A decade of Measuring Patient Reported Experience of Care in British Columbia: Lessons Learned

Presented to:
Patient-Reported Outcome & Experience Measures Forum

November 27 & 28, 2014
Calgary, Alberta

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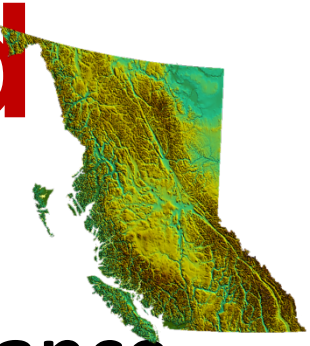
What have we learned in BC about …?



… the science of patient centred performance measurement

BC Goal #1: *Measurement of the quality of the health care system "through the patient's eyes"*

To share the learnings from a decade of patient-centred data collection and reporting in BC about the science of the measurement (and our evolving understanding) of patient satisfaction, patient experience, and patient-centred care;

… best practices for reporting on performance

BC Goal # 2: *Translation of patient-centred data into information and information into action to improve patient experiences of care*

To share promising practices developed in BC for reporting quantitative and qualitative information about the quality of care and services from the perspective of those who have received care (patients and families).

Coordinated, province-wide surveying in BC. A look back …

Patient-Centred Health Care in British Columbia

December 12, 2001

The BC government streamlines the province's network of 52 regional health boards into 6 health authorities

Goal -- *to build a Sustainable, Accountable Structure for Delivery of High-Quality Patient Services*

June 2002

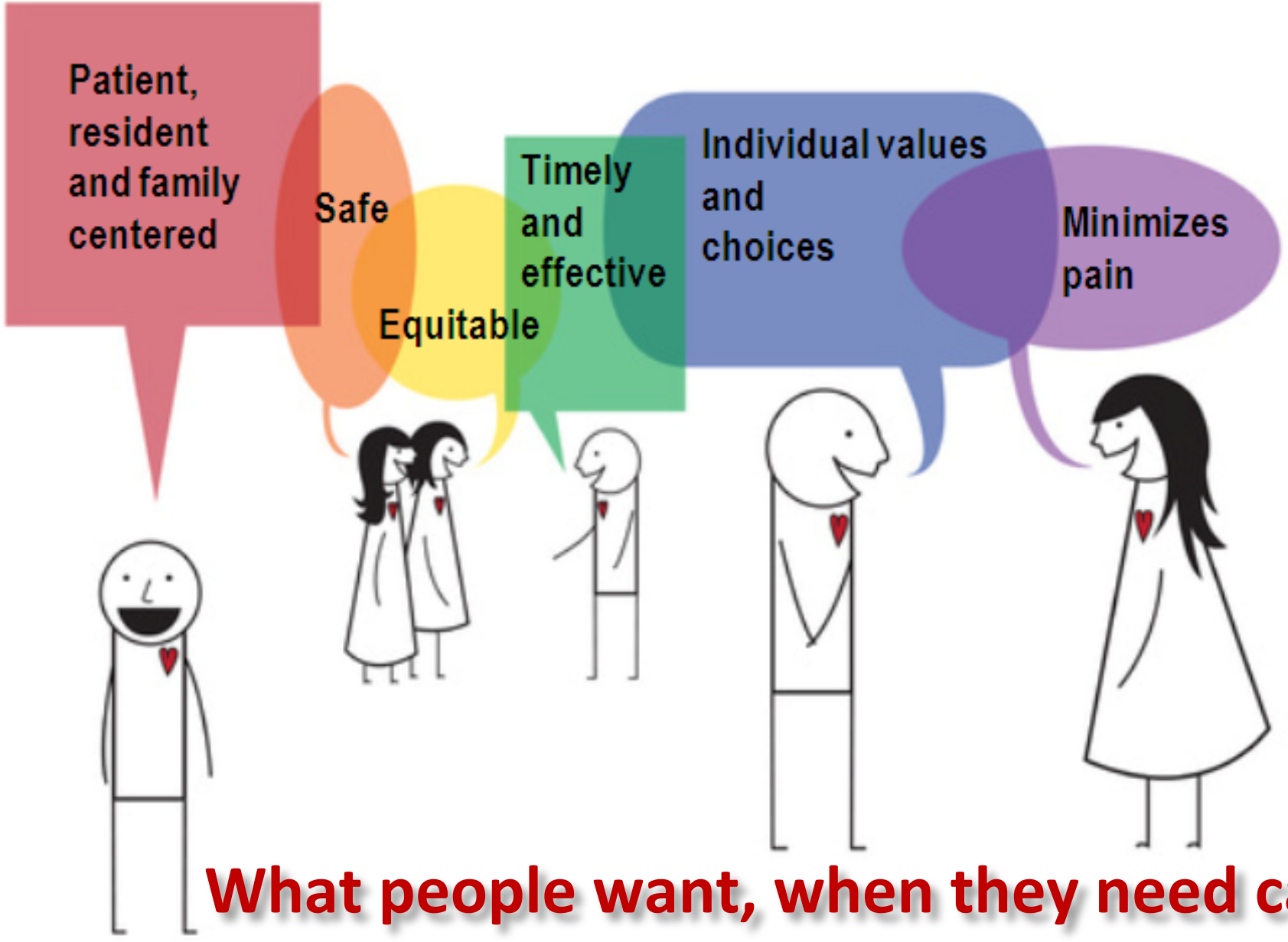
The "British Columbia Patient Satisfaction Steering Committee" (BC PSSC) was established.

February 2014

The BC MoH publishes its health system strategy, *Setting Priorities for the B.C. Health System*

Three key areas of focus: Patient-Centred Care
Performance Management
Cross System Focus Areas

Influences on our thinking about measurement of patient-centred care…



What people want, when they need care

(1) In 2000 and 2001, the Institute of Medicine issued two reports, To Err is Human and Crossing the Quality Chasm, documenting a glaring divergence between the rush of progress in medical science and the deterioration of health care delivery.

