PATIENT EXPERIENCE MEASUREMENT:

BUILDING A STATEWIDE SHORT FORM PROGRAM

MHQP
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CHPI
California Healthcare
Performance Information System

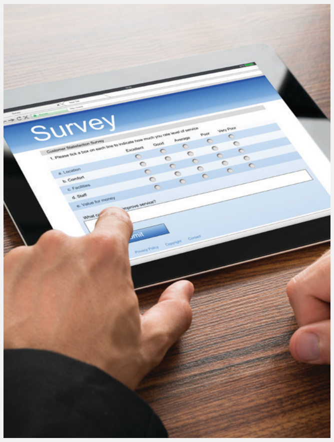
Findings from a joint undertaking between

Massachusetts Health Quality Partners (MHQP)

and

California Healthcare Performance Information System (CHPI)

INTRODUCTION



▶ This guide is intended to provide a thorough description of our work for the reader who may be considering developing their own short form and/ or electronic patient experience survey program.

The California Healthcare Performance Information System (CHPI) and Massachusetts Health Quality Partners (MHQP) are pleased to present a fielding guide for the development of a patient experience program with information culled from our experience piloting a short form and electronic mode of survey. Over the course of a 1-year pilot, funded by the Center for Healthcare Transparency (CHT), our two entities undertook efforts to create, field, and analyze responses to a short form survey instrument that at 23 questions is considerably shorter than the standard PCMH CG-CAHPS 2.0[1] patient experience survey that both organizations had been using. The pilot survey was delivered to patients bi-modally via email and posted mail. We used standard CG-CAHPS survey questions as the basis for our pilot short form survey and sought to answer the following questions:

1. Will patients respond more frequently to a short form survey as compared to an existing long form instrument?
2. Will patients respond more frequently to a survey delivered online via email, than to a mailed paper-based instrument?
3. Will the patient responses from the pilot be comparable to patient responses using the current means of survey collection?

The joint project team also included open-ended questions on the electronic versions of each state's survey to assess the value of collecting patient free-text feedback with a standard set of questions. It is clear that patients are demanding the opportunity to provide their own commentary (as is evidenced by sites such as Yelp and Angie's List), but creating a scientifically-valid method for obtaining free-text feedback is still an outstanding need for survey programs nationwide[2]; this pilot offers new insight into the value of standardized collection of free-text feedback.

This guide is intended to provide a description of our work for the reader who may be considering developing a regional patient experience survey program, and includes insights and resources from our experience fielding an electronic and short form survey with patient free-text feedback. We describe what we considered and how we approached implementation, and include some basic technical advice. We have also proposed what we would do differently upon reflection. In light of the ever-evolving survey environment, we hope that our learnings are helpful for anyone launching new efforts in patient experience, and can easily be assimilated into that work. The need to keep pace with changes in the modern communication culture is an imperative for organizations with existing survey programs, and for those designing future programs.

Lastly, we would like to express our gratitude to the Center for Healthcare Transparency for this opportunity to pilot new ways to engage patients in their health care, and we would like to thank all our partners who contributed to the work both directly and indirectly.

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[1] Released on July 21,2015. The Adult Survey 3.0 now has 31 total items rather than 34 as in Version 2.0. Revisions reflect input from survey users and stakeholders, analyses of survey data, and ongoing efforts to improve the consistency of this survey's implementation across multiple stakeholders, including the Centers for Medicare & Medicaid Services (CMS).

