Osteopathic Family Physician (2013) 5, 153–157

ELSEVIER

acofp Osteopathic Family Physician

Consumer assessment of healthcare providers and systems survey: Implications for the primary care physician

Lindsay Fowler, DO,* Ashley Saucier, MD, Janis Coffin, DO

From Georgia Regents University, Department of Family Medicine, Augusta, GA.

KEYWORDS:
Healthcare reform;
Patient care experience;
Core measures;
PhysicianCompare

Medical care is under constant reform. Physicians are encouraged to stay current and well informed to receive maximum reimbursement, while still providing high-quality medical care to our patients. The trend has been that insurers are following the Centers for Medicare and Medicaid standards in the new wave of quality reporting with a patient assessment of their experience, or the care received, in regulated surveys for inpatient as well as ambulatory settings. These surveys, Hospital-level and Clinician and Group–level Consumer Assessment of Healthcare Providers and Systems survey(s), would begin to dramatically affect physician reimbursement(s), potentially change the way we practice medicine to meet guidelines to be consistent with the Patient-Centered Medical Home model, as well as making other important changes based on patient feedback provided in the surveys mentioned previously.
© 2013 Elsevier Inc. All rights reserved.

Introduction

In 2001, the Institute of Medicine published *Crossing the Quality Chasm*, which was offered as a guide for patient-clinician relationships and a redesign for the American healthcare system.[1] They named patient centeredness as 1 of 6 healthcare quality aims.[1] Since then, patient centeredness has been the forefront of healthcare reform.[1] A pivotal part of patient-centered care is the patient experience and measuring the patient care experience is becoming the new standard of care. Hospitals are already using patient experience surveys through the implementation of Hospital-Consumer Assessment of Healthcare Providers and Systems survey (H-CAHPS), a self-reported survey that looks at patient interactions with clinical and administrative services. This survey was developed by the Centers for Medicaid and Medicare Services (CMS) in collaboration with the Hospital Quality Alliance, as a public-private team attempt to improve hospital's quality of care by the use of an easy-to-understand standardized report on hospitals performance as part of CMS larger Hospital Quality Initiative.[2] Since 2007, most hospitals have been collecting data using a standardized core CAHPS survey and then publically reporting these data quarterly to "Hospital Compare." There have been multiple studies showing that measuring the patient care experience in the hospital setting is tied to better health outcomes, improved employee satisfaction, and decreased employee turnover.[1] These surveys are tied to hospital reimbursement as well. The Hospital Value-Based Purchasing program links a portion of hospitals' Acute Inpatient Prospective Payment System payment from CMS to the patient experience of care, which is based on the H-HCAPS survey.[3]

Measuring the patient care experience is now filtering into the ambulatory setting through Clinician and Group–level Consumer Assessment of Healthcare Providers and Systems survey (CG-CAHPS), a self-reported and standardized tool

*Corresponding author: Lindsay Fowler, DO, Georgia Health Sciences University, Department of Family Medicine, 1120 15th St., Augusta, GA 30912.

E-mail address: lfowler@georgiahealth.edu.

1877-573X/$ - see front matter © 2013 Elsevier Inc. All rights reserved.
http://dx.doi.org/10.1016/j.osfp.2013.03.001

that would be used to measure patient perceptions of care.[4] In the new era of patient- and family-centered medical care, ever-changing regulations and mandates can be intimidating, frustrating, and confusing. However, the CG-CAHPS would have a wider spread of influence than the H-CAHPS, as it targets individual and group primary care practices. In the future, this survey would be linked to licensure, board certification, and compensation; would give providers valuable feedback on areas in which to improve; and like H-CAHPS, the results would be publically reported.[1] Therefore, it is important for providers to embrace these changes now before they become linked to high-stakes consequences. This article is meant to briefly overview the importance of CG-CAHPS, how it would affect primary care practices and physicians in the future, and explain how it would be implemented.

Definition and purpose of CG-CAHPS

CG-CAHPS is designed to monitor patient care, patient satisfaction, and financial performance in the ambulatory setting as well as provide a standardized and validated survey tool to measure patient experience. This survey has versions for primary care and specialty care.[4] The survey is endorsed by the National Quality Forum, and is available free of charge.[1] It is different from a patient satisfaction survey in that it measures valuable patient experiences that are tied to important clinical outcomes. There are 7 core measures that are evaluated by this survey including access to care, provider communication, provider rating, access to specialists, health promotion or education, shared decision making, and health or functional status.[5] Currently, there are 3 forms of this survey. There is the 12-month survey, which measures patient experience with the provider over the past 12 months; the visit survey, which assesses the patient's experience at their most recent visit; and the expanded 12-month survey with the Patient-Centered Medical Home (PCMH) Item set, which allows the patient to address their experience during the past 12 months with an additional item set specific to the PCMH.[6] Please find some types of commonly asked CG-CAHPS survey questions in Figure 1.