Through the Patients Eyes (Picker Institute, 1986) (8 dimensions)	Model for Patient & Family Centred Care (IPFCC, 1992) (4 core concepts)	Achieving an Exceptional Care Experience (IHI, 2012) (5 primary drivers)
Respect for patient values & preferences	Respect and Dignity	Respectful Partnerships
Information, Communication & Education	Information Sharing	Evidence Based Care
Coordination of Care	Collaboration	Leadership
Involvement of Family	Participation	
Emotional Support		Hearts & Minds
Physical Comfort		
Preparation for Discharge /Continuity & Transitions in Care		Reliable Care
Access		

Mandate of BC PREMS

(BC Patient Reported Experience Measures Steering Committee)

To develop a coordinated, cost-efficient, and scientifically rigourous provincial approach to the measurement of patient experience in order to:

1. *enhance* **public accountability**

2. *support* **quality improvement**

BC PREMS Guiding Principles:

- ✓ Promote a common, scientifically rigorous, province-wide approach to measurement of patient satisfaction and experience;
- ✓ Work towards evidence-based benchmarks that will enable objective comparisons and trending over time;
- ✓ Compliment existing national and/or provincial measurement strategies;
- ✓ Minimize data collection burden for Health Authorities;
- ✓ Provide data that **simultaneously** supports and promotes:
  - ✓ quality improvements efforts at the point of service; **and**
  - ✓ accountability of the health care system;
- ✓ Recognize that the strategy and process for a complex undertaking such as this will evolve over time

The Role of BC PREMS

BC PREMS' mandate

- Selection of survey tools with strong psychometrics
- Development of tools or custom questions
- Defining methodology (survey design and sampling plan)

- Distributing surveys
- Collecting completed responses/ surveys

- Processing surveys
- Collating results
- Case mix adjustment; weighting for disproportional sampling, if necessary
- Analyzing data

- Production of reports
- Quantitative and qualitative
- Graphic and narrative

- Dissemination of results to all stakeholders
- Public Reporting

- Knowledge sharing
- Promoting "mini surveys or point of service QI initiatives
- Secondary analysis and promoting x-HA collaboration
- Recommending targets for accountability & system level improvement

From data collection…
To dissemination of results…
To acting on results…
REPEAT!

"Only when data has been analyzed, interpreted and presented in a manner that makes it understandable and useful to others does it become information"

Michael Murray, PhD

Accomplishments of BC PREMS

2003 to 2014

- Coordination of province-wide surveys in BC for 11 years
- Feedback from more than 1million users of health care services across 13 sectors/subsectors and all age groups
- Quantitative AND qualitative reporting and analysis
- Practical support to make effective use of data for QI and for accountability
- Public reporting of results
- Developed a “modular” approach (core tools for sector; modules for subsectors)

From whom have we heard?

BC PREMS Sectors Surveys 2003 - 2014

Year	Sector	Methodology	Timeframe
2003	**Emergency**	Mail; Random sample 103 facilities	Point in time -- 3 months July 1st to September 30th , 2003
2007		As above 111 facilities	Point in time – 3 months February 1st – April 30th , 2007
2007 to 2015		As above 111 facilities	Continuous May 1st, 2007 to March 31, 2015
2004	**Long Term Care**	**RESIDENTS:** Interview; Census 102 facilities	Point in time -- Oct 2003 to March 2004 All residents and their most frequent visitor (who was sometimes a family member, but not always) in directly funded and managed facilities
		FAMILY/FREQUENT VISITOR: Mail; Census 102 facilities	
2005 2008 2011/12	**Acute Inpts** **Medical, Surgical, Maternity, Pediatrics Freestanding Rehab**	Mail 80 hospitals	Point in time – 3 or 6 months I) June 1st to Nov 30th, 2005 II) Oct 1st to Dec 31st, 2008 III) Oct 1st/11 to Mar 31/12
2006 2012/13	**Outpatient Cancer Care**	Mail 5 regional cancer centres and 45 community cancer hospitals/services	Point in time -- 6 months I) Nov 15th, 2005 to May 15th, 2006 II) June 15 to December 16, 2012
2010	**Mental Health & Substance Use**	**PATIENTS/CLIENTS:** Short stay Inpatient care Handout with telephone follow up	Point in time – 6 months Oct 12th/2010 to April 11th/2011
2014		**FAMILY/SUPPORTERS** Development of Survey Tool	Focus groups, cognitive interviews, pilot testing – in progress

NOTE: 17,933,679 records of eligible patients extracted from BC ADT systems since 2003

Evolution of Sector Surveys in BC 2002 - 14

2002 - 2004

- Use of "ready to wear" tools; participation in validation of US tools for use in Canada/BC
- Copy cat processes as recommended by vendors and/or other jurisdictions
- Developed processes to meet privacy requirements of BC's OIPC, including completion of PIA's and exclusion of youth to meet privacy risks/ requirements
- Results reported without weights (actual volumes NOT reflected)
- Use of vendors' standard reporting templates
- All surveys conducted as Point in Time (PIT) studies

2005 - 2007

- BC custom questions developed and tested to augment "ready to wear" tools; addressed ethnicity, patient safety (harm, hand-washing, check ID before meds)
- Alternate languages introduced (French, Chinese, Punjabi, German)
- Added web based response option via unique access codes to all surveys
- Results weighted to reflect actual volumes (from facility level up)
- "Made in BC" peer groups defined and national benchmarks adjusted to ours
- Risk mitigation strategy developed and approved by OIPC to permit inclusion of youth
- Narrative summary reports introduced
- Core tools and modular subsector approach adopted
- Communication Strategy for public release of results developed and approved by PAB

2007 – 2013

- Intro of simultaneous continuous surveying in ED and PIT surveys in other sectors
- Analytical reports commissioned (CHSPR/UBC, survey research experts)
- "Made in BC" reports introduced (storyboards, monthly facility quantitative trending reports of select questions based on correlation to overall sat and performance, monthly facility comments reports, aggregated APRs, raw data returned to HA's for further analysis)
- Further customization of survey tools & cognitive testing of new/ changed items
- Increased focus on reducing lagtimes to reporting, analyzing subsector popl'n results and producing special reports, updating peer group alignments, producing special reports for specific audiences, etc.

2013 & beyond…

- Interest in combining PREMS & PROMS
- Decision to develop a survey instrument to address a gap in the literature and in practice--a tool for MH/ Addictions family/ supporters
- Moving from data collection and reporting to focus on use of results to promote QI at the point of service
- Early adopter province in CIHI's CPERS
- Focus on info at transition points/ continuity across transitions in care
- Change from proprietary to non-prop tools
- Change from sector based to continuum based surveying

BC adopts a Modular Approach to Measuring PX

POPULATION	SURVEY INSTRUMENT	RESPONDENT POPULATION
Acute Inpatients 2005, 2008, 2011/12	• core Picker Acute Inpatient Care tool • validated for use in Cdn in 2003 with BC input	All patients sampled receive the core questions
SUBPOPULATIONS		
Maternity 2005, 2008, 2011/12	• BC module developed in 2005 with input from maternity care providers across all 6 HA's and the MoH • Items selected from Picker Cdn Maternity validated survey instrument, representing gaps and "actionable" items	Patients whose acute inpatient admission was related to a childbirth experience receive the core questions PLUS the Maternity module
Pediatrics 2005, 2008, 2011/12	• BC module developed in 2005 as above with input from pediatric care providers • Items selected from Picker Cdn validated pediatric instrument	Patients under the age of 17 receive the core questions PLUS the Pediatric module Patients between 13 and 18 receive a letter addressed to them; surveys to patients under 13 are sent to the parent or guardian
Surgery 2008, 2011/12	• skip pattern iintroduced in 2008 survey • surgical questions selected from a NHS/UK validated tool by the BC SPR-SMC (Surgical Patient Registry Strategic Management Committee)	Patients who self report having had a surgical procedure or operation answer the questions specific to a surgical experience during the acute inpatient stay; all other patients follow a skip pattern
Rehabilitation 2011/12	• BC module developed in 2011 with input from Rehab care providers and leaders • Items selected from the Client Perspectives of Rehab Services, a Cdn validated, survey instrument	Patients who were discharged from a freestanding Rehab facility or a designated Rehab bed/unit in an acute care hospital receive the core questions PLUS the Rehab module