[2] Taking Patients' Narratives about Clinicians from Anecdote to Science: Mark Schlesinger, Ph.D., Rachel Grob, Ph.D., Dale Shaller, M.P.A., Steven C. Martino, Ph.D., Andrew M. Parker, Ph.D., Melissa L. Finucane, Ph.D., Jennifer L. Cerully, Ph.D., and Lise Rybowski, M.B.A. N Engl J Med 2015; 373:675-679August 13, 2015DOI: 10.1056/NEJMsb1502361

TABLE OF CONTENTS

PAGE

CONSIDERATIONS FOR A SHORT FORM PATIENT EXPERIENCE PROGRAM

Both CHPI and MHQP have longstanding programs that were started before patient experience measurement had become integral to new regulatory and value based reimbursement programs. To sustain our efforts, we have needed to continually reassess the environment for support and also consider how we can innovate and adapt our efforts to keep pace with the changes. Consequently both organizations are well aware of the need to modernize survey administration protocols to make them less costly and burdensome to patients and providers.

In July 2014 the Center for Healthcare Transparency (CHT) stepped forward to call for national advancements in measurement and transparency. Recognizing the need for innovation in this area, CHT issued a Request for Proposal (RFP) to develop and evaluate new methodological approaches to make high value performance information available to the public. In response to the RFP, CHPI and MHQP expanded our environmental scan to assess specific areas of readiness for innovation in our regions.

The development of a patient experience program is a major undertaking and involves a number of factors that must be considered prior to the project's initiation. While CHPI and MHQP work in different geographic areas, both organizations began our pilot work by reflecting on our respective markets' desires or need for a patient experience program, assessing the resources we would need to build our pilot test, and evaluating the readiness of our target participants.

Creating a clear and realistic project timeline that includes an environmental scan or strategic analysis, and the development of infrastructure for engaging participants is instrumental to fielding a successful patient experience program that uses a short form survey and an electronic mode. These elements are described below in more detail and in the context of CHPI's and MHQP's experience developing a Short Form Survey Pilot (SFSP).

ENVIRONMENTAL SCAN

In order to understand the patient experience measurement environment and identify opportunities to test or field a survey in your region or state, there are a number of questions that could be considered. These questions can help determine where you have strengths, where there are opportunities for innovation, and how to focus your efforts.

Questions to consider:

- What patient experience survey tools are already being used by physician organizations in your region/state?
- What regulatory or accreditation requirements could your survey measurement effort support?
- Is there an opportunity to reduce patient and provider burden by collaborating and aligning survey efforts?
- Who are your supporters and potential partners?
- Can your supporters and partners contribute resources?
- Do you have the expertise, experience, resources, partners, and capacity to manage this program? Consider survey administration, data analysis, costs for fielding, medical group or health plan partners, project management support, survey instrument development, technology licensing, legal support, etc.
- Are there innovators in the use of patient experience measurement in your region?
- Are electronic survey instruments being used?
- Are there short form patient experience efforts ongoing in your region/state?
- How well have electronic or short form surveys been received?
- Is there demand and/or funding for the development of a short form survey program?

Because CHPI was already fielding the long form Patient Assessment Survey (PAS) survey in California, and MHQP was fielding the Massachusetts Statewide Patient Experience Survey there was an evident interest in patient experience among California and Massachusetts physician organizations (POs) and health plans. Both organizations rely upon funding support from POs to cover the cost of these efforts. The CHT funding and support bolstered the interest in a short form pilot among these POs because limited or no additional financial resource was required to participate in the pilot.

CONSIDERATIONS FOR A SHORT FORM PATIENT EXPERIENCE PROGRAM

PARTICIPANT READINESS

For this pilot, we expanded our ongoing efforts to focus on finding potential innovation partners – assessing their readiness, willingness, and ability to participate in an electronic short form pilot. In order to do this we developed an organizational readiness assessment plan and applied it to our existing survey participants.

We asked these questions to conduct our assessments of potential POs:

- Do practices already have patient experience measurement programs?
- What methods do the organizations currently use to engage their patients?
- Do practices already communicate with patients via email or through a patient portal?
- Is there a standard process to ask patients about their preferred mode of communication outside the physician office?
- Do practices have proper authorization in place to release contact information?
- Do practices have updated Notice of Privacy Practices and Terms of Service for use of electronic methods and tools?
- What is the electronic infrastructure of targeted organizations?
- Is the infrastructure secure?
- What is motivating the organization to participate in a patient experience measurement program (e.g., alignment with others in the region, pay for performance or lowering costs)?
- Who are the key contacts and decision-makers?

