Twice as Inclined to Leave the Plan

(Kerr et al., Journal of General Internal Medicine, 14, 287-296, 1999)

Quality of Care and Outcomes of Care



Testing Mediators



Evaluation of Mediation

- Model 1: A direct effect on C
- Model 2: A direct effect on B
- Model 3: B direct effect on C*
- Model 4: In multivariate model predicting C from A and B, A direct effect on C reduced compared to Model 1

Evaluating Moderators

- Moderator = significant interaction
  - Education is a moderator of relationship between patient involvement in care and satisfaction with care if it has a positive effect for those with at least a high school degree but a non-significant effect for those without a high school degree

Making Sense of Associations

- Non-randomized study designs
  - Self-selection of treatment
- Statistical Adjustments
  - Casemix adjustment
    - Age, education, prior health, etc.
  - Propensity models
  - Instrumental variables
    - Sicker patients receive more intensive process of care.
    - Standard regression analyses show that more intensive and higher quality care is associated with worse outcomes

CAHPS®

- Consumer Assessment of Healthcare Providers and Systems
- https://www.cahps.ahrq.gov/

CAHPS® Goals

- Develop public domain consumer surveys and reports focused on the quality of health care
- Evaluate surveys and reports
- Disseminate products and support use

CAHPS® Design Principles

- Provide information consumers say they want and need to help select a health plan.
- Collect information for which the consumer is the best or only source.
- Develop core items applicable to everyone.
- Develop a smaller set of supplemental items to address needs of specific populations:
  - Medicaid, Medicare, Children

National Standard

- NCQA uses CAHPS for accreditation
- CMS uses Medicare version nationally
- Many other organizations use CAHPS
- 130 million Americans enrolled in health plans that collect CAHPS data
- Over one-half million Americans complete CAHPS surveys each year

Darby, C. et al. (2006). Consumer Assessment of Health Providers and Systems (CAHPS): evolving to meet stakeholder needs. Am J Med Qual. 21(2),144-147

CAHPS® Surveys

- Standardized survey instruments.
  - Reports about health care.
  - Ratings of health care.
- Adult and child survey versions.
- Spanish and English survey versions.
- Phone and mail modes.

https://www.cahps.ahrq.gov/CAHPSkit/files/1108_HP40_ReportingMeasures.pdf

CAHPS® 4.0 Health Plan Survey Global Rating Items

- Health care
- Personal doctor
- Specialist
- Health plan

Example of Global Rating Item

Using any number from 0 to 10 where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care in the last 12 months?

- ☐ 0 WORST HEALTH CARE POSSIBLE
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7
- ☐ 8
- ☐ 9
- ☐ 10 BEST HEALTH CARE POSSIBLE

Reports about Care (11 items)

- Getting needed care (2)
- Getting care quickly (2)
- How well doctors communicate (4)
- Health plan customer service, information, and paperwork (3)

Getting Needed Care (2 items)

In the last 12 months, how often was it easy to get appointments with specialists?

In the last 12 months, how often was it easy to get the care, tests, or treatment you thought you needed through your health plan?

Never, Sometimes, Usually, Always

Getting Care Quickly (2 items)

In the last 12 months, when you needed care right away, how often did you get care as soon as you thought you needed?

In the last 12 months, not counting the times you needed 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?

Never, Sometimes, Usually, Always

How Well Doctors Communicate (4 items)

In the last 12 months, how often did your personal doctor explain things in a way that was easy to understand?

In the last 12 months, how often did your personal doctor listen carefully to you?

In the last 12 months, how often did your personal doctor show respect for what you had to say?

In the last 12 months, how often did your personal doctor spend enough time with you?

Never, Sometimes, Usually, Always

Health Plan Customer Service, Information and Paperwork (3 items)

In the last 12 months, how often did your health plan's customer service give you the information or help you needed?

In the last 12 months, how often did your health plan's customer service staff treat you with courtesy and respect?

In the last 12 months, how often were the forms from your health plan easy to fill out?

