



Measuring and Improving Patient Experience in the Safety Net

Introduction

With the 2001 publication of the Institute of Medicine's *Crossing the Quality Chasm Report*, patient-centered care emerged as one of six key components of high quality health care in the United States. Partly in response to that report, health care organizations across the country have focused on developing and improving patient- and family-centered approaches to the care they provide. As part of this movement, significant public and private resources have been invested to develop and implement measures that evaluate patient experience of care (PEC) in various health care settings. One of these, the Consumer Assessment of Healthcare Providers and Systems (CAHPS) program, was funded by the Federal Agency for Healthcare Research and Quality and the Center for Medicaid and Medicare Services to develop standardized surveys of patients' experiences with ambulatory and inpatient care.

Currently, however, most data collection is being funded by health plans and has focused solely on the experiences of the commercially insured population. As a result, there is very little verified data on PEC among patients served by safety-net providers. So, to better understand measuring and improving PEC in the safety net, the California HealthCare Foundation (CHCF) supported two initiatives regarding the use of standardized PEC survey tools in safety-net clinic settings, as well as the creation within a large urban clinic system of two quality improvement (QI) collaboratives focusing on PEC. This paper summarizes two full reports that offer the results of these two CHCF-sponsored PEC projects:

- *Improving Patient Experience: A Hands-On Guide for Safety-Net Clinics* (www.chcf.org) presents the results of two collaborative PEC improvement efforts by the San Francisco Health Plan (SFHP) clinic network, one of which focused on patient access, the other on communication between patients and providers/staff. The SFHP report is structured as a hands-on, step-by-step guide to help clinics and small practices improve the patient experience. It includes appendices that offer the specific changes and related solutions that worked for SFHP to improve both access and communication, as well as reference to the resources the clinics relied on in making their improvements.
- *Feedback Loop: Testing a Patient Experience Survey in the Safety Net* (www.chcf.org) describes the results of testing a CAHPS visit-based survey through two different implementation modes: an in-office handout survey administered by non-staff personnel, and an Internet-based survey. Each was measured against a standardized CAHPS survey administered by mail. The full report includes the CAHPS visit-based survey as modified and translated for safety-net clinics, the scripts used for approaching patients, and copies of the printed cover materials. The survey is also available in Spanish, Korean, Chinese, and Vietnamese.

Background

There is a conceptual distinction between “patient experience” and “patient satisfaction.” PEC surveys seek to learn what patients actually did or did not experience in their interactions, while patient satisfaction surveys focus more narrowly and subjectively on how patients rate their experience. Because of their greater specificity, PEC surveys are typically less biased and more actionable.

In 2009, CHCF gave support to the Stoeckle Center, in coordination with the RAND Corporation, to conduct a study of California safety-net providers to assess:

- Current use, and potential barriers to use, of patient satisfaction and experience data
- How and why these providers use patient satisfaction and experience data to drive quality and operational improvement efforts
- The types of resources and tools that would make the collection and use of patient satisfaction and experience data more feasible for these clinics, health centers, and practices

The results of this assessment indicate that the majority of safety-net organizations are collecting some level of data on patient satisfaction or experience. Federally Qualified Health Centers have a government mandate to collect patient feedback, so most perform some level of patient satisfaction surveying. The survey instruments they use are not validated, however, and in most cases there is very little benchmarking across clinics. In addition, many clinics are challenged by data collection and analysis and/or by the cost of external vendors if they are unable to identify clinic staff with appropriate expertise. However, there was a strong interest among the providers studied to gain access to PEC resources and best practices, and to better understand how to use PEC data for QI.

The Safety-Net Clinic Patient Experience: A Guide for Improvement

To better understand PEC improvement in the safety net, CHCF supported an effort to tailor QI resources to meet the unique needs of safety-net populations within the constraints faced by clinics. SFHP led two multi-clinic learning collaboratives that targeted PEC improvement. SFHP’s *Hands-On Guide* for improving patient experience offers the results of these collaboratives’ systematic improvement tools, lessons, and surveys, along with specific change solutions that the clinics found effective.

SFHP established two clinic-based collaboratives — one addressing patient access, the other communication between patients and providers/staff — that focused on enhancing PEC, using a four-step process:

- Step One: Identify Areas for Improvement
- Step Two: Prepare for Improvements
- Step Three: Make Improvements
- Step Four: Sustain and Spread Improvements

Early in the process, the SFHP collaboratives implemented a CAHPS PEC survey and used the results to identify areas for improvement in the clinics’ two lowest scoring domains: provider-patient communication and timely access to care. Both areas are highly correlated with patients’ overall ratings of care, and SFHP scored below state and national averages on each.

The surveys were used not only to identify areas of PEC on which to focus QI efforts but also later to measure the effects of those efforts. In addition to the standardized CAHPS surveys, the participating clinics also used the following methods to obtain rapid feedback on whether changes being made were resulting in improvement:

- Brief point-of-care surveys (asking a few qualitative questions specific to the changes being tested)
- Brief point-of-care comment cards

- Interviews with patients when exiting a visit
- Patient advisory boards to obtain patient input on changes and their effectiveness

Also, key data points, such as no-show rate, visit demand and supply, and panel size were measured monthly to track progress.

