



## Data Collection to Improve the Patient Experience

California's 21 public health care systems (PHS) are committed to putting patients at the center of their own care, continually seeking new and better ways to engage patients and apply their feedback.

Examples include:

- Revamping customer service phone systems and protocols based on patient preferences
- Reducing wait times for appointments and expanding clinic hours to provide better access to care
- Offering an online communication portal, allowing patients to interact with their health care team without coming into the clinic
- Providing post-visit summaries to help patients understand their health conditions and participate more fully in a shared decision-making process about their own care
- Integrating patient experience criteria into employee performance measures and staff recognition programs
- Hiring senior hospital leaders and appointing advisory committees who are accountable for patient experience

The first step in making these improvements is to gather data and feedback from patients, which gives the health care systems appropriate direction in how to make care more patient-centered. Indeed, patient experience data can identify key areas for delivery system improvement and inform new, more patient-centered ways of delivering services that help patients manage their health conditions and stay healthy. Patient experience data can also be used to compare health care quality by patients, providers, payers, policymakers and the general public. For patients especially, such information can help inform their selection of providers. With millions of Californians eligible for new coverage as a result of the Affordable Care Act, PHS are working to compete as providers of choice for this newly eligible population, while also retaining patients who already use a PHS clinic as their primary care health home by improving their care experience.

## California's Delivery System Reform Incentive

California's five-year Section 1115 Medicaid Waiver, which began in November 2010, provided California's 21 public health care systems an unprecedented opportunity to expand coverage and transform care. The waiver includes the DSRIP, a pay-for-performance initiative for public health care systems to achieve delivery system-based performance milestones and earn up to \$3.3 billion in federal incentive payments. The DSRIP has provided an opportunity for these public health care systems to expand upon their existing quality improvement efforts and make them large-scale. In each of the DSRIP's five years, individual health care system's DSRIP plans include an average of 15 projects across the inpatient and outpatient setting in five major categories: developing and strengthening their infrastructures, implementing innovative models of care; advancing the health of the populations they serve; continuing to make improvements in quality and patient safety; and improving care coordination for patients with HIV/AIDS.

Recognizing that health care systems must first measure what they seek to improve, in 2010, California's Delivery System Reform Incentive Program (DSRIP) included a new reporting requirement for patient experience for all 21 public health care systems. While these systems were already reporting patient experience scores in the inpatient setting, the DSRIP expanded this reporting to the ambulatory care setting, where patients receive primary and specialty care services. By the end of 2012, all systems began to utilize the Consumer Assessment of Healthcare Providers and Systems Clinician & Group Survey (CG-CAHPS) to measure and report patients' perspectives on five aspects of care:

- 1) getting appointments, care and information when needed;
- 2) how well providers communicate with patients;
- 3) helpful, courteous, and respectful office staff;
- 4) patients' global rating of the provider; and
- 5) shared decision-making.

Implementing an ambulatory patient experience survey across 21 large systems in a way that allowed for meaningful, comparable data proved to be no small feat. As a result of this experience, California's public health care systems have identified key lessons learned, which we share in this brief in the hopes that they may be instructive for other providers implementing or planning to implement a similar survey to understand and improve patient experience.

### **Lesson #1: Standardized Implementation Allows for Greater Comparability across Systems**

Though the DSRIP required all PHS to use a common survey (CG-CAHPS), there was significant potential for variation in the implementation of the survey. Such variation would have hindered the systems' ability to generate compatible data for benchmarking and peer-to-peer comparison. In response, the systems decided to go beyond DSRIP requirements and develop a standardized protocol for CG-CAHPS implementation. The systems worked with the California Health Care Safety Net Institute (SNI) and other experts and consultants to develop consensus around several key issues, including the specific version of the survey to be used, a common survey mode, and languages for administration.

As PHS worked through the standardization process, methods of sampling proved to be a particularly complex issue to resolve. The DSRIP required that each PHS' data sample include a minimum of 300 completed patient surveys per year, in order to offer a representative sample of all adult primary care patients in the system. However, many PHS aimed to go beyond the system-level sampling to generate more granular data that could yield the necessary information to support internal quality improvement efforts focused at the clinic or provider level. Systems therefore agreed upon threshold sample sizes for each sampling level, allowing provider and clinic level data to be rolled-up into the system-level DSRIP report. In early 2013, California PHS began to generate survey results following these standardized consensus guidelines. The systems are now able to produce compatible data, forming a solid foundation for comparison and collaboration on improvement efforts to strengthen primary and specialty care services through an enhanced patient experience.