Never, Sometimes, Usually, Always

Spheres

- Ambulatory
  - Health plan
  - Group/individual provider
- Institutional
  - Hospital, nursing home, and assisted living

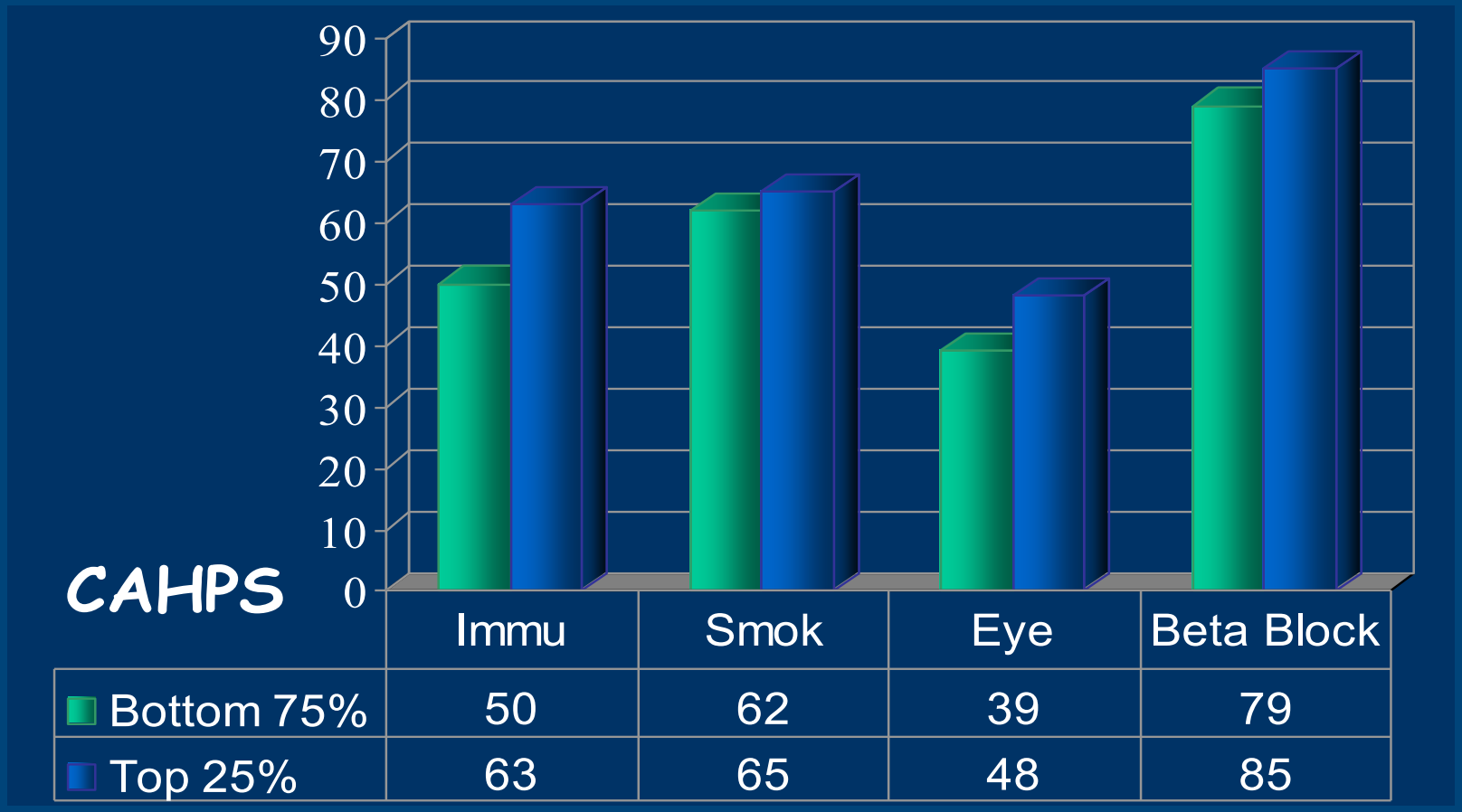
  http://www.hcahpsonline.org/
- Special populations
  - Home health, ICH
  - AI, PWMI, Chiropractic, Dental
  - Behavioral health care

  http://www.hcp.med.harvard.edu/echo/home.html

National Committee on Quality Assurance 1999 State of Managed Care Quality

- 247 managed health care organizations
- 410 health plan products (HMO and POS plans)
  - there were 650 HMOs in US (half NCQA accredited)
- 70 million Americans represented