The importance of CG-CAHPS to the practicing physician

Measuring the patient care experience is now becoming more important to physician licensing, board certification, and practice group recognitions.[1] The driving force behind the use of CG-CAHPS is multifactorial and includes, but is not limited to, the Aligning Forces for Quality, PCMH/National Center for Quality Assurance (NCQA), the U.S. Department of Health and Human Resources/Health Resources and Service Administration, American Board of Medical Specialties, state mandates, accountable care organization (ACO) like Centers for Medicare and Medicaid, as well as rising patient and consumer expectations.[7] Currently, to achieve PCMH recognition, the NCQA Physician Practice Connections requires the implementation of a patient experience of care survey.[1] In addition, the American Board of Medical Specialties' revision of Maintenance of Certification requires that each of its 24 Member Boards contain the core CG-CAHPS items.[1] Through early implementation and understanding of this process, providers can begin to make beneficial changes in response to their scores, and further their progress in obtaining the PCMH status as well as achieving maintenance of certification.[4] In 2011, the NCQA PCMH Standards began offering "distinctions" to practices collecting data through the PCMH version of the CG-CAHPS.[8]

An increasing number of public and private payers are starting to incorporate CG-CAHPS scores into their compensation structures.[1] Blue Cross Blue Shield of Massachusetts has an Alternative Quality Contract compensation model, in which a part of provider payment is based upon CG-CAHPS results. The Centers for Medicare and Medicaid Services is considering including patient experience survey results as part of pay-for-performance programs.[1] As required by the Affordable Care Act, an ACO must demonstrate that it meets required standard quality performance for the year before it can share in any created savings by the Shared Savings Program through CMS. There are 33 quality measures used to determine eligibility, 7 of which are based on patient or caregiver experience. In 2012, CMS finalized the use of the 12-month CG-CAHPS survey to assess patient and caregiver experiences. They are currently in the process of finalizing a standardized survey and the steps through which this survey would be administered. Once the initial standardization of the survey is performed, CMS will administer the survey for use by pioneer ACO. Based on the results, they will refine survey administration and sampling. All the while, CMS will also be working toward finding CMS-certified vendors to administer this survey. Within the next few years, all ACO will be required to contract with a CMS-certified vendor for administration of the survey and report their patient experience data using their standardized survey to participate in the Shared Saving's Program.[9]

There are proven benefits to measuring and improving upon patient experience and taking an active approach to addressing issues in care. When feedback is collected in such a way that is it standardized and acted upon, true improvements can be made to increase patient satisfaction.[10] Measurements from survey results could expose a delay in returning test results, or a lack of communication that could drastically alter patient experience.[1] The internal medicine department of a multispecialty practice, Stillwater Medical Group, with 2 sites in Minnesota and Wisconsin, used the CG-CAHPS tool to survey patients and target areas for improvement. Through conversations with physicians and analysis of CG-CAHPS survey items submitted by patients, they chose to target improvements in patient-physician communication through the implementation of an After Visit Summary that was given to patients. As a result, the practice saw an improvement in their survey item score for

Types of questions that are commonly asked by a CG-CAHP Survey (answers often in multiple choice form).
- In the past 12 months, how many times did you call this provider's office for an illness, issue or injury that needed to be address immediately?
- In the past 12 months did you make any routine/follow-up appointments?
- In the past 12 months how often did you get an appointment in the amount of time your felt was appropriate?
- In the past 12 months did you phone your provider's office with a question during medical office hours? If so, did you get an answer right away?
- In the past 12 months how often did you see your provider within 15 minutes of your scheduled appointment time?
- During your most recent appointment, if you received laboratory or x-ray results were they explained to you in a way that you could understand?
- During your most recent appointment, did your provider listen to you carefully?
- During your most recent appointment, did your provider give you easy to understand instructions about taking care of your health problems or concerns?
- During your most recent appointment, did your provider seem to know important information about your medical history?
- During your most recent appointment, did your provider show you respect?
- During your most recent appointment, did your provider spend enough time with you?
- Would you recommend this provider to your family and friends?
- During your most recent appointment, did the clerks and receptionists treat you with respect?
- How would you rate your overall health?
- In the past 12 months have you seen a health care provider more than 3 times for the same medical problem (excluding pregnancy)?
- If you answered yes to the previous question, has this problem lasted more than 3 months?
- Do you take medicine prescribed by your doctor for this problem?
- Age, race, sex, education and the question "has someone helped you fill out this survey" are often asked.