Made-in-BC Subsector Modules

Step 1:

Review of published lit on tools to confirm psychometric properties and testing to confirm "importance" of items to patients

Crosswalk of core tool to existing validated tools for each subsector

Step 2:

Clinicians across all health authorities in each subsector rank order the questions they deem to be "most actionable"; each HA submits "Top 10" list

Step 3:

Weighting of ranked items to create master "Top 10" (or other number TBD) of questions for subsector module

Step 4:

Post-fielding questions are psychometrically analyzed to confirm performance of items and importance

What have we learned?

The results from our provincially coordinated, standardized surveys are VALUED...

"What a better way to stimulate quality improvement than hearing it from patients. Patient satisfaction impacts everything we do."

- Vancouver Coastal Health Authority
ED Manager

"If we didn't have this data, the patient experience may not have been hardwired into the Health Authority's strategic plan."

- Northern Health Authority
ED Manager

BUT our stakeholders asked for:

FASTER, BETTER and EASIER to read reports!

Criticisms

Timeliness: Infrequency of reports meant data geared to system level improvement only

Burden of Data: frontline staff and leaders were overwhelmed by the amount of information

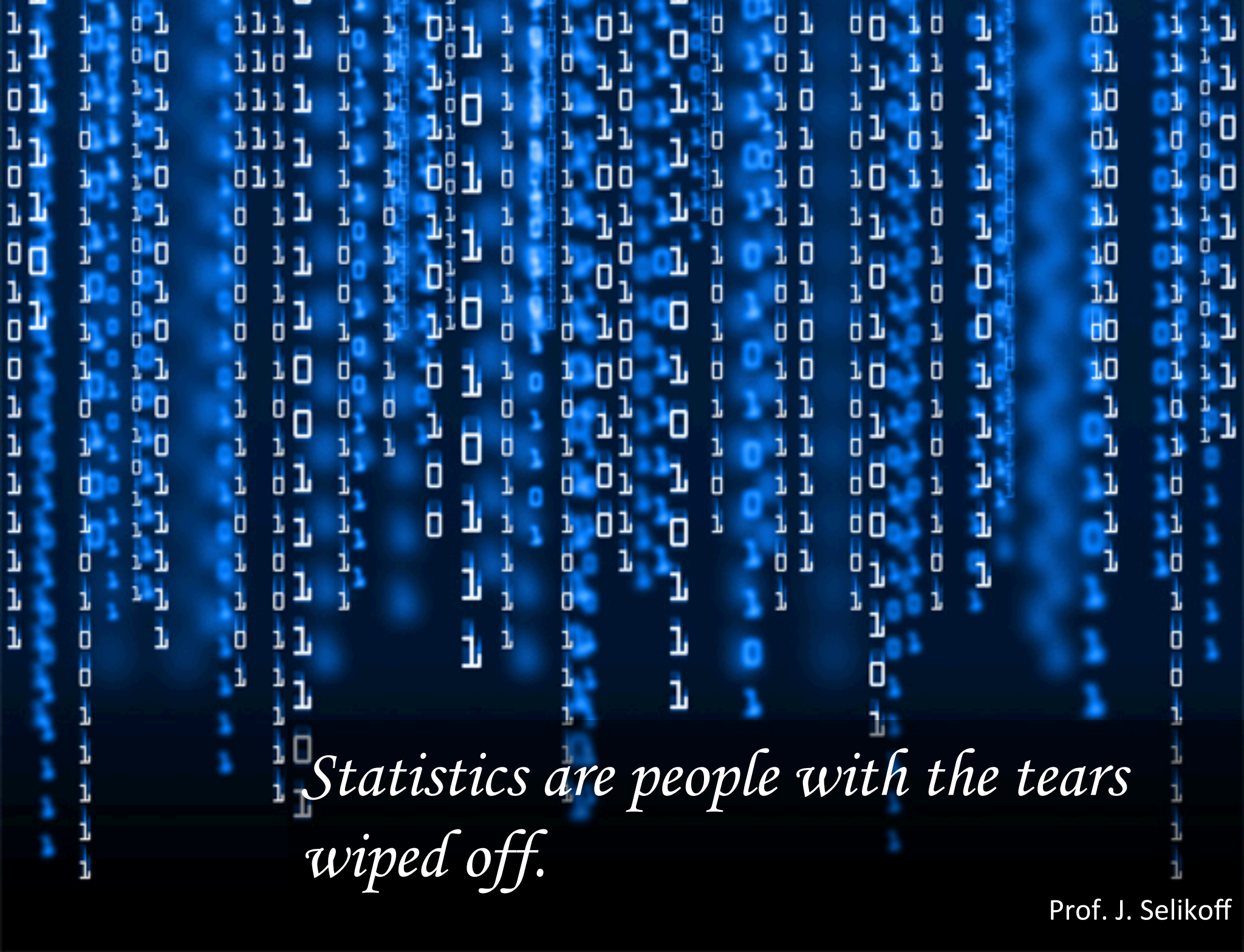
Accountability: frontline staff and leaders were overwhelmed by the amount of information

Our response

FASTER! Introduce more frequent reports that would allow quicker access to the results

BETTER! Introduce reports that are more succinct and focused

EASIER (to read)! Create reports that represent a quick snapshot of patients' experiences and relevant at the facility level



Statistics are people with the tears wiped off.

Prof. J. Selikoff

The solution!
REAL examples,
from REAL people, for REAL stories...

INTEGRATED ***qualitative, quantitative, and annotated*** reports now provide timely monthly information to **support** the people who are directly involved in care **to better understand the perceptions** of **THEIR patients** about **THEIR patients' care experiences**.