Plans in Highest Quartile on CAHPS® Provide Better Quality of Care



National Healthcare Quality Report
National Healthcare Disparities Report

http://www.ahrq.gov/qual/nhqr06/nhqr06report.pdf

http://www.ahrq.gov/qual/nhdr06/nhdr06.htm

Table 1.4. Composite measures in the 2006 NHQR and NHDR *(new measures)(continued)*

Composite measure	Individual measures forming composite	Model
Communication with nurses in the hospital	• Nurses sometimes or never treated you with courtesy and respect • Nurses sometimes or never listened carefully to you • Nurses sometimes or never explained things in a way you could understand	CAHPS®
Communication about medications in the hospital	• Hospital staff sometimes or never told you what a new medicine was for • Hospital staff sometimes of never described possible side effects of a new medicine in a way you could understand	CAHPS®
Discharge information from the hospital	• Hospital staff talked with you about whether you would have the help you needed when you left the hospital • Hospital staff provided information in writing about what symptoms or health problems to look out for after you left the hospital	CAHPS®
Postoperative complications	• Postoperative pneumonia • Postoperative bladder infection • Postoperative blood clot	Additive
Complications of central venous catheters	• Bloodstream infection due to central venous catheter • Mechanical problem due to central venous catheter	Additive

[a] This composite measure was modified between the 2004 and 2005 reports. Starting with the 2005 composite, two tests, flu vaccination and lipid profile, were omitted due to differences in the manner in which they were collected. The current composite measure on diabetes care focuses on the receipt of three processes for which the best data are available: HbA1c testing, retinal eye examination, and foot examination in the past year. Starting in 2006, the target age group for this measure changed from age 18 and older to age 40 and older.

receipt of discha
present state of
measures which

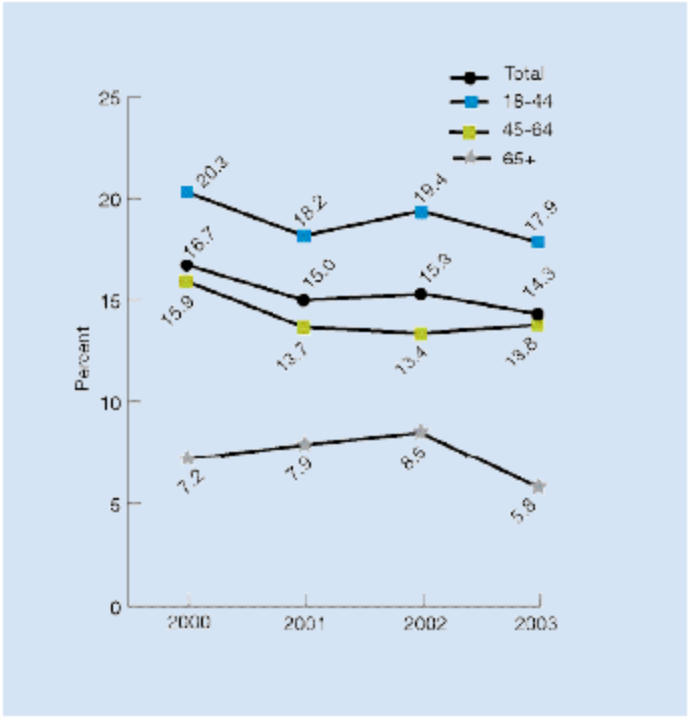
These and other
NHQR, includin
other users.

Findings

Getting Care for Illness or Injury As Soon As Wanted

A patient's primary care provider should be the point of first contact for most illnesses and injuries. The ability of patients to receive treatment for illness and injury in a timely fashion is a key element in a patient-focused health care system.

Figure 4.1. Adults age 18 and over who reported sometimes or never getting care for illness or injury as soon as wanted in the past year, by age group, 2000-2003



Source: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, 2000-2003.

Reference population: U.S. civilian noninstitutionalized population age 18 and over.

Best Health Plans 2006

In association with NCQA

GITAL VISION/GETTY IMAGES

est Health Plans 2006

s year's rankings of commercial, Medicare, d Medicaid HMOs and POS plans show eful information about most of America's ger plans as well as the majority of the tion's smaller ones.