Figure 1 This figure displays some commonly asked questions in the CG-CAHPS survey.

"received easy to understand instructions" from 84% in 2009 to 100% 1 year later, and an "increase in their overall physician score ratings" from 79% in 2009 to 82% the following year.[11] Primary care physicians see many chronic conditions, and it is difficult for physicians to achieve positive health outcomes without patient commitment to and involvement in their care.[1] Patients with better care experiences feel more empowered, and are more engaged and compliant.[1] Patient care experiences can correlate with patient compliance to treatment plans, and to improved outcomes of care.[1]

The data collected in CG-CAHPS would not only provide valuable feedback for physicians, but would also be used to provide physician information to consumers as the surveys would be publically reported. In January 2011, CMS launched the *PhysicianCompare* site, which reports on physicians who satisfactorily participated in the Electronic Prescribing Incentive System and the Physician Quality Reporting System. Very soon, physician performance data on this site will include an assessment of patient experience. The likely survey to be used in meeting this assessment requirement will be some form of the CG-CAHPS.[5] There are some places where public reporting of patient experience is already required. In Minnesota, state legislation requires all physicians to conduct and publically report CG-CAHPS.[5] Although some may be hesitant about the consequences of reporting physician data publically, it may prove to have one particular advantage. According to the American Medical Association, patients are less likely to share opinions of experience with medical staff or physicians, but are more likely to share on a consumer-rating website.[10] A simple Google search on "physician ratings" pulls up multiple sites like *Angie's List* and *HealthGrades*. These sites contain word-of-mouth reviews of selected physicians based on nonstandardized information. Right now, these sites are influencing consumer opinion of physicians or practice groups. Therefore, reporting CG-CAHPS scores on an official regulated website such as *PhysicianCompare* would provide a standardized form of information for consumers on other patient's prior experiences with individual physicians and practice groups. Additionally, this reporting system may provide physicians with added motivation to improve the experience for patients.

Implementation of CG-CAHPS

The method of implementation would certainly vary, along with the type of medical practice that seeks implementation. In larger communities where there are many medical practices already engaging in multiple surveys through various vendors, there is a community-wide approach that can leverage upon the already existing surveys.[12] In this instance, a common group of core CG-CAHPS questions would be incorporated into each existing survey, which is called the leveraged approach.[12] This allows for direct

comparison between each practice site, meanwhile preserving each practice's original survey.[12] Alternatively, in settings without surveys already in place, a centralized approach may be adopted where 1 vendor administers 1 survey throughout the community.[12] The costs for leveraged or centralized approaches should be the same based on the following components: patient sampling, data collection, data aggregation and analysis, reporting, and project management with the most costly component being data collection.[12] Reports from previous survey projects' data collection, based on a mailed survey, was $8-$15 per survey. To achieve adequate reliability from public reporting, the number needed per practice was 200-250, and per provider was 40-50.[12] There are some forms lower in cost, yet the data collection is still experimental, such as email or in-office kiosk.[12]

An early model of implementation and scoring

In 2011, the Agency for Healthcare Research and Quality performed a CG-CAHPS survey analysis for volunteering practice groups. The 12-month and the visit version of the survey were used and the results were reported to the CAHPS Database Online Reporting System. This database contained 2 main components: a public site for the general public to access and a submitter site for users that contributed data. The results were completed and released in March of 2012 along with a detailed report about the general overall practice specifics and scoring system used. Each practice was required to report characteristics about its group. Most of the groups represented were from the Midwest. The top 3 practice types were categorized as missing, other primary care, and family medicine. Given the high distribution of practice types characterized as missing, the process for characterizing practice types needs to be revised. Most of the surveys were collected by mail with automated voice response systems coming in second. Some were done on the web as well, with the least amount of surveys collected via phone. It has not yet been determined how mode of delivery of the survey will affect CG-CAHPS response and scores, however, the results were adjusted for factors beyond the control of the practice to make sure that the scores are actually a comparison of patient experience and not differences between the actual practice groups or modes of delivery, as much as possible.[13]

Once the data were gathered from the surveys, the results were calculated on 3 levels: individual survey responses for patients, totals for a single practice group, and totals for a group of practice groups combined. The top box score is the percentage of responses to a question that were rated high. Their scores were determined for item sets as well as a composite score. Scores were also placed into a percentile for comparison to other practices comparing the performance to the mean top box scores for a category. Each practice's composite scores were also compared with the mean overall composite score and reported as how far greater than or less than in percentages the practice was from the mean composite score. Statistical t-tests were used to see if this percentile more than or less than the mean composite top box score was significant. If significant, the practice would get an up or down arrow next to their score. There were certain guidelines and criteria that had to be met for scores to be included, and if this criterion was not met, composite or particular item scores were reported as N/A. Most data exclusion had to do with too few surveys or responses to a particular question.[13]