PROJECT TIMELINE

With a clear understanding of the need and/or desire for a patient experience program in your region, the work to implement the program can begin. As a first step, a detailed project plan that identifies a timeline for executing various stages of the project and deadlines for deliverables should be developed. The high level project timeline we established as a part of our funding proposal is included here:

Project Management Activity	Month											
	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
General Project Oversight and Management	■	■	■	■	■	■	■	■	■	■	■	■
Recruitment: Identification and Engagement of POs	■	■										
Contracts: Vendor, Health Plan Permission to Use Data, POs	■	■										
Survey Instrument Content and Methods Review	■	■	■									
Finalized Short Survey	■	■	■									
Data Management/Sampling Plan: PO Data Specifications/ Obtaining Emails, Sampling Plan, Coordination of Data Exchange	■	■										
Survey Administration					■	■	■	■				
Scoring and Analytics							■	■	■	■	■	
Final Report												■

It should be noted that the terms of our grant funding required that the development, administration, and analysis of our SFSP be completed in a one year time frame. Depending on where you are starting from, your desired scope, and available resources this may or may not be feasible; your project plan will reflect your circumstances.

COST CONSIDERATIONS

While cost containment may not be the only reason for considering a short form or electronic patient experience program, Regional Health Information Collaboratives (RHICs) are often charged with managing costs and using the most cost effective methods to produce program deliverables on time and on budget. To this end, it is important to weigh options and communicate with stakeholders about how different choices impact costs in order to develop a business model that can sustain program support.

ELECTRONIC SURVEYS

For organizations that are engaged in patient experience measurement programs or interested in launching a program, the opportunity to survey electronically to both lower the cost of administering surveys and to reduce survey burden with improved survey design is compelling. However, the ability to shift to electronically based surveys is evolving in tandem with the increased use of technology by patients and providers, adoption of mobile devices by patients, and continuous collection of email contact information by provider organizations. For regional programs, this means a full transition to an electronically based survey may take time.

With that said, the advantages of moving to electronic modes of survey are seen across the survey administration process. A few examples of the ways costs can be reduced include:

- Reducing the production and printing costs for paper survey materials.
- Reducing postage costs. (Most regional efforts will use a mixed-mode approach to obtain fuller population coverage and reduced costs for the mail portion of the survey. Fielding an email based survey first reduces the number of mail surveys needed to obtain a sufficient response).
- Shortening the time needed for data collection and coding of results - data collection periods can be shortened and turnaround time for reporting can be closer to real time.

SHORT FORM SURVEYS

The advantage of fielding a shorter survey lies mainly in the potential for reducing patient burden and adapting to new electronic modes of survey. However, there are also savings in marginal costs for survey administration where savings are realized through decreased costs for printing and mailing.

The following table shows the marginal costs CHPI experienced fielding a short and long form survey electronically and by posted mail. The costs cited represent survey administration only and do not include setup costs, data management, analysis and reporting. Phone follow up costs are shown for reference purposes. Figures are based on the cost for phone follow up on the traditional long-form PAS assessment, and include an estimate for the short form (not done for the pilot), based on survey length and time spent by interviewers.

	Short Form	Long Form
Paper*	$1.97/patient	$2.15/patient
Email	$0.25/complete	$0.25/complete
Phone Follow up	$14.25/complete	$20.37/complete

** Base cost per surveyed sample member, discounted to $0.25 if the patient responds by email/web prior to the first paper mailing.*

Although there is a significant opportunity to reduce costs via an electronic and/or short form survey, it is important to consider the costs that are incurred in launching a program. The following are some important factors that can impact those costs.