Specific lessons from the collaboratives included the importance of involvement of the staff and clinic leadership in establishing specific project aims, front-end training on measurement and data management, regular and frequent measuring, and developing a framework for sustainability and spread.

As a result of their efforts, the collaboratives achieved sustained improvement not only in patient access and patient-provider communication but also in overall satisfaction measures. Based on its experience in these collaboratives, SFHP developed the *Hands-On Guide*, which outlines the specific interventions, lessons, and concrete examples of changes that addressed the areas targeted for improvement.

Measuring Patient Experience: Testing CAHPS Survey Implementation Options

Recognizing the lack of research and development regarding PEC surveys among safety-net providers, CHCF supported a project — with participants from the John D. Stoeckle Center for Primary Care Innovation at Massachusetts General Hospital, the Center for Survey Research at the University of Massachusetts, Boston, Shaller Consulting Group, and the RAND Corporation — that tested a modified CAHPS Clinician and Group survey in six safety-net clinics, using three different implementation methods:

1. In-clinic distribution by non-staff administrators, a protocol specially developed by the project team

2. An Internet-based survey, specially developed by the project team
3. A standardized CAHPS mail survey protocol, administered by an outside vendor

The project team modified, for use in safety-net clinics, the CAHPS Clinician and Group visit-based survey and developed special scripts for approaching safety-net patients. (The survey and the scripts are available in the full report *Feedback Loop: Testing a Patient Experience Survey in the Safety Net*.)

The project did not produce a definitive determination of the best method for a safety-net clinic to employ when conducting its own PEC survey. However, regarding the relative merits of in-clinic handout, Internet-based, and standardized CAHPS-type mail protocols, the project did suggest several things:

- It strongly indicated that an Internet-based survey is presently out of reach for safety-net clinic patient populations.
- Neither the in-clinic handout nor the mail survey produced a sufficient sample to adequately represent the full patient populations of the clinics. With either survey method, clinics face the task of producing complete, survey-usable daily appointment lists. A mail survey also requires accurate addresses, as well as telephone numbers for follow-up, which was challenging in the study sites.
- Despite the presence of non-staff survey administrators to address the bias and other problems associated with staff-implemented PEC surveys, the reliability of in-clinic handout survey responses may be compromised by premature distribution and completion of the surveys.
- The cost of a mail survey can be lower than in-office distribution conducted by non-staff personnel. The overall per-clinic mail survey costs (\$5,777) were 36% lower than for the handout survey (\$9,066).

Costs per return, however, were much more comparable: \$35.11 per returned survey for the mail protocol, and \$38.15 per returned survey for the handout protocol.

While a standardized mail survey may be slightly more cost effective than a non-staff administered in-clinic handout survey, ultimately clinics may need to employ a mix of modes (mail with telephone follow-up, for example) in order to achieve sufficient returns for a single, point-in-time survey, and might also be advised to supplement surveys with other PEC-gauging alternatives (see “Qualitative Methods” below).

Measuring the Patient Experience: Qualitative Methods

Less rigorous, qualitative methods can be very useful complements to systematic survey data. Such methods can confirm or question survey data results and can offer detailed insights into specific problems and possible solutions. Because they are easier and less expensive to implement, these methods can also be used more frequently, providing real-time feedback valuable to providers and staff. Finally, such methods may also engage patients and families as partners in the improvement process, adding their voices to assessments of their experience as well as valuable ideas that may not occur to professionals on their own.

The following are several supplemental patient feedback methods, culled from the CAHPS Improvement Guide, that practices might consider as tools to support their improvement activities, and that are also discussed in the full *Feedback Loop* report:

- **Focus groups.** Staff and/or patients are brought together in a moderator-led discussion group to collect information about a specific problem and ideas for improvement strategies.
- **Walk-through.** One staff member plays the role of patient and another plays an accompanying family member. They go through a clinic, service, or

procedure exactly as a patient and family member would, to identify system, flow, and attitude problems.

- **Shadowing.** With permission, a staff member accompanies a patient through a visit and takes notes on the patient’s experience. This does not require taking a slot away from a real patient and so can be especially useful where visits are at a premium.
- **Complaint/Compliment letters.** By reviewing these letters systematically, a clinic often can get a picture of where it needs to do additional research.
- **Comment cards.** These can be made available for patients to complete prior to and after a visit and can include patient ratings of service quality as well as space for feedback on the experience.

Conclusion

Improved collection of PEC data by safety-net organizations can help those practices improve the quality and efficiency of their services by targeting their improvement efforts. The use of a standardized survey tool, such as that offered by CAHPS and implemented in one of several ways, can not only sharpen this targeting but also allow for benchmarking and tracking of improvements over time. As demonstrated by the SFHP collaboratives, this sort of tool, supplemented by qualitative methods for rapid feedback, can be critical for QI efforts to make and sustain changes to patient experience in safety-net clinics.

ABOUT THE FOUNDATION

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