



Track: Improving Patients' Experiences With Care
Session: Improving Physician-Patient Communication
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Using Standardized Encounters to Understand Reported Racial/Ethnic Disparities in Patient Experiences with Care

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Racial/ethnic disparities in patient experiences with care

- Have been repeatedly demonstrated
 - Even when using well-validated measurement tools
- Apparent paradoxes
 - Minority patients report having more problems, but provide higher global ratings

Potential explanations

- Expectations of care
 - Some groups may be more easily satisfied
- Scale use
 - E.g., Extreme Response Tendency (ERT)
previously demonstrated for global ratings
- Differing interpretations of the same events



Interpreting disparities is increasingly important

- CAHPS Hospital Survey data now publicly available
- Medicare Improvements for Patients and Providers Act of 2008
 - Mandates public reporting of Medicare plan data by race/ethnicity

New contribution

- Prior studies use real-world data
 - Primarily from CAHPS
 - Cannot distinguish among the three explanations
- Our study
 - Online
 - Simulated written and video encounters
 - Experimental design allows for systematic examination of the three explanations

Study design

- Knowledge Networks panel
 - Online
 - RDD-based
 - Free Web-TV access for those without connections
 - Represents lower-income adults
- Previously used in health-related studies

Sample

- Random sample of 1,275 adults from panel
- Stratified to obtain similar numbers by race/ethnicity

| Group | n | Response rate |
|------------------|-----|---------------|
| White | 204 | 57.3 |
| African American | 163 | 41.6 |
| Latino | 200 | 49.9 |
| Total | 567 | 49.4 |

Study part I – Expectations of care

- 5 questions
 - Used in previous studies
 - Roughly how many doctors do you think
 - Take the time and effort to learn about the most up-to-date treatments and drugs?
 - Don't take enough time to talk with patients about their medical care?
 - Treat all patients fairly regardless of race?
 - 2 additional
 - Responses are no doctors at all, some doctors, most doctors, all doctors

Study part II – Written vignettes

- Patient complains of headache, physician responds
- Respondents answer 3 modified items from CAHPS Clinician and Group survey
 - Listen carefully
 - Show respect
 - Spend enough time
- 5 vignettes presented in randomized order
- Ordinally scaled measure of responsiveness

Study part III – Video encounter

- A single 4-minute simulated encounter
 - Diabetic patient with longstanding physician relationship
 - Frustration at lack of blood sugar control
 - Discuss alternative strategies for improving health
- Respondent answers
 - 5 report questions modified from CAHPS Doctor Communication composite
 - 0-10 global rating

Study part III – Rationale for video response

- Perceived positive and negative physician behaviors
- To what extent was the physician
 - Positive: Kind, helpful
 - Negative: Impatient, intimidating
- Attributes developed via local qualitative interviews
- Exploratory factor analysis yielded 2 factors with 10 items each

Analyses - I

- Expectations
 - Means compared via independent sample t-tests
- Written vignettes
 - Multivariate linear regressions adjusted for correlation within respondents
 - Responses to each CAHPS item predicted from physician responsiveness and race/ethnicity

Analyses - II

- Video
 - Reports and 0-10 rating
 - Means compared via independent sample t-tests
 - Multinomial regression and tests of variance used to test for ERT
 - 0-10 rating only
 - Multivariate model predicting rating from race/ethnicity, perceived positive and negative behavior, and their interaction

Results - Expectations

- Average responses fall near middle of scale
- Only 1 of 5 questions demonstrates racial/ethnic differences

| Roughly how many doctors do you think: | All | White | African American | Latino |
|--|------|-------|------------------|--------|
| Make too many mistakes in taking care of their patients? | 2.06 | 2.09 | 2.03 | 2.05 |
| Treat all patients fairly regardless of race? | 2.78 | 2.98 | 2.53* | 2.78* |

1 = no doctors at all; 2= some doctors; 3 = most doctors; 4 = all doctors

Results – Written vignettes

- Perceptions of physician responsiveness increased linearly with designed level of responsiveness
- All three racial/ethnic groups responded similarly

| To what extent did this doctor listen carefully to the patient? | | | |
|---|-------|------------------|--------|
| Vignette | White | African American | Latino |
| 1 | 1.63 | 1.64 | 1.71 |
| 2 | 1.91 | 1.85 | 1.94 |
| 3 | 2.77 | 2.72 | 2.85 |
| 4 | 3.31 | 3.29 | 3.22 |
| 5 | 3.73 | 3.64 | 3.58 |

1=not at all; 2=very little; 3=to some extent; 4=to a great extent

- Confirmed in repeated-measures multivariate models

Results - video

- No evidence of racial/ethnic differences in responses to Doctor Communication report items
 - Independent sample t-tests
 - Repeated-measures multivariate regression

Results - video

- Mean 0-10 rating was below 5 for all groups
 - Encounter was perceived far more negatively than typical in real-world data
- Similar mean scores across racial/ethnic groups
- African Americans and Latinos
 - Greater standard deviation
 - More likely to use both ends of the response scale
 - Evidence of extreme response tendency

Results – video

- 0-10 global rating regressed on race/ethnicity, positive and negative perception scales, and interaction
- Main race/ethnicity and interaction terms were nonsignificant
 - Perceptions of physician behavior have a similar influence across racial/ethnic groups

White, African American, and Latino respondents

- Had generally similar expectations of physician behavior
- Used CAHPS report items similarly when exposed to the same stimuli
- Had similar mean responses on 0-10 ratings
 - African Americans and Latinos more likely to use both extremes of the response scale more often
 - 0-10 ratings were similarly responsive to perceptions of physician behavior
 - One video encounter with mean atypically near 5

Limitations

- Online panel participants may differ in unmeasured ways
- Study administered only in English
- Unable to study Asians
- Internet administration, rather than mail or phone
- Single video encounter, no experimental manipulation of quality
- Asked about a third-party encounter rather than one's own physician

Implications

- Future work should use multiple videos
 - Manipulate physician responsiveness over multiple dimensions
- MIPPA implementation should emphasize reports rather than 0-10 global ratings
 - Concern about extreme response tendency
- Stronger basis for interpreting differences in real-world CAHPS report items as reflecting true disparities in need of remedy