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laking a Decision

hoosing health coverage isn't getting asier—or cheaper.

lans That Won't Report

ome insurers don't want to make their erformance data public.

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Which plans were chart-toppers in *U.S. News*'s rankings this year? Find out now.

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Proportions of Beneficiaries Reporting Major Access Difficulties Were Relatively Small and Stable

The percentage of beneficiaries who reported major difficulties accessing physician services did not vary substantially from 2000 through 2004. (See table 2.) For example, among those who needed to find a personal doctor or nurse,[34] about 7 percent of beneficiaries reported a big problem in 2000, and about 5 percent reported a big problem in 2004. Similarly, among those who needed to see a specialist,[35] the percentage of beneficiaries who reported having a big problem varied by less than 2 percentage points—from a high of 5.6 percent in 2000 to a low of 4.3 percent in 2004. Among beneficiaries who needed to schedule an appointment,[36] the percentage who reported never being able to schedule an appointment promptly remained at less than 2 percent throughout the 5-year period.

Table 2: Medicare Beneficiary Responses to Three CAHPS Survey Questions regarding Access to Physician Services, 2000-2004

CAHPS survey questions regarding access to physician services	Percentage of respondents who reported having major difficulties				
	2000	2001	2002	2003	2004
How much of a problem was it finding a personal doctor or nurse you were happy with since enrolling in Medicare?	7.1	5.6	6.0	5.8	5.3
In the last 6 months, how much of a problem was it seeing a specialist?	5.6	4.6	5.0	4.9	4.3
In the last 6 months, how often did you get an appointment promptly?	1.1	1.1	1.6	1.5	1.5

Source: GAO analysis of CMS's Medicare CAHPS surveys.

Notes: We define major difficulties as reporting "a big problem" finding a personal doctor or nurse or seeing a specialist or as reporting "never" being able to promptly schedule a health care appointment. These questions were paraphrased for the purposes of this report. The total number of individuals responding to each question varied from year to year. We reported proportions only for those beneficiaries who needed to find a personal doctor or nurse, needed to see a specialist, or needed to schedule an appointment.

Race/Ethnic Differences in Patient Evaluations of Care

- Hispanics and (especially) Asians tend to report more negative experiences with health care

- Among Hispanics and Asians, those who speak a language other than English report more negative experiences with care
  - Language effect bigger than race/ethnicity effect
  - Some variance in Spanish language effect by insurance and region of country

Race/Ethnic Differences Continued

- There are between and within plan disparities
  - Within plan differences exceed between plan differences

- Greater disparities in care are observed for reports than ratings of care

Four Main Datasets

- 1994 UMGA (n = 7,093)
  - 65% female; 93% high school grad; 10% Hispanic, 4% Asian, 3% AA
- 1998 NRC Health Care Market Guide (n = 98,204)
  - 64% female; 94% high school grad; 3% Hispanic, 1% Asian, 6% AA
- 2000 CAHPS Medicaid managed care (n = 49,327)
  - 77% female; 65% high school grad; 20% Hispanic, 5% Asian, 24% AA
- 2002 CAHPS Medicare managed care (n = 125,369)
  - 58% female; 59% high school grad; 7% Hispanic, 7% AA, 4% other race/ethnic minorities

Asians tend to have the most negative perceptions of care

- 6,911 Unified Medical Group Association patients
  - 72% of Asians vs. 55% whites believed improvement needed in obtaining treatment (Snyder et al., 2000)

- 120,855 National Research Corporation Healthcare Market Guide respondents (Haviland et al., 2003)
  - e. g., confidence in plan's doctors rated 1/3 SD less favorably

- Especially Asians who speak a language other than English

  - National CAHPS® Benchmarking Database
    - 28,354 adults and 9,540 children in Medicaid (CAHPS® 1.0)
    - 49,327 adults in Medicaid for CAHPS® 2.0
      - Less favorable reports (1/2 to 1 SD) by non-English speakers compared to whites (getting needed care, getting care quickly, communication, staff helpfulness)

Hispanics also have less positive experiences with care

- More negative perceptions of adult and children's care than non-Hispanic whites
  - 9,540 children in Medicaid for CAHPS® 1.0 (Weech-Maldonado et al., 2001)
  - 49,327 adults in Medicaid for CAHPS® 2.0 (Weech-Maldonado et al., 2003)