Components of Monthly Reports:

Principle: *Frontline leaders and clinical teams should monitor quality of care from the patient's perspective as often as they monitor budgets, labour distribution, overtime, etc.*

1. Quantitative Results

Scientifically robust results displayed in run charts with confidence intervals

2. Qualitative Results

Patient comments to 'give life' to the numerical data

3. Annotations

Used to explain trends. Add flags in the data and ask prompting questions for those at the point-of-care (front line leaders and clinicians) to consider/answer

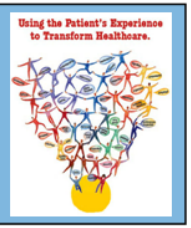
Stage 1: Qualitative & Quantitative Reports

Patient Comments Report: Chilliwack General Hospital

Emergency Department Patient Experience of Care Survey

May and June 2014

Produced on behalf of the BC PREMS (Patient Reported Experience Measures Steering Committee)



Background

This document collates patient comments from BC's Emergency Department Patient Experience of Care Survey. These comments were derived from responses to the following open-ended question:

Is there anything else you would like to tell us about your Emergency Department visit?

Though responses are drawn from a random sample of patients, these comments are not necessarily representative since all patients surveyed do not provide comments.

Comments are transcribed verbatim, with minimal editing (e.g. spelling is corrected though grammar is not). During the transcription process, comments are also categorized as: *positive, negative, both,* or *neutral*. Every attempt is made to ensure that any information that has the potential to compromise anonymity is severed from the comment.

It would be appropriate for Health Authorities and/or facilities to use patient comments as qualitative evidence to support the quantitative results of patient experience of care surveys. Such comments could be used in annual reports, news releases etc. in a privacy-sensitive manner. Anyone deciding to use comments should screen them to ensure that residual disclosure is not possible, especially within the geographic domain of a particular health authority or facility.

Patient Comments

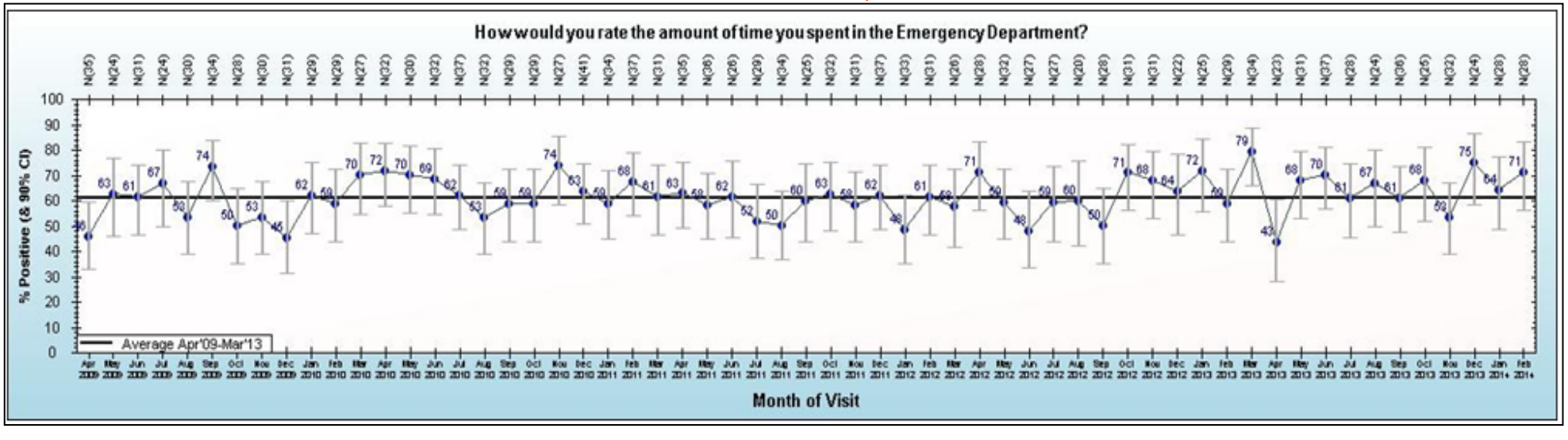
Below are the comments from Chilliwack General Hospital's patients that visited the Emergency Department in May and June 2014.

Patient Comments Reports

Developed from open-text responses to, *"Is there anything else you would like to tell us about your Emergency Department visit?"*

Monthly ED Run Charts

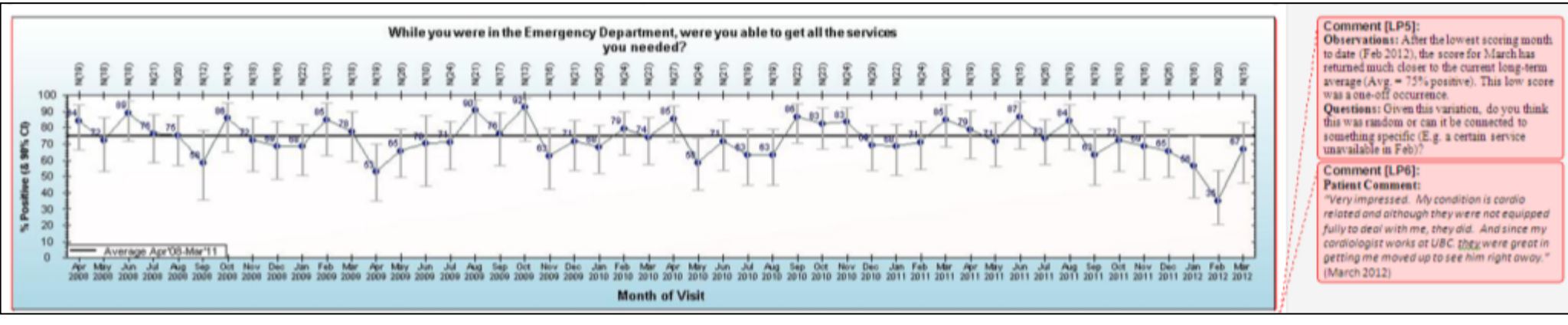
A graphical representation of **9 indicator Qs** to illustrate trends by detecting variation and 'flags'