COST CONSIDERATIONS

PARTICIPANT PHYSICIAN ORGANIZATIONS

The organization fielding the survey is not the only contributor to a successful patient assessment program. The physician organizations (POs) that submit patient data are an equally important component of the program and the impact on their resources – both staffing and financial – should also be considered.

POs are most impacted by the need for skilled IT staff to work with their systems to generate accurate and consistent patient data, or alternatively, to build a system that automatically generates files with the patient information needed to field a survey. Through our pilot both MHQP and CHPI found that POs vary considerably in how effectively they collected usable patient data and email contact information, and those with more robust IT capabilities were more successful.

DATA MANAGEMENT

A second consideration is how patient data from the POs are managed, cleaned, validated, and prepared for use by survey administrators. RHICs reporting quality information usually employ one of two data models and the model choice can have an impact on costs. Using a leveraged approach, POs in a region submit results that are collected and submitted under a common data collection protocol by a vendor chosen by the medical group. With a centralized approach POs submit data to a single vendor who manages data validation, survey administration and aggregation of results. Both models offer advantages and disadvantages when considering costs and it is important to consider which model will work best with your regional health system characteristics and the funding model for your survey program. In our efforts both regions used a centralized approach and found it to be quite effective in that there was one point of contact with knowledge of each individual PO's infrastructure and data related issues.

PLATFORM DEVELOPMENT

Although there is general agreement that electronic surveying is less costly, it is important to note that start-up costs for this mode could exceed those for a mailed survey program[3]. Our programs both started with an established paper based survey from which we then needed to create, test, and validate a new user-friendly electronic survey. Once setup is achieved, however, marginal costs are reduced with savings expected over the long-term. As noted above, even with the rapid acceleration of the use of new communication technologies, a standard large scale patient experience survey based on sampling should be implemented using multiple modes to ensure an adequate response rate. Before the survey could be administered, the project team spent over a month working with an external data management company, advisory committee, and other external stakeholders to develop the survey content, plan analysis, and develop the sampling plan that would meet analytic needs. MHQP needed added preparation time because this was the first time survey data had been collected through email.

SURVEY ADMINISTRATION

While many organizations can administer surveys electronically, patient experience results for public reporting and value based reimbursement programs should be collected through standard and accepted survey protocols. Therefore, it is important to assure that survey vendors have sufficient expertise and capacity to successfully implement large scale standard survey protocols including mixed modes of surveying. The best way to evaluate services offered by a vendor is to create an RFP that clearly states criteria for selection and requires vendors to provide detailed information about their proposed approach to supporting the program. When reviewing RFP submissions, carefully evaluate vendor capabilities to ensure the success of what is an expensive and resource intensive process.

In addition to a survey vendor, it is often necessary to work with a statistician to develop a survey sample plan. Many survey administration vendors offer statistical support as part of their services. It can also make sense to work with an external statistical consultant as many regional programs adapt standard processes to ensure valid and reliable responses for their particular surveyed population.

As noted briefly above, CHPI and MHQP assumed responsibility for engaging support and executing agreements with funders and participants. We also contracted with and budgeted for vendors to provide the fielding of our surveys, the accurate collection of patient data, the security of data, statistical analysis of data, and results.

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[3] Evaluating Patients' Experiences with Individual Physicians A Randomized Trial of Mail, Internet, and Interactive Voice Response Telephone Administration of Surveys; Hector P. Rodriguez, MPH,Ted von Glahn,William H. Rogers, PhD, Hong Chang, PhD,Gary Fanjiang, MD, MBA,and Dana Gelb Safran, ScD

SURVEY TOOLS

The development of the very best survey tools for use in your electronic and/or short form is a key step in the development of a successful patient assessment program and should begin as soon as your organization makes the decision to move forward with this program. There are many considerations and working with a survey administration vendor to develop the survey tool(s) will allow this work to get done timely and accurately. In anticipation of this step, we've provided a checklist of considerations that will help you and your vendor set up and manage an online survey.

