

RI HCQP Update: Home Health Satisfaction Pilot

Meg Richards, PhD
Quality Partners of Rhode Island
March 12, 2007

Background Information

- Working with Press Ganey
- [Nearly] all R.I. Home Health Agencies are participating, regardless of Medicare certification and/or type of license (n=53)
- Excluded from the outset agencies offering: hospice, pediatric, maternal-child health, or infusion services only

The Pilot Survey Effort - Statewide

- Pilot took place Oct. '06 – Jan. '07 (~14 wks)
- No. of deliverable surveys mailed: 8576
- No. of surveys returned statewide: 2530
- Response rate overall: **29.5%**
- No second mailing, no tickler postcards, etc.

The Pilot Survey Effort – Agency Level

- Response rates varied from **6% - 63%**
- Number of weeks of active participation (uploading patient names & addresses to Press Ganey) ranged from **1 - 14 weeks**
- Number of surveys mailed on behalf of an agency ranged from **3 (!) - 1129**
- The most active agency uploaded patient lists **14** times, had **1129** surveys mailed on their behalf, and achieved a response rate of **35%**

The Pilot Survey Effort: Agencies 'left behind'

- For 5 agencies, no surveys were ever mailed (technical difficulties with uploads?)
- For an additional 28 agencies, survey returns were less than the 30 min. recommended for public reporting (due to small patient census, infrequent uploads, or both)
- Thus, only 20 agencies met the proposed min. (for public reporting) of 30 returned surveys

Problems Noted / Proposed Solutions: Survey Instrument

One instrument fits all:

Skilled care patients are answering questions about non-skilled services and vice versa. Skilled care patients are also calling their agency to ask why they don't get homemaker-type services.

Fix?

Create two instruments, one for skilled care and one for non-skilled care. Surveys will share a core set of questions but will otherwise be distinct. Publicly report satisfaction data according to this split.

Problems Noted / Proposed Solutions: Survey Instrument

Attribution:

Patients served by multiple agencies are not sure for whom they are responding, may receive multiple surveys and confuse their responses, or may elect not to respond at all out of annoyance.

Fix?

- Use correct names and logos on all surveys.
- Use two kinds of distinct-looking surveys (skilled and non-skilled).
- Mail only 1x to a patient or client. (First agency to upload that pt/client name has 'dibs'.)

Problems Noted / Proposed Solutions: Survey Instrument

JCAHO certification:

Surveyors felt that the current questions on pain (sensitivity to pain) missed the mark (need to ask about pain mgmt. effectiveness). Also noted that we don't ask patients about improving patient safety.

Fix?

Modify existing questions and/or add new questions from Press Ganey's stable. Check with JCAHO surveyors first, however, to make sure that they will suffice.

Problems Noted / Proposed Solutions: Survey Process

Patient Status:

Surveyed active rather than discharged patients in the pilot to guarantee a sufficient n for low-turnover agencies. Some patients were getting a survey after only a few days (1-2 visits) on service.

Fix?

Allow agencies to choose, or to survey both groups. Tighten 'rules' so that - for example - an active patient is surveyed *only* after 30 days/4 visits. Discharge surveys would be mailed 5-14 days post-discharge.

Collateral issue:

Two very different groups, with different experiences?

Problems Noted / Proposed Solutions: Survey Process

Minimum Returns:

Agencies with fewer than 30 returns will have empty or asterisked cells in the public reporting table.

Agencies with fewer than 7 returns do not receive a Q.I. 'benchmark' report from Press Ganey.

Fix?

- Lower the minimum to 10 (the min. used for clinical data), or to a response rate of 50% – whichever is larger.
- Survey for **16** (not 14) wks.
- Let agencies know that they can still get a basic report of their performance, but it will be without state, regional, national comparisons.

Problems Noted / Proposed Solutions: Survey Process

IT ~ Commun. difficulties:

Some agencies were unable to successfully upload patient lists, were unsure how and when they should contact Press Ganey (PG) for help, and struggled with the 'high-tech' [electronic] features of this process.

Fix?

- Hold another round of training with PG before the public wave.
- Pair small, low-tech agencies with a higher tech 'buddy' agency to help as needed. (Larger agencies have offered this support.)
- Ensure that PG is providing robust support to agencies that struggled w/ the pilot.

Next Steps: Public Wave

- Home Health Sub. will meet again on April 9th to plan changes to the survey and the process. Press Ganey is aware of proposed modifications.
- Will begin surveying again in early August and work through late November (16 weeks).
- Public reports of Home Health Satisfaction will be posted at HCQP web pages early in 2008.