Stage 2: Linking Qualitative & Quantitative Feedback

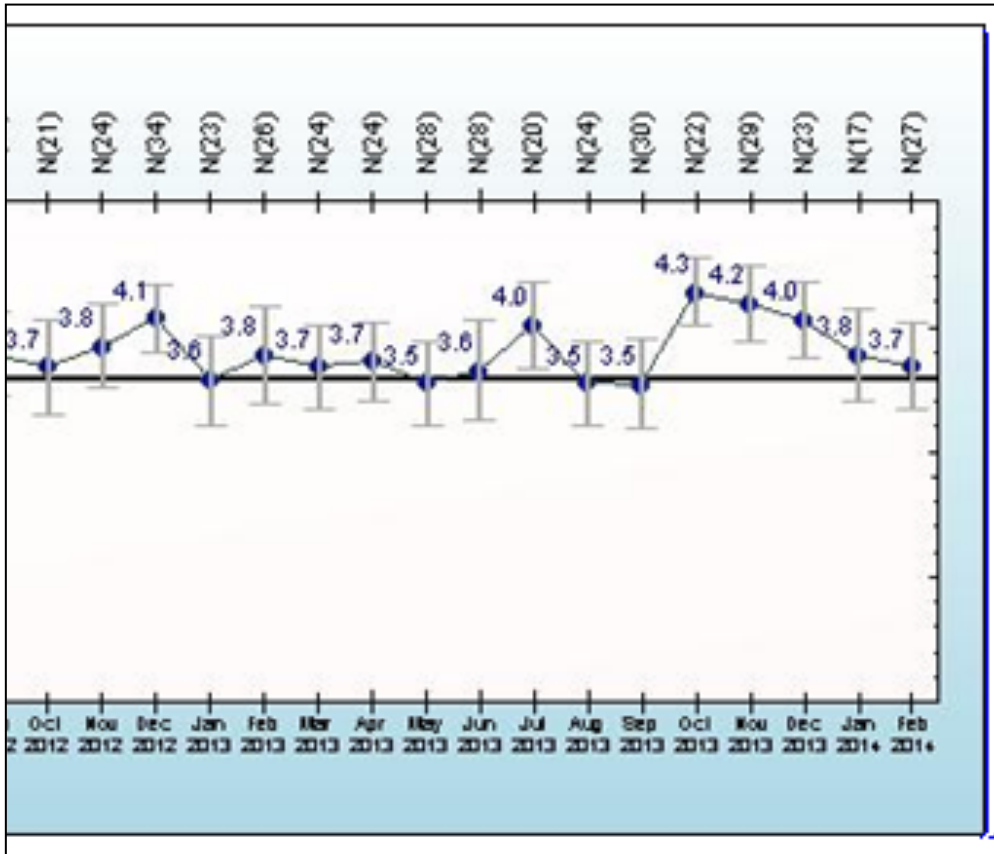
Sample of an **ANNOTATED MONTHLY EMERGENCY DEPARTMENT REPORT** that shows results from 9 questions (of the total of 69 on the ED survey).

The nine items were selected based on provincial results (low performance and high correlation to overall quality). Note: The "courtesy" question was added due to results of separate analysis (see slide 33).



Let's take a closer look at the annotations …
(Observations, Prompting Questions, Suggested Actions, and Qualitative "stories")

“Overall, how would you rate the quality of care you received in the Emergency Department?”



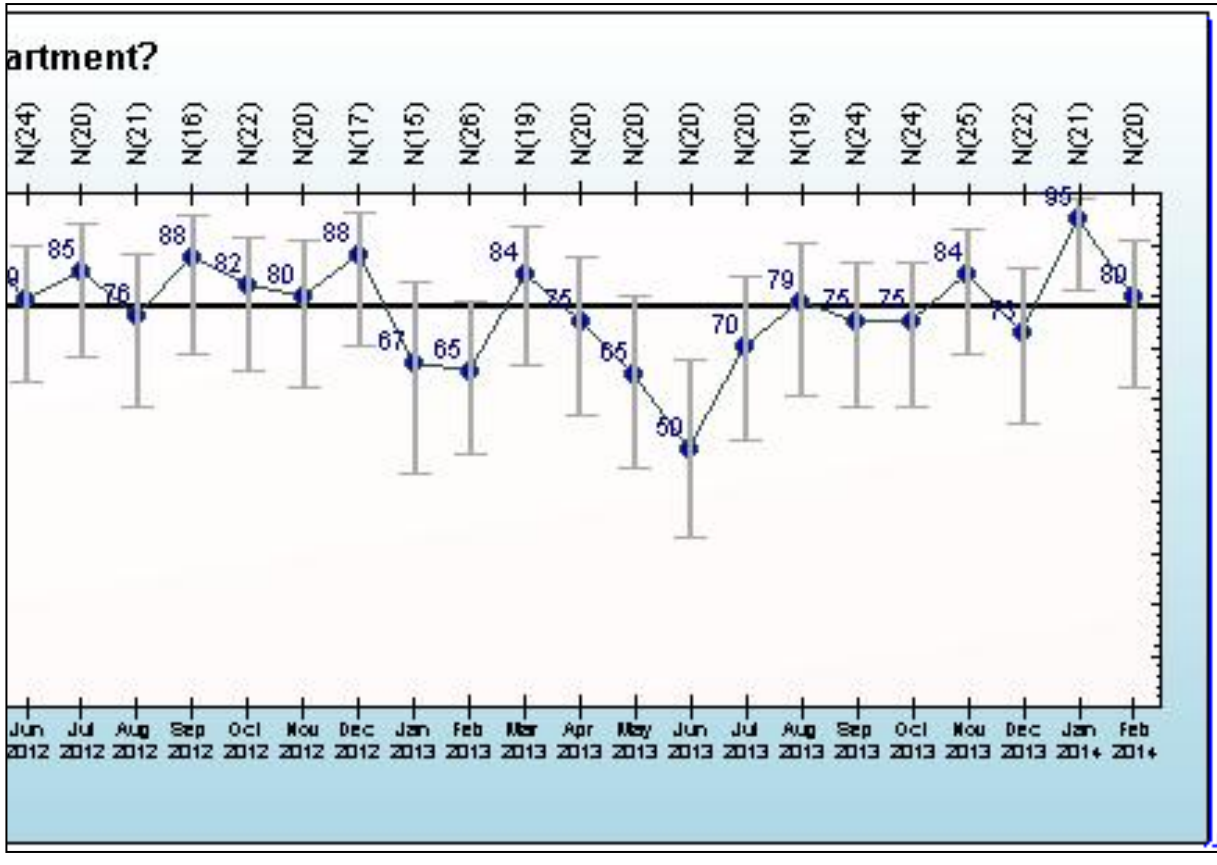
Comment [LP1]:
OBSERVATIONS: While the score in February is still above the current long-term average (Avg = 3.5), it is also the 4th consecutive month where the scores have incrementally declined from the month prior. This is indicative of a new negative trend (aka a sustained negative change) which started as early as October 2013. All this being said, the scores are still above average!

QUESTIONS: Looking through the other 8 indicators in this report, there is no obvious pattern of negative scores over the last few months. Acknowledging that, can you think of any other circumstances (e.g. construction) that could have impacted the Overall Quality score in a negative way? Are these circumstances within your control?

Comment [LP2]:
Patient Comments:
“When I was in emergency dept XXX, nursing staff were discussing their household matters really aloud. I had to tell them to stop talking as we, patients in emergency, needed quiet place.” (Feb 2014)

“Overall felt well attended, being sick and next to a crying child all night. Also I don't like the way the security personnel behave with emerge patients after first being attended it took 2 1/2 hrs. before seeing a doctor.” (Feb 2014)

“How would you rate the amount of time you spent in the Emergency Department?”