Conclusion

It is obvious that the patient care experience is becoming more important as a measure of healthcare quality. Measuring the consumer experience through CG-CAHPS would have a far greater reach than H-CAPHS as it would affect individual physicians and practice groups in multiple areas including compensation, certification, practice recognition, and consumer choice of physicians. It also would offer a clear opportunity to respond to patients' experience and improve delivery of care

If you would like to find a sample of a nationally used CG-CAHP survey, please visit: https://cahps.ahrq.gov/clinician_group/cgsurvey/adult12mocoresurveyeng2.pdf.

References

1. Good for Health, Good for Business: The Case for Measuring Patient Experience of Care. Aligning forces for quality. Available at: http://c354245.r45.cf1.rackcdn.com/Case%20for%20Patient%20Experience.pdf. Accessed July 30, 2012.
2. Centers for Medicare & Medicaid Services. Quality Assurance Guidelines. HCAHPS: Hospital Care Quality Information from the Consumer Perspective Web site. Available at: http://www.hcahpsonline.org/files/hcahps%20QAG%20V4%200_1.pdf. Published February 2009. Accessed August 10, 2012.
3. HCAHPS Fact Sheet. HCAHPS: Hospital Care Quality Information from the Consumer Perspective Web site. Available at: http://www.hcahpsonline.org/files/HCAHPS%20Fact%20Sheet%20May%202012.pdf. Published May 2012. Accessed August 12, 2012.
4. CG-CAHPS Survey Fact Sheet. Avatar International. Available at: http://www.cgcahps.com/cg_cahps_fact_sheet.pdf. Accessed July 30, 2012.
5. Shaller D. CG-CAHPS: What Physician Groups Need to Know. Association for Patient Experience Web site. Available at: http://www.patient-experience.org/Education—Research/Articles/CG-CAHPS–Why-These-Should-be-on-Your-Radar.aspx. Accessed August 20, 2012.
6. Shaller D. Getting to Know CG-CAHPS Surveys: Three Versions Point to Future. Association for Patient Experience. Available at: https://www.patient-experience.org/education-research/articles/getting-to-know-CG-CAHPS-Survey.aspx. Accessed August 10, 2012.
7. Shaller D. Implementing CG-CAPHS: Issues and strategies. Agency for Healthcare Research and Quality Web site. http://www.ahrq.gov/about/annualconf11/crofton_edgman_hays_ricketts_rybowski_shaller/shaller.htm. Updated December 2011. Accessed August 12, 2012.
8. Burton R, Devers K, Berenson R. Patient-centered medical home recognition tools: A comparison of ten surveys' content and operational details. Centers for Medicare & Medicaid Services Web site. Available at: http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Reports/downloads/Burton_PCMH_Recognition_Tools_May_2011.pdf. Published May 2011. Accessed August 20, 2012.

9. RTI International and Telligen. Acountable Care Organization 2012 Program Analysis. Centers for Medicare & Medicaid Services Web site. Available at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/ACO_QualityMeasures.pdf. Published December 12, 2011. Accessed August 13, 2012.
10. Patient Satisfaction/Experience. American Medical Association Web site. Available at: http://www.ama-assn.org/ama/pub/physician-resources/practice-management-center/practice-operations/patient-satisfaction-experience.page. Accessed August 11, 2012.
11. Shaller Consulting Group. A tale of three practices: How medical groups are improving the patient experience. Robert Wood Johnson Foundation Web site. Available at: http://forces4quality.org/tale-three-practices-how-medical-groups-are-improving-patient-experience. Accessed August 12, 2012.
12. Leverage existing efforts or use a centralized approach? Two strategies for community-wide implementation of CAHPS clinician and group survey. Available at: http://www.rwjf.org/content/dam/web-assets/2010/07/leverage-existing-efforts-or-use-a-centralized-approach-. Accessed August 13, 2012.
13. CAHPS: The CAHPS Clinician and Group Database. Available at: http://cahps.ahrq.gov/clinician_group/cgsurvey/cahps_clinician_group_database_report.pdf. Accessed January 16, 2013.

CME Resource: Osteopathic Family Physician offers 2 hours of 1-B CME

ACOFP members who read the Osteopathic Family Physician can receive two hours of Category 1-B continuing medical education credit for completing quizzes in the journal. Visit acofp.org/resources/publications.aspx to access the quizzes.

May/June 2013 Answers

1. c, 2. d, 3. a, 4. b, 5. c, 6. d, 7. a, 8. a, 9. d, 10. b