

Survey Instrument

1. What is CAHPS?

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) program is a multi-year initiative of the U.S. Agency for Healthcare Research and Quality (AHRQ) to support and promote the assessment of consumers' experiences with health care. First launched in October 1995, the program has expanded beyond its original focus on health plans to address a range of health care services and meet the information needs of health care consumers, purchasers, health plans, providers, and policymakers.

For more information and all tools: <https://cahps.ahrq.gov/about.htm>

2. We have been told that CMS would not allow CAHPS to be translated to some minority populations' languages. Do you know if this is true?

CAHPS provides guidance on translation practices here:

https://cahps.ahrq.gov/resources/guidelines_translation.pdf

CMS does have HCAHPS (the Hospital CAHPS) translated into several languages. For public reporting purposes, CMS does have additional requirements.

See: <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/downloads/HospitalHCAHPSFactSheet201007.pdf>

Our routine HCAHPS and CG CAHPS surveys at MGH that are reported to CMS are done only in English and Spanish in accordance with official policies and procedures. The research project we reported on was a special effort to pilot test a few CAHPS questions with patients who speak other languages. We relied on standard translations where possible.

3. How were you able to stratify HCAHPS data into race & ethnicity? We've tried this in our organization, and the breakdown of the survey was only available by patients' primary language.

We gather patient race and ethnicity at registration and link that data to the sample files.

4. How many questions are asked via phone and how long does it take to conduct the phone interview?

The survey we created was approximately 50 items and took an average of 15 minutes to complete by telephone.

Sampling Design

- 1. What percentage of patients provide REaL information and what tips do you have for improving response rates to REaL data collection? Can patients provide their REaL data through an EMR patient portal?**

This process is managed during patient registration. We get a very high response to these items—certainly above 90%. At this time patients cannot register via a patient portal—registration is accomplished by telephone with human assistance.

- 2. Within these measures, was specific feedback gathered about availability of interpretation and quality of services rendered?**

Yes. We did not present these questions, but we asked a series of questions about interpreter service quality. We plan to publish them soon but are happy to share them if you contact Dr. Donelan at kdonelan@partners.org.

- 3. Have you done any surveys including the "voice" of the deaf and hard of hearing?**

We have done focus groups at MGH. We are actually working on a project now to improve our patient experience surveys for people with all disabilities, and we are seeking federal funds for a large scale project in that vein in MA.

Here is a helpful citation:

<http://digitalcommons.ilr.cornell.edu/edicollect/191/>

- 4. Do you have any strategies for effective sampling in a population with prevalent behavioral health issues?**

We have a research patient data registry that is created using data from our electronic health record system. We are able to get good estimates of the prevalence of different conditions in our inpatient and outpatient populations using these data. We have surveyed many patients with different behavioral health conditions but we do rely on clinicians to help us in contacting patients so as to assure we approach patients safely. Residential setting, cognitive impairment, and other factors must be considered.

- 5. "Online" wasn't shown as a mode but discussed. What has the success been with online surveys?**

We do not use online surveys with our general patient population. We have used online surveys in targeted populations and are exploring the use of web-based administration through our patient portal. Many hospitals do not have portals in languages other than English; fewer than half of our patients use the portal, and a disproportionately smaller

share of our underrepresented minority patients. We have good results with online surveys of our workforce, but not of our patients. We did ask patients if they would prefer to be surveyed in this way—it was a popular option among about 50% of our portal users.

6. Do you take "health literacy" into consideration when formulating patient surveys? If so, what are some of the standards or design strategies out there to incorporate different health literacy rates across cultures and ethnicities?

We absolutely do. We have found that one of the most important things we can do is to allow responses by telephone, not just self-administered mail. It allows us to hear in real-time whether people are struggling with words or concepts or scales. We do a reading level check on our letters and questions—this is not perfect but is helpful. We have found that reading and writing literacy varies considerably among our immigrant populations, as does experience completing surveys.

Some resources:

http://www.popcouncil.org/Horizons/ORToolkit/AIDSQuest/appendix_dtk.html

The National Center for Education Statistics has outstanding resources and has designed and conducted national surveys about literacy: <http://nces.ed.gov/naal/>

7. Many written survey vendors discourage additional phone surveys because of the survey bias created by using a surveyor by phone. Any thoughts on how to reconcile the delivery modality bias?

CAHPS surveys are tested for administration in multiple modes; many surveys have been done in multiple modes for years following pretesting. If a vendor is discouraging telephone supplementation, that vendor probably has not tested or developed the survey for administration by telephone. Surveys conducted by interviewers by telephone are prone to interviewer bias if interviewers are not trained and supervised appropriately. But surveys only done by mail or self-administration are prone to other sources of error or bias—non-response, differential response, missing data, problems with scanning and data entry. High quality data collection is possible in all modes.

8. We want to look at outcomes according to REaL, but we feel we really can't draw conclusions from our small minority patient population. Do you have any suggestions?