RI HCQP Update: Ambulatory Care / Provider Transparency

Meg Richards, PhD
Quality Partners of Rhode Island
March 12, 2007

Definitions

- **Ambulatory care:** Medical services provided on an outpatient (non-hospitalized) basis. Services can include diagnosis, treatment, and rehabilitation.
- **Primary Care:** Basic or general health care focused on the point at which a patient ideally first seeks assistance from the medical care system.
- **Transparency:** When healthcare providers conduct their business in a way that supports the sharing of information on price, process, and outcomes.
- **Provider:** A physician or other licensed practitioner with responsibility for the care, treatment, and services rendered to a patient.

Provider Transparency: Nationally

- NY, PA - cardiac surgery mortality at the health insurance, hospital, and surgeon level (since 1990s)
- HealthGrades
 - reports (for sale) on individual MD's board certification, disciplinary actions, educational background, and
 - ave. charges, health plan payment, and out-of-pocket costs* on all expenses related to 56 procedures (*inc. hosp, MD, Rx, and lab costs)
- MA, CA, MN: quality measures at the medical group practice level
- CMS: 2007 Physician Quality Reporting Initiative (processes of care)

Provider Transparency: Rhode Island

In June 2006, SB 3170 amended the HCQP legislation to include reporting at the individual provider level, and to make available information which would, “help consumers make informed choices regarding the facilities, clinicians, or physician practices at which to seek care.”

The act is known as:

The Rhode Island Health Care Affordability Act in 2006 – Part II – Transparency of Information on Health Care Quality and Cost.

Ambulatory Care & Provider Transparency: Rhode Island and Nationally

Focus to Date:

Facilities
Clinical Outcomes and
Patient Satisfaction
Inpatient, Home Care
Ambulatory Care = CHC
New and/or obtrusive
data collection (by
HEALTH or CMS)

New, Added Focus: 2007+:

Providers
Structure, Price, (Process) and
Volume Measures
Outpatient Care
Ambulatory Care = all outpatient
Routine, unobtrusive data
collected administratively or as
part of ongoing care of patient

Making Ambulatory Care / Provider Transparency (AC/PT) Happen Here

First, the Steering Committee (SC) approved last year the formation of two subcommittees to provide stewardship for AC/PT (subcommittee formation is underway):

- a **primary care / chronic disease subcommittee** to identify structure and process measures of interest for public reporting at the provider (and group) level with respect to primary care disease management
- a **surgical procedures subcommittee** to identify ambulatory surgical procedures (possibly elective) for which volume, cost and outcome data can/should be made available to the consumer

Making AC/PT Happen Here: Guiding Principles

Ultimately, subcommittees will choose measures and make a recommendation to the SC, but consider that we can:

1. **Start with structure measures** at the provider level. Why?
 - ✓ They include consumer-friendly and valued information such as practice location/mapping, evening/weekend hours, languages spoken, use of e-prescribing and electronic (portable!) medical records, etc.
 - ✓ Structure measures are less threatening to providers than risk-adjusted outcome measures such as mortality. They provide a framework to which outcome, process, and even cost measures can be added over time.
 - ✓ The most basic structure data element – practice location – is a critical piece of info. in public health preparedness and public health program delivery.

Making AC/PT Happen Here: Guiding Principles

2. **Build on existing efforts**, and capture database (db) information that is both meaningful and up-to-date.

More than a dozen public and private programs around the state collect information about providers (e.g., licensing db at HEALTH; 'Find a Provider' db through BCBSRI, etc.) Variables differ and information is often inaccurate or out-of-date. A central provider database that serves multiple programs, is updated with ease (via secure web portal) and on a quarterly basis would be a gift to all Rhode Islanders.

Making AC/PT Happen Here: Guiding Principles

3. Collaboration is essential.

The most successful approaches to public reporting and transparency have resulted from partnerships involving the public and private sectors as well as purchasers and providers.

(Colmers J: "Public Reporting and Transparency." Prepared for the Commonwealth Fund / Alliance for Health Reform: 2007 Bipartisan Congressional Health Policy Conference, January 2007.)

A look at some of the pace-setters ...

- **Massachusetts Health Quality Partners (MHQP)**
<http://www.mhqp.org/>
- **HealthGrades**
<http://www.healthgrades.com/>
- **Pennsylvania CABG Reports (PA HC4)**
<http://www.phc4.org/cabg/?year=2004/>
- **NY Hospital Report Cards (Niagara Health Quality Coalition)**
<http://www.myhealthfinder.com/newyork06/glanceshow.php/>
- **Physician Quality Reporting Initiative (CMS)**
<http://www.cms.hhs.gov/pqri/>
- **Value-Drive Healthcare (US-DHHS)**
<http://www.hhs.gov/transparency/>

Thank you!

- Questions?
- Discussion?