

# **Surveying Patients About Their Physicians**

*Replicable, Low-Cost, Collaborative Models*

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Consumers' Checkbook/Center for the Study of Services

*CAHPS Users Group Meeting*

*December 4, 2008*

# Checkbook/CSS Perspective

- Nonprofit consumer research organization, founded in 1974.
- Publisher of consumer ratings of service providers, from auto repair shops to plumbers to various healthcare services, in *Checkbook* magazine, *checkbook.org*, books.
  - First published patient ratings of individual physicians in 1980 in *CHECKBOOK* magazine, based on surveys of *CHECKBOOK* and *Consumer Reports* magazine subscribers.
- Have been a consumer representative on committees for IOM, NQF, NCQA, AHRQ, etc.
- Survey consultant/administrator, including various CAHPS surveys—
  - Do all Health Plan CAHPS surveys for Aetna, CIGNA HealthCare, UnitedHealthcare, some others.
  - Manage all CMS's CAHPS surveys for Medicare Advantage and Drug plans.
  - Aggregate/prepare all Health Plan CAHPS data for U.S. Off. of Personnel Mgmt.
  - Do HCAHPS surveys for some hospitals.
  - Administer variants of C/G CAHPS for Pacific Bus. Group on Health, MHQP, Minnesota Quality Measurement, Johns Hopkins and UCLA medical groups.

# Our Objectives for C/G CAHPS

- **Long-term objective:** to produce, for most physicians in the U.S., measures of their patients' experience of care, using the scientifically sound, NQF-endorsed Clinician/Group CAHPS survey instrument.
- **Short-term objective:** to use pilot projects in several communities to refine and test a low-cost model to get this done.
- Want the model to be flexible, so it can—
  - Meet the needs of organized communities (Aligning Forces, Chartered Value Exchange, business coalition, etc.)
  - Also serve physicians and consumers in less-organized communities.
  - Be organized around health plans, medical groups, or both.
- Model draws on the leadership of MHQP and PBGH.

# Checkbook/CSS Model

- Checkbook/CSS, as a nonprofit consumer organization, is the survey sponsor.
- Sample frame data can be provided by health plans, medical groups, or direct from physicians.
- Results will be reported *free* to the public at the individual physician level on a Checkbook/CSS website.
- Checkbook/CSS will also license the results *free* to community coalitions to report on their websites (e.g., Kansas City Quality Improvement Consortium, Colorado Business Group on Health).
- Checkbook/CSS will license results *for a fee* to health plans—and possibly medical groups and others—which can use in provider directories, P4P, quality improvement, etc.
- All licensees must follow AQA Alliance's Principles for Public Reporting, including full disclosure of methods and limitations.

# The Checkbook/CSS Pilots

- Initial pilot projects are in Kansas City, Denver, Memphis. (Now in the field in Kansas City and Denver.)
- Pilots have gotten sample to survey for each doctor from health plan claims data—working with Aetna, UnitedHealthcare, and Blue Cross plans (and probably one other plan in Memphis).
- Pilots using C/G CAHPS instrument core questions—
  - Plus “recommend” question.
  - Not including some questions that are not included in NQF-endorsed analysis specs.
- Pilots using basic NQF-endorsed mail survey protocol, but—
  - No thank-you/reminder postcard (same number of mailings as in NQF-endorsed specs for Hospital CAHPS).
  - Cover letter offers an Internet response option.
- Instrument includes the six never-to-always response options and asks about last 12 months.

# Challenges

- Will physician resistance be too great?
- Will we be able to use data from plans to create sampling frames?
- Will we be able to get enough sample of patients for each physician?
- Will the cost be too high?
- Can plans and/or medical groups be persuaded to participate and pay?

# Physician Resistance

- Plans have been concerned about this, after some negative feedback with clinical measures.
- In pilots, physicians have been uneasy but accepting, helped by—
  - Fact that survey is scientifically sound and NQF-endorsed—in contrast to much that is currently on Internet.
  - Fact that a consumer organization is doing survey and making results public, not asking for permission.
  - Collaboration of health plans, not separate surveys/conflicting results.
  - Promise to disclose methods and limitations in all reporting.
  - Checkbook/CSS's close alliance with local health care coalitions.
  - Promise to write to all doctors in advance of survey, engage informal committees of doctors in designing reports, give each doctor a 60-day period to confidentially review his or her results.
  - Meetings with local medical societies; having doctors sign letters to docs.
  - Promise that CAHPS team and others will have resources to help physicians improve.