How small is small? You gain statistical power by comparing a small population to a larger one—so if you have 10% minorities and 90% majority patients, you should be able to compare some clinical and attitudinal measures even with small numbers of patients. Collecting survey data over a longer time frame—a year rather than a few months, may

help. Analyzing clinical quality measures by race ethnicity is also possible if you expand the time horizon. You may have to look quarterly instead of monthly, annually rather than quarterly—for some things we even have to look at 2 years. But generally speaking we have found that we gain valuable information that has helped us to improve everything from cancer screening to diabetes management to information desks.

Survey Implementation

1. Did the demographics of the staff mirror the community of the patients?

Do you mean the survey staff? Yes, but we did not explicitly “match” interviewers and respondents by race and ethnicity, although we did match for language and we drew interviewers from multiple different cultures.

2. When doing research studies, how do you make sure that the same opportunities are available to all populations? It is expensive to get consent forms translated.

This is a challenge for many institutions. We have found that our investments in training a skilled interviewing workforce have been helpful to other researchers who need trained bilingual interviewers. We also work closely with our translation and interpreter services to recruit and train interviewers. Translation costs are managed in-house for Spanish and are outsourced for other projects—research grants will pay for translation in most of the studies we do.

3. How do you share patient quotes with staff and providers involved in that patient's care?

Quotes are de-identified, and any information is removed. We also allow there to be some time between the stay/visit and the collection and reporting of the data. All comments are typed verbatim, no handwritten comments are shared. Comments are available for the CAHPS surveys in an online portal that our vendor provides. For our research study, comments were disseminated to leadership in reports, presentations and meetings,

4. What are your thoughts on conducting surveys as patients finish their interactions, and before they leave your campus? Do we have to double back to them after the fact?

There is an extensive literature to suggest that for most measures of patient experience, this is not a good idea.

5. I would like to survey the Latino population on the inpatient side after an integrative intervention to create a greater healing environment/decrease anxiety. Any ideas how to proceed?

In our hospital, there are two ways we might do this. In one approach, if the intervention was on a particular unit, we might use our standard HCAHPS surveys to look at the patient experience on that unit BEFORE the intervention, and then analyze the data on the same unit AFTER the intervention. Existing questions in HCAHPS look at a number of aspects of the healing environment. Another approach might be to compare units WITH the intervention to units that did not have the intervention—say if you did the intervention on a general medical floor, you might compare the HCAHPS results for that floor as compared with other floors that do not have the intervention.

If you cannot get the HCAHPS data for that unit, you might consider surveying Latino/a patients about the environment using other questions about issues the intervention is trying to address—using standard scales to measure anxiety, for example. How many patients have anxiety during their hospital stay BEFORE the intervention vs. WITH the intervention. Good luck!

Further Impact and Implications

1. Who are you disseminating the data to? Internal staff or external stakeholders?

Our research project data have been disseminated internally to hospital leadership in several meetings. Our presentation and research publications will be part of our external dissemination strategy.

2. What data points have you found most impactful for engaging and activating staff around patient experience issues? Data, percentile ranks, comments?

It depends on the audience :-). Many people are moved by the comments, but we actually do not have that many comments to share. We have found that qualitative data alone are not enough to gain credibility with hospital leadership—high quality sampling, response rates and research methods are appreciated by many decision makers who want and need that kind of data.

3. What do you think is an optimum time frame to be able to respond and implement change?

In our large system, some issues can be addressed immediately (certain patients needed specific resources right away). But a reasonable cycle is 2-3 years—to gather the data, decide and craft an approach, disseminate and implement, and then assess the impact.

4. What would it take for *Hospital Compare* to start reporting patient experience results by REaL?

I would defer to policy makers.

5. Do you see a future where health care disparities are also evaluated based upon zip code and linked to outcomes?

This is already happening through the science of geocoding with disparities measured by income, insurance, other population characteristics, the BRFSS and other surveys. The Dartmouth Atlas, Health United States and other sources look at small area variations in many aspects of health and health care.

6. What do you think would be the best effective way to convince/make specialist doctors who provide care for the increasing Arabic-speaking LEP populations in San Diego County to use language services?

This is an important legal issue. We have seen change happen in this regard when the lack of professional interpretation leads to medical errors.

7. Cultural concordance can be a controversial issue for organizations, especially regarding its leadership composition. How has MGH dealt with this issue and are there changes anticipated within the organization?

MGH is currently engaged in a system-wide effort to advance workforce diversity through department-based initiatives and hospital-wide measurement, led by our multicultural affairs office (MAO).

<http://www.massgeneral.org/mao/>

In Patient Care Services, the following link is to the chapter in our Magnet designation document on workforce diversity at MGH:

http://www.mghpcs.org/pcs/magnet/documents/evidence/Volume_3/Force_4/4_5_Workforce_diversity.pdf