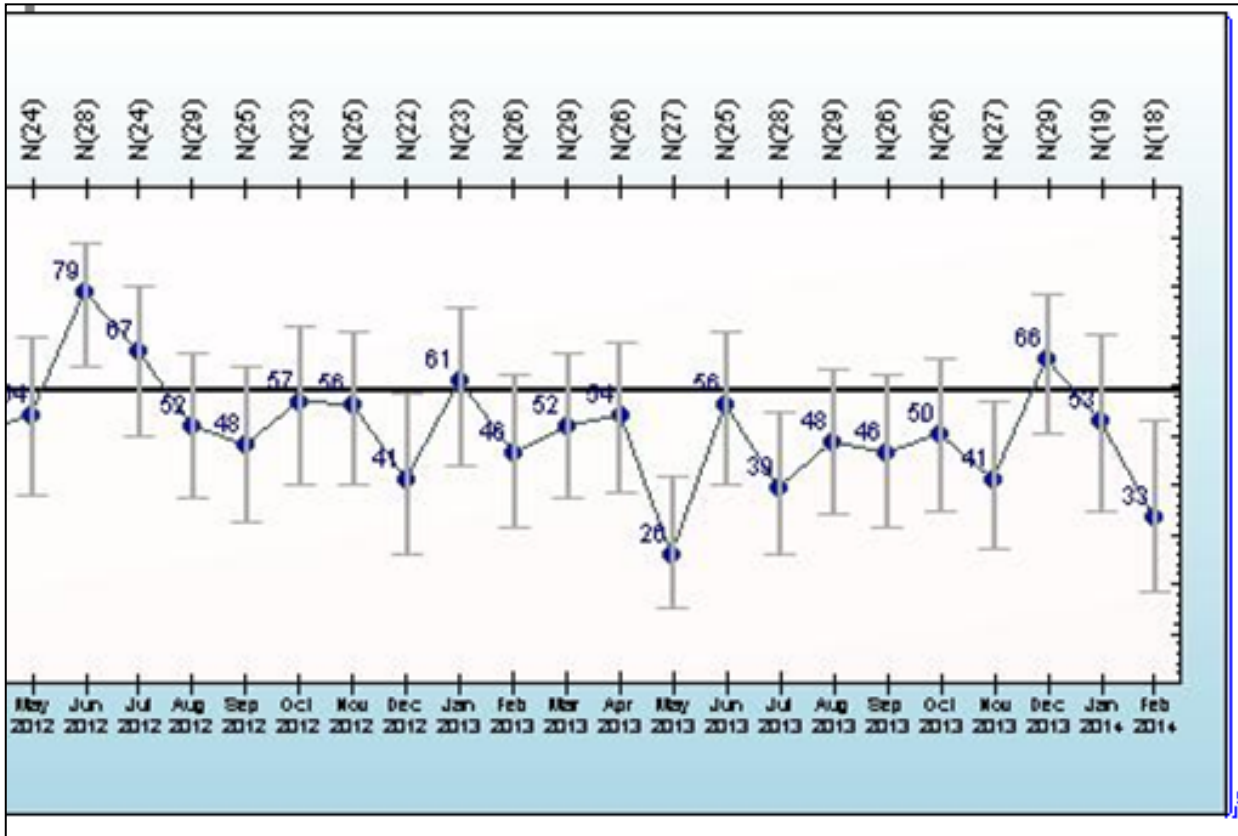


Comment [LP2]:
OBSERVATIONS: The score in February – which is still above average (Avg = 78% positive) – is demonstrating that the very high score in January was not illustrative of a sustained improvement. Acknowledging that this is one of the higher scoring indicators over time, it would be interesting to investigate further into January’s score.

QUESTIONS: Can you think of any circumstances factors that could have positive affected this score in January? Do you think that these factors could be replicated or sustained moving into the future?

Comment [LP3]:
Patient Comment: “I have been fortunate to receive excellent care from Dr. XXXX in Fast Track on 2 separate occasions. I cannot say enough about the great care from all the professionals that work there.” (Feb 2014)

“Did you have to wait too long to see a doctor?”



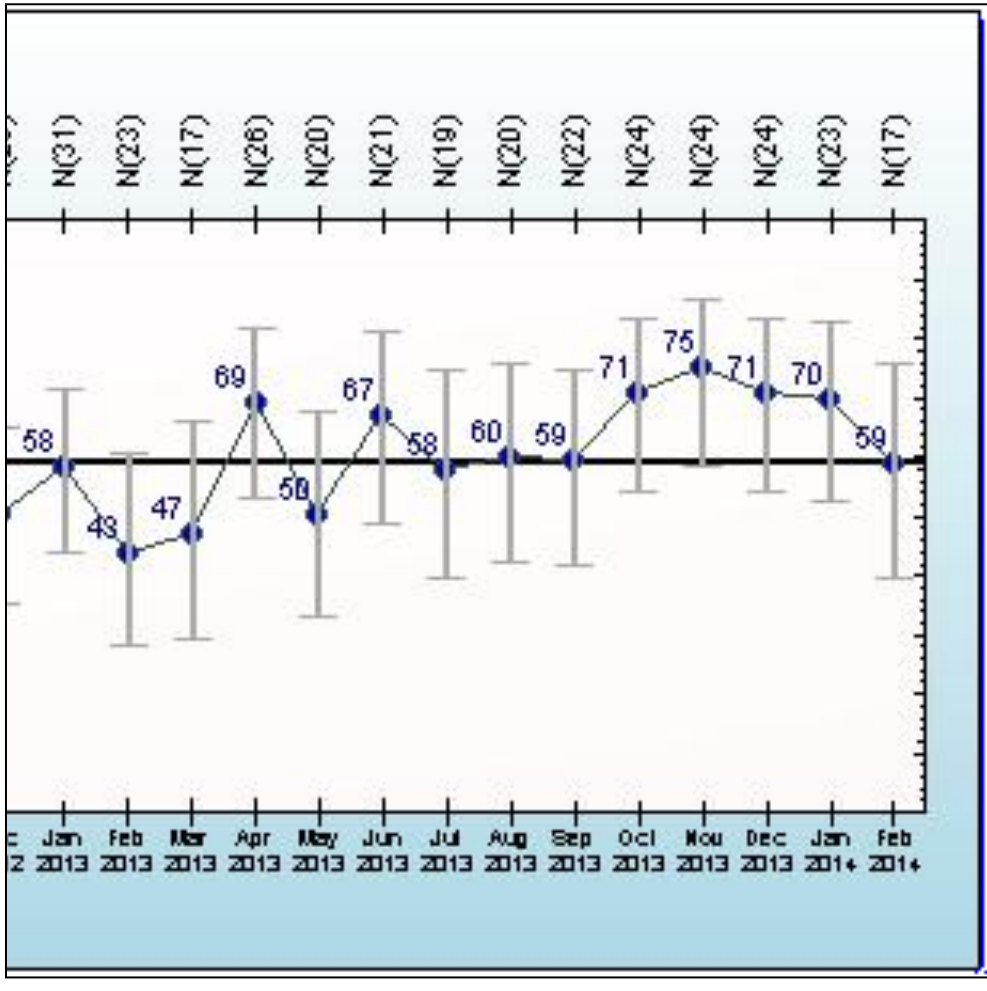
Comment [LP2]:
OBSERVATIONS: The score in February is not only well below the current long-term average (Avg = 58% positive) but also one of the lowest scores to date! While this data point is by no means indicative of a lasting change, it is worth flagging.