- Especially Spanish-language Hispanics
  - More negative perceptions of provider communication than reported by Latino/English or non-Hispanic white respondents in sample of 6,911 adults (Morales et al., 1999)

Hispanics compared to whites in Medicare managed care

- Hispanic-English reported worse experiences with care than whites for all dimensions except provider communication

- Hispanic-Spanish reported worse experiences with care than whites for several dimensions of care (including provider communication), but better perceptions of getting needed care

Hispanic-Spanish compared to Hispanic-English

	FL	Other	Versus Whites
Communication	+	---	---
Staff helpfulness	+	---	---
Getting needed care	NS	NS	+

Within plan effects account for majority of race/ethnic differences

- Vulnerable race/ethnic subgroups (e.g., African Americans, Hispanic-Spanish speakers,non-English language whites) more likely than white-English language speakers to be clustered in worse plans.

- But within plan differences by race/ethnicity exceeded between plan differences.

Weech-Maldonado et al. (2004)

Staff Helpfulness

	Between	Within	Overall
Asian/non-English	-0.64	-9.15	-10.27*
American Indian	-0.25	-3.34	-3.71*
Missing Race	-0.52	-2.85	-3.84*

Provider Communication

	Between	Within	Overall
Asian/non-English	-0.64	-6.52	-7.16*
American Indian	-0.25	-1.69	-1.93
Missing Race	-0.52	-1.59	-2.11

Differences in reports greater than for ratings

- Compared to whites, Asian adults reported worse experiences with care but similar global ratings in commercial and Medicaid plans (Morales et al., 2001)
- Worse reports of care but similar global ratings for Asian children compared to whites in Medicaid managed care (Weech-Maldonado et al., 2001)
- Correlations between global ratings and reports differed for Spanish and English language respondents to CAHPS 2.0 survey (Morales et al., 2003).

Conclusions one might draw about differences in reports about care

A) Reports about care are not psychometrically equivalent for Asians and Hispanics compared to whites

B) Care delivered to Asians and Hispanics is not as good as care for non-Hispanic whites

C) Both A & B

Assessing psychometric equivalence

- CFA supports equivalence of CAHPS® 1.0 data for Hispanics and non-Hispanic whites (Marshall et al., 2001)
- Similar reliability and construct validity for English and Spanish language respondents to CAHPS® 2.0 survey (Morales et al., 2003)
- 2 of 9 rating items displayed DIF between Hispanics and non-Hispanic whites (Morales et al., 2000).

If reports about care are not psychometrically equivalent:

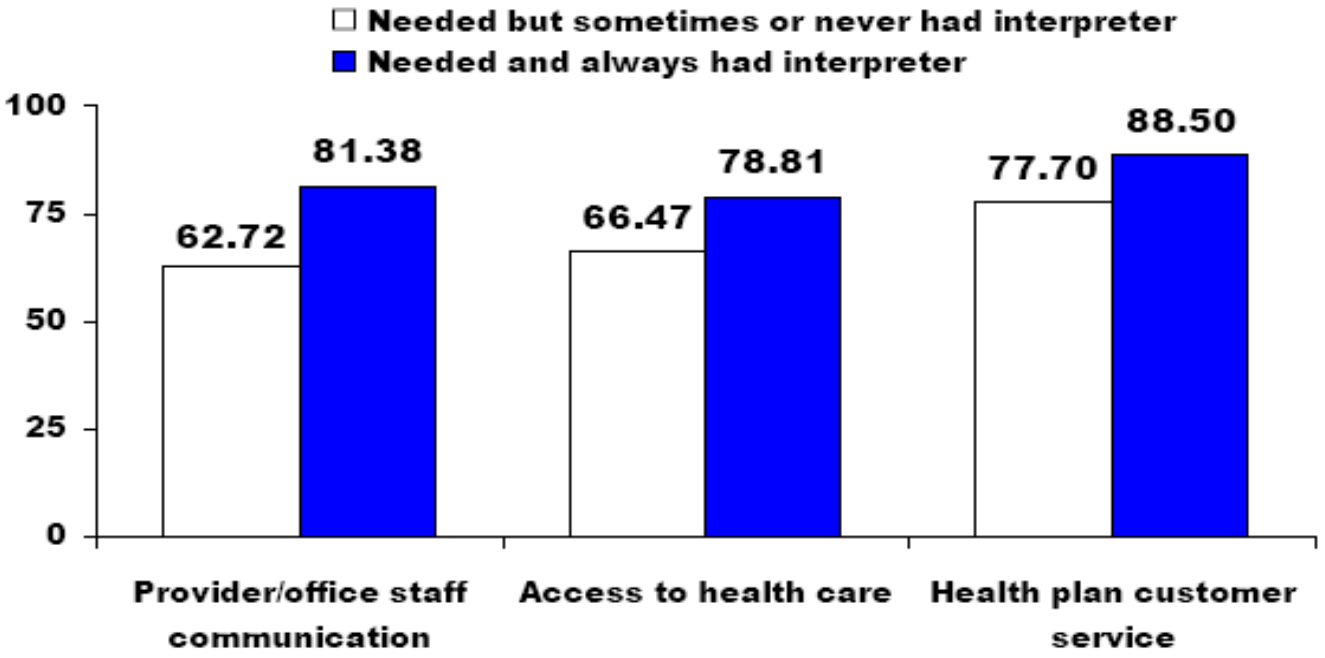
- Might be able to adjust using anchor items
  - "parking item"
  - IRT (items shown to be equivalent)
- Stratified reporting of results