PRIVACY AND SECURITY

☐ Ensure that privacy is protected through secure data collection systems. Ask your vendor to provide you with information about system evaluations and audits by independent entities.

☐ Provide respondents with information about how their privacy is protected. This can be done through the invitation to survey or made available through a link on the landing page.

☐ Web surveys should be password protected. Options are an individual specific code or sign-in procedure. It is important to have some means of assuring that the individual responding to the survey is the sample member.

☐ Provide PO's with documentation to describe how patient information is protected.

DESIGN

☐ Provide respondents with an estimated time to complete of the survey.

☐ Make sure that only a few questions appear per screen view. It is hard to see multiple survey questions and response options on many handheld devices such as smart phones.

☐ Use few graphics. Graphics are distracting and electronic graphics may display differently on different devices.

☐ Consider and test how the layout looks on a full sized monitor vs. a smart phone.

☐ Force answers only when absolutely necessary. Balance the potential for frustration on the part of the respondent with the importance of obtaining needed information.

☐ Make sure to automate skip patterns so that respondents do not have to manage multiple pages.

☐ Offer respondents a way to report problems on each page. Respondents can help identify system issues.

☐ Allow respondents to have the ability to save responses and return to the survey later. Respondents should be able to use the same passwords to reenter the survey.

☐ Include an option for respondents to finalize their responses and submit data. This option helps determine whether respondents have finished taking the survey.

TESTING

☐ Ask independent testers to take the survey to make sure it is functional. It's important to have testers who are not involved in the development take the survey. Make sure all functions are tested.

☐ Test the survey on different devices and systems, including:
- Low-end computers with slower Internet connections
- Display settings (e.g., screen resolutions set at 800 x 600 pixels versus 1,152 x 864 pixels
- Different smart phone types (e.g., Apple, Droid)
- Various Internet browsers (Internet Explorer®, Netscape®, Safari®, Chrome®)

☐ Have individuals of different age groups test the survey.

☐ If there is more than one version of the survey, make sure that you test each version in all testing areas.

SURVEY TOOLS

SURVEY MANAGEMENT

☐ If you are sending a large number of invitations, stagger invitations so that you do not trigger system firewalls. Systems are set up to protect against spam and they may reject invitations.

☐ Plan to send emails at different times of the day to account for differences in respondent email use. Electronic surveys follow a shortened field period (3 weeks) with follow up emails sent at weekly intervals. Emails can be sent at different times of day for each wave.

☐ Make sure survey administrators and project managers have the ability to monitor the survey while it is in progress.

☐ Monitor response and completion rates to assure that the survey fielding is going as expected. Anticipate that adjustments, such as leaving the survey in the field an extra week, may be needed.

INCORPORATING PATIENT COMMENTS/NARRATIVES

For the electronic versions of the survey used in our pilot, CHPI and MHQP added an additional section to test the collection of comments from patients. We wanted to find out how patients would respond to the opportunity to provide comments about their care experience. To help elicit actionable comments, we tested 2 versions of open-ended questions developed by survey methods experts as part of our study. Researchers at RAND have qualitatively evaluated the responses we received, which will help us define future work in this area.

Here are some suggestions for the development of a survey instrument that allows for the collection of patient comments:

☐ Set up the survey so that respondents close out their survey responses before providing comments. This maintains the integrity of survey data collection.

☐ Provide a disclaimer that advises respondents that the opportunity to provide comments should not be used to seek care and direct them to call their provider's office if they have an immediate medical need.

☐ Ask respondents to confirm that they understand that the comments they provide will be shared with their provider and that they understand that their comments may make it possible for others to identify them.

ENGAGEMENT AND ENROLLMENT METHODS

INITIATING ENGAGEMENT OF PROVIDER ORGANIZATIONS

Communicating with prospective participants early and often is the best way to begin generating interest and encouraging participation. Shortly after securing grant funding, CHPI and MHQP both began focused recruiting efforts by promoting the pilot to existing stakeholder audiences, both formally and informally via email, one-on-one email follow-up, and one-on-one phone conversations.