ACTIONS: Watch the score for this indicator in the next reporting period to see if the score remains very low or returns somewhat closer to the average.

Comment [LP3]:
Patient Comments:
“It took really long to see someone and after I did it was another 1.5 hrs for the blood work to be explained to me by the doc. I was told it should be only 1/2 hr. I was in extreme pain the whole time. I am 75 years old and if my daughter-in-law wasn't there I would of been there longer.” (Feb 2014)

“Did not like the fact that the emergency room was virtually empty and still had to wait OVER 2 HOURS to see a doctor. I looked around and the doctors were not in any hurry to help us Disgusted with the patient care at that hospital!” (Feb 2014)

“Did you have enough to say about your care?”



Comment [LP2]:

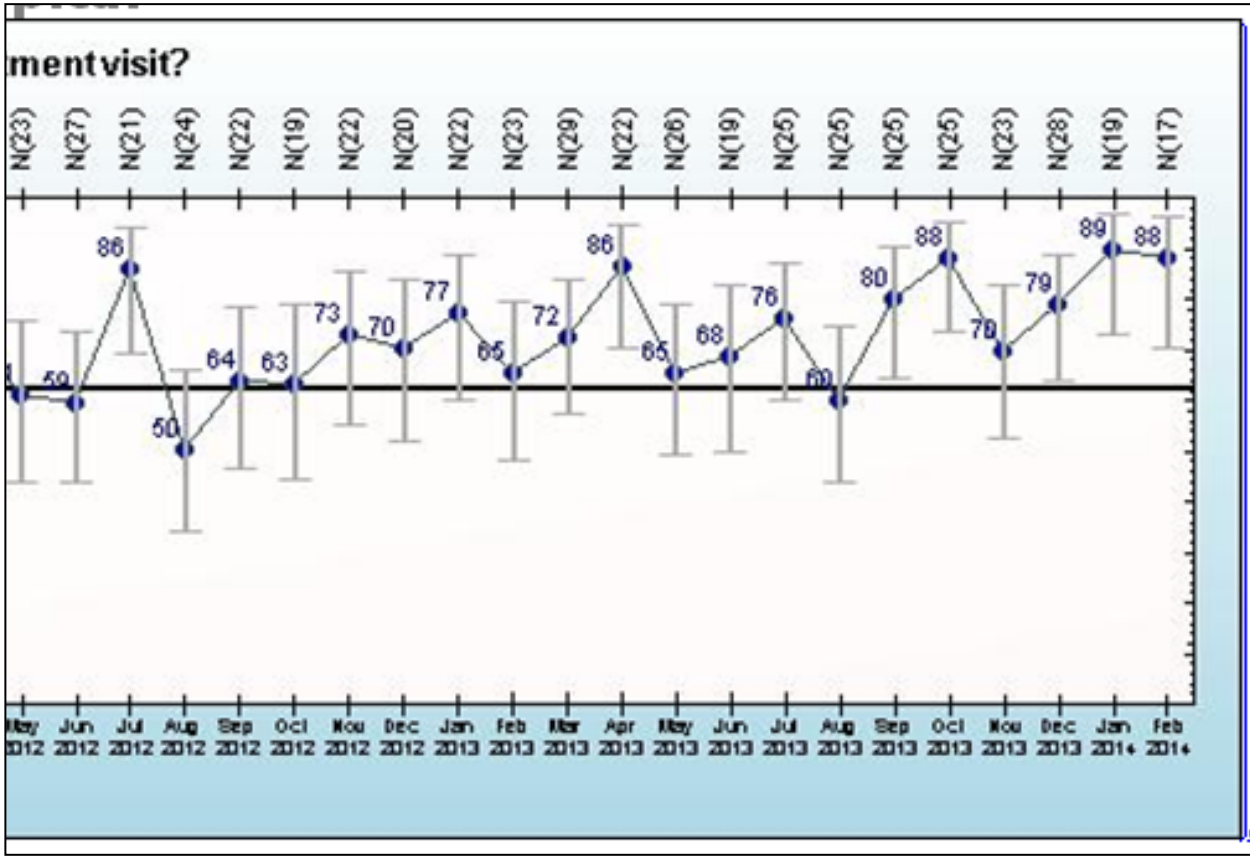
OBSERVATIONS: The score in Feb 2014 is indicative of the fourth consecutive data point where the scores have all incrementally declined since the previous reporting period. While this is NOT yet indicative of any sustained change, if the score continues to show a decline in March 2014, then a negative trend will have occurred.

ACTIONS: Watch this indicator in March to see if a negative trend has occurred or not.

Comment [LP3]:

Patient Comment: “I am also in XXXX and I'm sure that your suppose to treat each pt. in respect and care. I'm glad I was sent a survey because the pt's voice needs to be heard and this hospital needs to get things together to provide better care to their patients I will also be calling in with complaints from the past XXXXXX staff is completely sickening.” (Feb 2014)

“Did you feel you had enough privacy during your Emergency Department visit?”