## **Lesson #2: Use the National CAHPS Database or Other Vehicle for Data Aggregation and Reporting**

Currently, six different patient experience survey vendors are used among California's PHS, each with a different way of synthesizing and reporting the survey results to its clients. This decentralized approach involving multiple vendors can make it difficult for each system to compare results to its peers, because the reporting rules and formats are often not aligned. Ideally, an independent data aggregation and reporting vehicle should be used to aggregate data files, calculate case-mix adjusted scores, and report the results in a consistent format across all systems and practice sites. California PHS chose the national CAHPS Database for this role based on its significant experience working with multiple vendors and producing comparative reports, as well as its ability to provide national benchmarks.

## **Lesson #3: Compare Survey Data to Inform Quality Improvement Collaboratives**

With a new ability to produce comparable CG-CAHPS data, a subgroup of California PHS joined together to analyze the information and form a learning collaborative. The SNI-led CG-CAHPS Improvement Network consisted of 15 outpatient clinics from four public health care systems working together to improve patient experience in primary care. Baseline performance was first compiled in a comparative report and used to set specific improvement aims in each clinic. Over the course of 10 months, clinics participated in skills-based training designed to strengthen caregivers' ability to communicate with compassion, while simultaneously helping the teams increase their capacity for data-driven improvement. At the end of the 10 months, data across the 15 clinics revealed improvements in the helpfulness, courtesy and respect that patients experienced interacting with clinic staff. For example, the percentage of patients at one clinic who gave a top score rating of "yes definitely" when asked about the helpfulness of clinic staff increased by 24% over the course of the collaborative.

## **Lesson #4: Strengthen the Pathways for Data to Reach Key Leaders and Front-Line Staff**

Public health care provider teams with a strong data-driven culture are able to use patient experience data for a range of continuous quality improvement initiatives, but only when the data makes it into the hands of the right leaders and front-line staff. In most large health care organizations, the relationship and contact with the patient experience survey vendor is managed by the organization's quality improvement department. The department usually produces and disseminates data reports at regular intervals for use by the organization's executive and mid-level leaders. In addition, most vendors maintain client Web portals, where leaders can generate custom-made reports for their areas of oversight. Despite this resource, few clinic leaders make regular, effective use of their patient experience data. The barriers most often cited include work overload, competing priorities, complicated and often confusing nature of the reports, and difficulties navigating the Web portals.

Ultimately, as part of building a data-driven culture of quality, health care organizations should strive to promote the capacity of leaders and front-line staff members to locate key data in a timely fashion,

understand and interpret it accurately, and take improvement action based on the results. Practices to promote more robust use of patient experience data include:

- Creating incentives for leaders to access their vendor portals;
- Designing these portals to be intuitive and user-friendly; and
- Providing frequent coaching opportunities around their use.

In addition, PHS have found that asking patients to respond to several quick patient experience questions as they leave the clinic can provide helpful real-time feedback to complement the retrospective review of CG-CAHPS results.

### **A View from the Field**

“One of the limitations of CG-CAHPS is the challenge of capturing the care experience of diverse populations. Depending on one’s culture and language, the framing of the questions may have different significance. Survey data is best used in conjunction with other forms of data gathering to best understand the patient’s experience with care. For instance, having clinic staff and leaders observe a patient’s experience with care during a clinic visit, ascertaining how long the patient waited, how staff and providers interacted with the patient, quality of education provided, etc. can allow for improvement ideas to be developed and implemented to ensure the patient’s needs are always met.”

- *Iman Nazeeri-Simmons, MPH*  
*Interim Chief Operating Officer, San Francisco General Hospital and Trauma Center*

## **The Outlook Going Forward**

The PHS experience with CG-CAHPS through California’s DSRIP provides valuable lessons to prepare health care organizations for a future where value-based purchasing strategies reward advancement of the Triple Aim. Guided by a deeper understanding of the patient experience, through tools like CG-CAHPS, PHS are transforming their systems to ensure patients receive improved care in the most appropriate setting. Only by listening to patients and involving them in their care will we succeed in designing systems that achieve improved health outcomes, more efficient and effective use of resources, and a better overall experience of care.