The CHPI team began building enthusiasm for the pilot before funding was secured through the grant with CHT. Because CHPI was already fielding the Patient Assessment Survey (PAS) in California, there was an engaged audience with whom to start initial outreach. Though several approaches were employed throughout the engagement process, the most successful approach for CHPI was positioning the Short Form Survey Pilot as a direct response to constituent feedback, requesting that a shorter, more relevant survey instrument be developed. Similarly, MHQP began building support for innovation by including the topic on regularly scheduled meeting agendas, specifically those related to the statewide PES project and also through regular newsletters.

Examples of early email communications are included here: Invitation from PAS and here: MHQP Recruitment Letter.

Once pilot funding was granted and confirmed, both MHQP and CHPI implemented a more direct recruitment strategy. Participants were primarily targeted if they already participated in CHPI's or MHQP's patient assessment survey programs. Additional criteria identified during our participant readiness assessment were then accounted for in efforts to hone in on the most "ready" potential participants. We looked for groups that had protocols for electronic surveying in place, utilized a patient portal, had a well-established and well-functioning EMR, and had defined methods for communicating with their patients outside of the office. Meeting these criteria supported the critical success factor of having enough valid email addresses to field an electronic survey that would yield statistically valid results. This will be discussed more in the Methods section.

While CHPI did garner initial interest from the groups, the email invitation alone was only successful for the onboarding of one group to the pilot. In order to secure participation from additional groups, further email correspondence was required to answer questions and clarify details about the pilot. Accordingly almost 50% of the CHPI groups who ended up participating had one or more telephone calls with the Program Manager to further discuss various aspects of the program.

MHQP had a similar experience and found that direct one-to-one communication by the CEO through phone and email was the most successful tactic to turn growing interest in the pilot into commitment to participate. In addition, MHQP offered a small discount on its statewide survey as an incentive for Massachusetts based organizations that were paying to participate in the core survey to offset the staff costs for participation in the pilot.

On the whole, our experiences indicate that while POs can easily see the value in this work, there are many questions that need to be answered before they can commit to participation. Many of the questions and concerns center on how patients would view being contacted by email, the security of the transmitted data, the intended use of the data, and the internal technical support needed to participate. Because of the importance of these concerns, these topics were best addressed through individual meetings with interested organizations, in combination with direct follow-up phone calls to key decision makers, making these methods the most effective recruitment tool.

OTHER HELPFUL DOCUMENTS

1. A one-page overview of the goals of the project

This document provides very clear documentation about what the study group wants to accomplish, and how it will benefit the participants. Due to a compressed recruitment cycle for the Short Form Pilot undertaken jointly by CHPI and MHQP, a one-page description was not created. For future efforts, a one-page summary of the goals and benefits of the program could be a helpful recruitment tool.

2. A FAQ document to circulate among groups

Anticipate the most common or important questions you might receive and present them with clear answers in a one-page document. This will either serve to minimize the number of questions that you receive, or serve as a foundation for groups to look for clarification or more information about particular issues. Please see examples of CHPI's and MHQP's FAQ documents here and here for examples of the issues we anticipated, and an additional Fact Sheet document from MHQP here. CHPI benefited from a longstanding relationship with participant groups who have fairly extensive Business Association Agreements in place with the survey vendor and therefore did not have to field as many data questions as MHQP did during the recruitment phase.

3. A PowerPoint presentation to share with interested groups

This is an all-in-one presentation that outlines the impetus for the pilot, the goals, the benefits for the participants, requirements for participation, comparison of survey instruments, testimonials, cost savings, etc. This is a tool that could be shared during a first encounter with a potential participant, or be used at meetings and to serve as a conduit for further follow up. CHPI created this presentation in the event that opportunities arose to share pilot goals with a wider audience.