Disparities in health care experiences indicate

- Opportunities for improvement in care
  - Provide professional translators
  - Cultural competency training
  - Employ bilingual providers
  - Provide transportation

Smedley et al. (eds.), Unequal treatment: Confronting racial and ethnic disparities in health care. IOM Committee on understanding and eliminating racial and ethnic disparities in health care, 2003.

Plan Members Who Always Have Interpreters Report Higher Rates of Satisfaction with Health Care Experiences



Note: Weighted means. Composite scores range from 0 to 100.
L. S. Morales, M. Elliott, R. Weech-Maldonado et al., "The Impact of Interpreters on Parents' Experiences with Ambulatory Care for Their Children," *Medical Care Research and Review,* Feb. 2006 63(1):110–28.

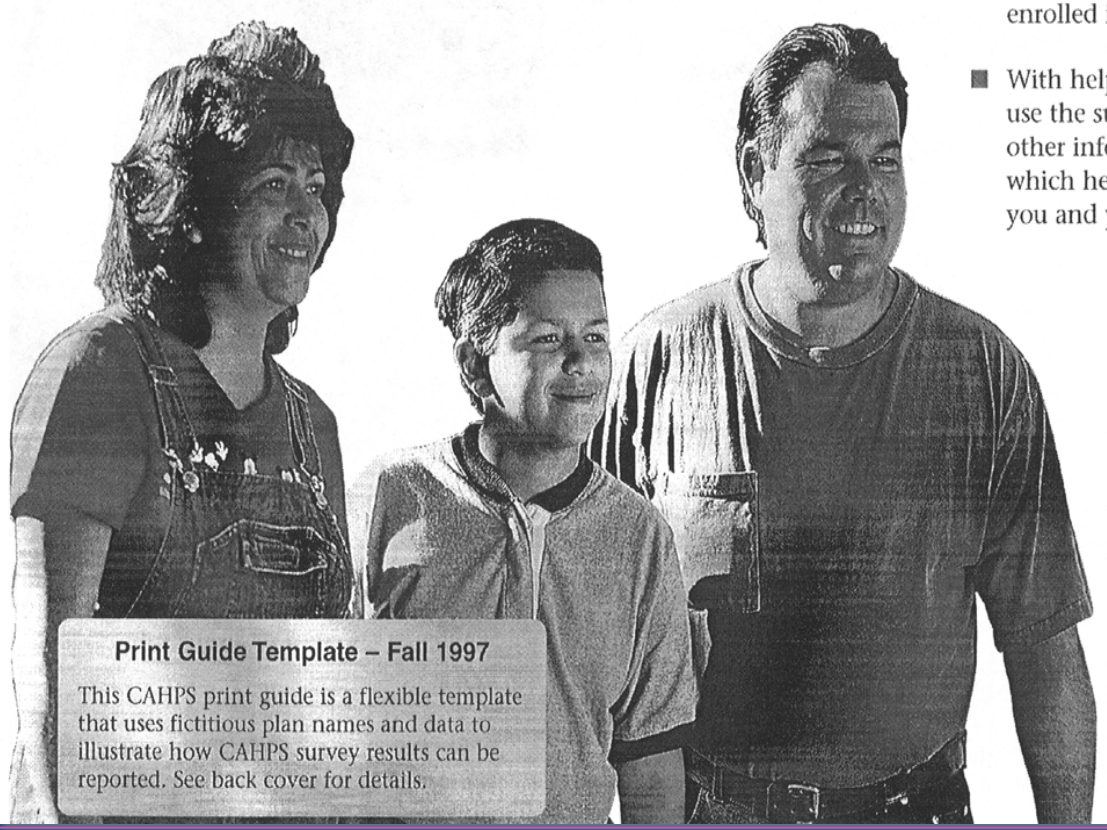
Compare Your Health Plan Choices™

1998

The health plan you choose can make a difference in the quality of care you get.

This booklet gives you new information on health care quality from a consumer perspective.

- See how health plans compare, based on results from an independent survey of people enrolled in each plan.
- With help from this booklet, use the survey results and other information to decide which health plan is best for you and your family.



The Sponsor LOGO

Print Guide Template – Fall 1997

This CAHPS print guide is a flexible template that uses fictitious plan names and data to illustrate how CAHPS survey results can be reported. See back cover for details.

CAHPS™
Health Care Quality Information From the Consumer Perspective

Design

(Spranca et al., Health Services Research, 35 (5Pt 1) 933-947, 2000)

- Research participants: 311 privately insured adults in Los Angeles County
- Asked to imagine they were trying to pick a health plan for themselves
- Presented with materials for four health plans
- Booklet on plan features plus:
  - Booklet or computerized guide with CAHPS® health plan reports and ratings
- Ask to "choose" a plan and then rate materials

Variation in Plan Coverage and CAHPS® Ratings

- Half of experimental group:
  - Plans with more coverage (higher premiums) were assigned higher ratings