# Using Sample-Frame Data from Plans

- Concerns expressed by many that it would be very difficult and costly to match physician lists across plans and then use claims and member data from plans to define sample frames for each doctor.
- In pilots, data initially supplied by plans did not meet Checkbook/CSS's detailed specifications. Had to work with each plan's unique data format.
- Through custom programs, drawing sample proved feasible, with a high degree of reliability. Very few physicians were kept out of the survey because of data uncertainty.



# Getting Enough Sample for Every Doctor

- Some doctors had insufficient number of plan members who had had visits to allow adequate sample size for survey.
- But in Kansas City, with three commercial plans participating, about 75 percent of PCPs did have sufficient sample (despite the fact that we did not have all self-funded members even for these plans).
- In future, need to—
  - Get more plans to participate, get all self-funded employers to approve participation, possibly get Medicare and Medicaid enrollees.
  - Also get sample from medical groups (Checkbook/CSS has efficient system for this).
  - Develop efficient ways to incorporate and audit sample directly from physicians.

# Cost

- Will be between \$100 and \$300 per physician, depending on many specifics. (Checkbook/CSS cost for Kansas City and Denver pilots was about \$100 per doctor plus cost of working with pilot communities and receiving and processing sampling data from plans. But conditions and requirements would be different elsewhere.)
- So, national cost for 500,000 doctors could be between \$50 million and \$150 million.
- Ways to keep costs down—
  - Do surveys for very large numbers of physicians at the same time.
  - Keep it simple, with lean protocol, the same sampling and survey procedures for all, and few if any variations in questions.
  - Get sampling frame efficiently—from plans, from large medical groups, or through standardized electronic procedures from individual physicians.
  - Use Standard (or Standard Non-Profit) rather than First Class mail rates.

# Ways to Spread Cost

## *How Best-Case \$50 Million National Cost Could Be Divided*

- Get multiple plans and others to share in the cost.
  - If the largest plan in the nation picks up no more than 1/5 of the national cost, the cost to that plan is \$10 million.
  - Largest plan in Kansas City (BCBS) paying about \$49,000 for its share of pilot survey (PCPs only), including setup costs.
- Don't do comprehensive survey annually—maybe once every 3 yrs.
  - That makes the annual cost to the largest U.S. plan about \$3.3 million.
  - Set up system for physicians/medical groups to pay to have standard survey done more often if desired.
- Get others to share with plans in the cost—
  - Medical groups.
  - Physicians who want to submit results for Maintenance of Certification.
  - Medicare and state Medicaid programs.
  - Foundations.
  - Consumer websites (Google, WebMD, etc.)

# There Is No Silver Bullet

- Passive websites.
  - Plans have tried and don't get enough responses.
  - Consumer websites don't get enough responses (and have unreliable, easily biased data).
- Handouts in physicians' offices.
  - Lack controls against manipulation, and thus lack credibility.
  - For the many offices with fewer than 10 or so physicians, not actually cheaper if outside organization structures and enforces uniform procedure.
  - Put hidden costs on physicians' office staff.
- E-mail surveys.
  - Should push for in future but neither plans nor medical groups now have good e-mail addresses.

# To Create Momentum to Go Nationwide

- Consumer organizations can make their members aware of the possibilities for patient experience surveys.
- Consumer organizations can communicate to employers, health plans, and public payers the strong consumer desire for patient experience ratings of individual doctors.
- Employers can make availability of patient experience ratings of doctors one criterion for choosing plans.
- Organized communities can lead.
- State Medicaid programs and Medicare can be encouraged to participate in these surveys along with private plans.
- Specialty boards can require periodic patient experience surveys as a condition of certification.
- Organizations following the NY Attorney General's agreement and the Patient Charter move to meet the commitment to incorporating patient experience survey results.
- Patient experience survey efforts can be a key part of Medical Home programs.