4. Testimonials to share with other groups

Testimonials are a powerful tool, especially in this day and age where they are used across all industries to inform consumers about all types of products. There is an expectation that something come highly recommended before trying it. While CHPI and MHQP were unable to use testimonials for the current pilot round, as it was the first of its kind, we plan to develop them moving forward. For example, we would consider adding a testimonial to our FAQ document about the integrity of data storage and transmission to mitigate concerns about these issues.

ENGAGEMENT AND ENROLLMENT METHODS

ENGAGING PATIENTS

For the purposes of maintaining statistical comparability to our current California and Massachusetts statewide surveys, CHPI and MHQP did not pursue any patient promotions, maintaining consistency with our current survey practices. While Group Participation Agreements specify that participating groups may not encourage patients to respond to surveys in a certain manner, the agreements do permit groups to proactively notify patients that they may be selected to participate in a survey. There is a need to improve response rates to patient experience surveys administered in all modes and we recommend working with provider organizations to implement a communication plan that creates awareness by patients that they may be contacted, and that encourages their response to the survey as a means to help improve care.

In summary, because financial constraints limited mass marketing efforts in both California and Massachusetts, outreach and engagement was focused on a number of targeted activities, including:

- Word of mouth recruitment through existing networks (medical groups, practice sites, health plans)
- Informational webinars or presentations on a one-to-one basis at scheduled meetings
- One-on-one discussions about the pilot with current long-form survey participants
- Direct communication to decision makers by executive staff

While both groups ultimately recruited enough participants for the pilot, there were several lessons learned during this phase of the program, including:

1. Identifying and meeting with the right person at organizations is critical. It’s important to determine who the key decision makers are and to be persistent in your attempts to make contact with them.

2. Be well prepared to answer questions about data processes, as security is a concern for all organizations that transfer data.

3. Email correspondence alone does not suffice for recruitment purposes; direct phone outreach and face-to-face conversations were needed to gain participation.

4. Give yourself enough lead time to recruit participants. Several months were needed to close on this initial pilot participation. It is likely that recruitment can be streamlined once organizations become familiar and comfortable with processes and results.

METHODOLOGY

SURVEY POPULATION

Our ability to generalize survey results and use results for public reporting and pay for performance depends on attaining broad coverage of the population of interest. As we move to new modes of surveying, it is important that provider organizations are encouraged to implement systems for collecting electronic contact information on an ongoing basis. Through our work on this pilot we found that provider organizations varied considerably in their collection of contact information. In Massachusetts organizations that had email contact information available for patients that had office visits ranged between 5-44%. The quality of email contact information also varied, with bounce-backs from emails sent ranging from 3-11%.

We did not have enough lead time for this project to implement a communications outreach effort that encouraged collection of contact information prior to data submission and survey fielding, but we strongly recommend it. Provider organizations implementing these processes have seen a significant improvement in response[4].

SURVEY DESIGN

MHQP and CHPI collaborated with our contracted statistician, NCQA, and the CAHPS Consortium to develop a common short form survey instrument here and here based on the Adult CAHPS Clinician-Group (CG) survey - an instrument developed by the Agency for Healthcare Research and Quality (AHRQ) and widely recognized as the standard for measuring patients' experience of ambulatory care. At this time, there is great consensus among survey researchers and health care policy-makers (including CMS and the NCQA) that there is a need to shorten the instrument. The instrument developed for this pilot is comparable to the CG-CAHPS 3.0 survey which is a shortened version of the standard 34 core question instrument. A comparison of the CG-CAHPS 3.0 and the Short Form for our pilot can be viewed here.

MHQP and CHPI worked with the Center for the Study of Services (CSS), a data management and survey administration organization to administer both core long form and short form test surveys and our statistician, Bill Rogers, Ph.D. to develop a plan to test our hypotheses. The short form mail survey was fielded on the same schedule as the core survey in each market and followed the same mail protocol; the survey was mailed in 2 waves with an internet option offered in the cover letter of the survey (the core survey also offered this option). The email survey invitations were sent over a 3 week time span. The email version of the survey also allowed for comments from respondents at the close of the survey.