- Other half of experimental group:
  - Plans with less coverage (lower premiums) were assigned higher ratings

Results

- Consumers spent an average of:
  - 10 minutes on plan features booklet
  - 15-20 minutes with CAHPS® information
    - 20 minutes on "Compare Your Health Plans" booklet
    - 15 minutes on Computerized guide

How Easy to Understand Information?

	Very Easy	Somewhat Easy	Very or somewhat hard
Plan Features Booklet	63%	32%	5%
CAHPS® Booklet	48%	41%	11%
CAHPS® Computer	42%	44%	14%

Importance Ratings

	Print Guide	Computer Guide	Control
Benefits Package	9.7	9.5	9.6
Premiums	9.5	9.1	9.5
Out-of-Pocket Costs	9.4	8.9	9.2
Type of Plan	8.9	8.8	8.6
Own Doctor In Plan	8.9	8.7	8.7
Consumer Reports/ Ratings	6.7	7.3	6.9

NOTE: Mean on a scale from 0 to 10.

Effects of CAHPS® Information on Choice of Plan

- Majority (86%) chose the more expensive plan that provided greater benefits (control group)
- If more expensive plans were linked with higher CAHPS® ratings, no shift in preferences
- If less expensive plans were linked with higher CAHPS® ratings, many consumers (41%) chose the less expensive plan (versus 14% in control group)

Conclusions

- Quality information about health plans from the consumer perspective is new, and consumers are not yet convinced of its usefulness and objectivity
- Even so, results suggest that, under certain conditions, consumers will use quality ratings in choosing a plan
- CAHPS® data affect plan choices in situations where they reveal high-quality plans that cost less

Demonstration Sites

- Positive association between self-report of use of report and perceived ability to judge plan quality, but…
- No overall effect on plan choice in Iowa

  Farley, D. O., et al. Impact of CAHPS performance information on health plan choices by Iowa Medicaid beneficiaries. Medical Care Research and Review, 59, 319-336, 2002.

- No overall effect on plan choice in New Jersey, but small effect on subgroup of "receptive" Medicaid beneficiaries.

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Discussion

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