Although MHQP and CHPI worked closely to align efforts as much as possible, there are some differences in the approaches. See the differences between MHQP and CHPI's sampling administration plan and survey elements here.

We recommend working with your survey administrator and statistician to define a sampling plan for your program with these considerations:

- Purpose of the survey – As we were implementing a pilot study, we needed a sufficient sample to be able to test our hypotheses. If you are planning a large scale electronic short form survey, consider whether you will use results for accountability (i.e., public reporting or pay for performance), quality improvement or both. In general, accountability reporting requires a larger sample size to ensure results are statistically valid and reliable.

- Level of information required – Your plan should take into account what level of information is needed: medical group (a group of affiliated practices), practice or physician level. CHPI reporting is based on medical groups and MHQP reporting is based on practice level data. Each requires a different sample to produce valid and reliable results.

- The quality of your contact information – Assess whether you need to field the survey in more than one mode. Electronic surveys will most often need mail follow up if there is insufficient contact information available.

- The population being surveyed – Additional efforts may be needed for populations with less access to electronic modes or lower response rates to mail surveys. A telephone mode may be recommended to improve response.

Mixed mode surveying (i.e., email, mail, and phone) allows the administrator to account for patient differences, obtain the maximal number of responses, and reduce costs. Email contact can also act as pre-notification prior to receiving a mail survey and improve mail response rates. A continued need to implement a mixed mode means that print design and production cannot be entirely eliminated, but significant savings can still be achieved by reducing print volumes and mail costs.

ANALYSIS OF RESULTS

The analysis of patient experience data should be performed by statisticians experienced in survey methodology and analysis. Introducing new modes of surveying means that we need to pay close attention to differences in patient characteristics for those responding to each mode and evaluate both response and non-response data to assess differences in patient characteristics.

This analysis informs appropriate adjustments needed to present representative results. Representative results are essential for making fair comparisons among organizations that might serve very different populations. Some of the patient characteristics that are typically considered in making adjustments include: age, gender, education, race, and health status.

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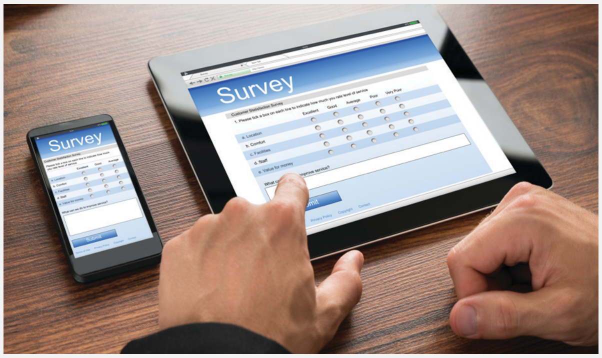
[4] Bergeson SC, Gray J, Ehrmantraut LA, Laibson T, Hays RD (2013) Comparing Web-based with Mail Survey Administration of the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Clinician and Group Survey. Primary Health Care 3: 132. doi:10.4172/2167-1079.1000132

CONCLUSIONS



We hope that the information provided in this fielding guide has answered some questions about the steps involved in the development of a patient experience program, and that our experience developing an electronic short form instrument will inform work for others interested in this path. The key lesson for MHQP and CHPI is that this process is dynamic and will continue to evolve. As changes in societal and communication norms take place, novel survey methods arise, new knowledge comes from testing new ideas, and hypotheses are developed, the status quo will be tested. We hope that others will also share their lessons they have learned and contribute to our collective knowledge about this important field of study.

If you have any further questions about our work, please contact Rose Judge at rjudge@mhqp.org or at 617-600-4950 (MHQP), Meghan Hardin at mhardin@pbgh.org (CHPI), or Rachel Brodie at rbrodie@pbgh.org (CHPI).