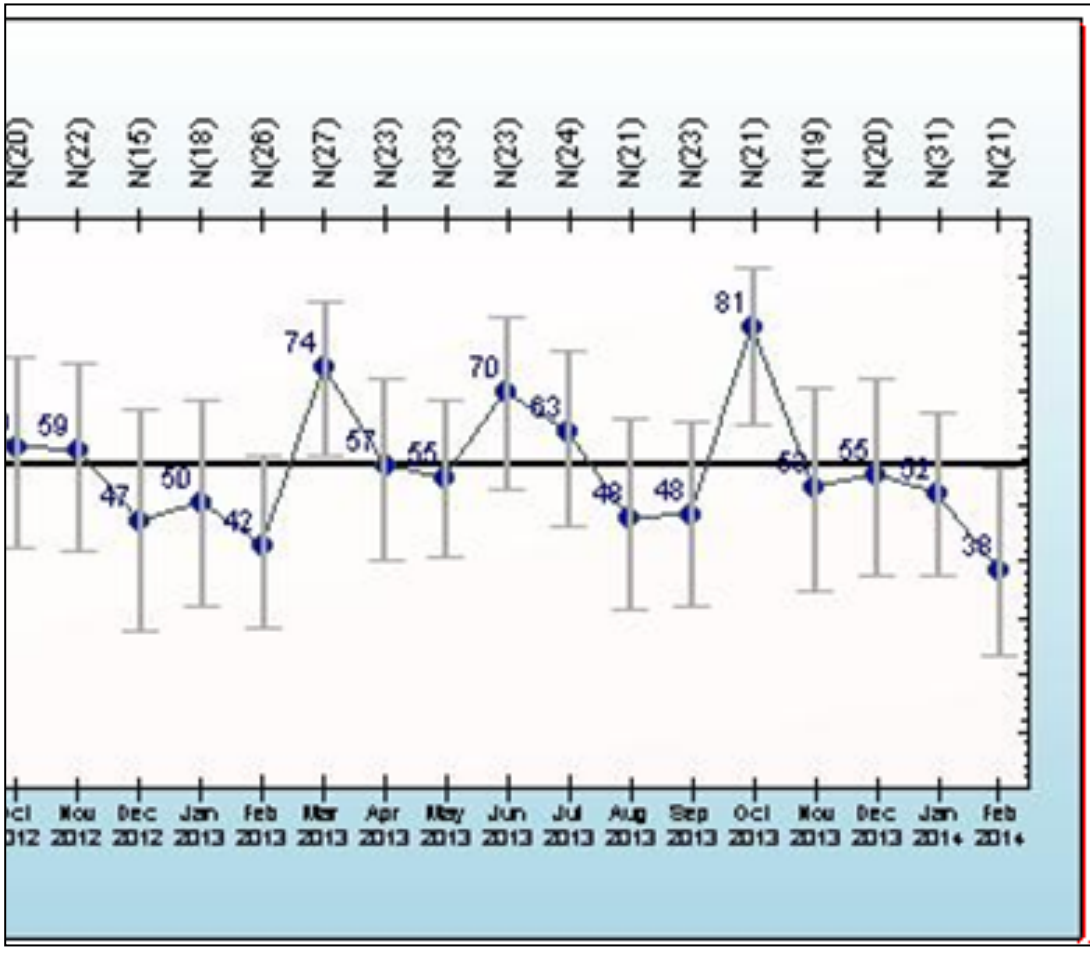


Comment [LP2]:
OBSERVATIONS: The score in Feb 2014 is not only well above the current long-term average (Avg = ~62% positive) but it is also the sixth consecutive month where the scores have remained above average. While this is NOT yet evidence of a sustained improvement in this area, if the score continues to remain above-average in March 2014 then a positive shift will have occurred.

ACTIONS: Watch this indictor in the next reporting period to see if a sustained improvement has occurred or not.

Comment [LP3]:
Patient Comment:
“New Emerg Dept is definitely superior to what it replaced.” (Feb 2014)

“Were possible causes of your problem explained in a way that you could understand?”



Comment [LP2]:

OBSERVATIONS: The score in February is the not only one of the lowest scores to date, but it is also the 3rd consecutive period where the scores have all declined from the previous month. While neither of these is illustrative of a sustained negative change, this indicator should still be monitored in the coming months.

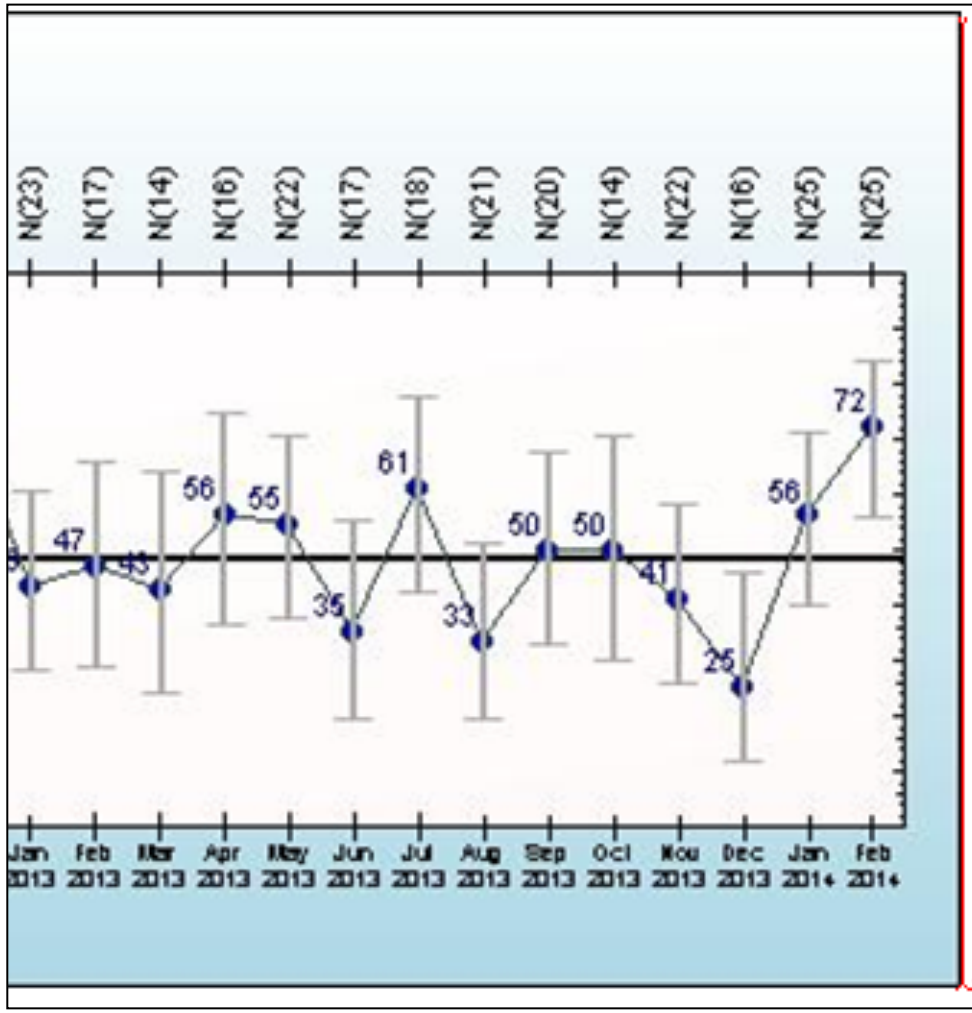
ACTIONS: Watch this indicator in the coming 2 months to see if a negative trend emerges, if the scores return closer to the long-term average (Avg = 57% positive), or otherwise.

Comment [LP3]:

Patient Comment:

“Long time waiting people or staff are in a hurry. No chance to talk to medical staff … doctor on duty (may be intern or call-in one) didn't do his job properly. Push responsibility … not following up … keep us waiting … had to look for him for the result of x-ray … under-qualification … SIGH!!!” (Feb 2014)

“Were you told what danger signals about your illness or injury to watch out for when you got home?”

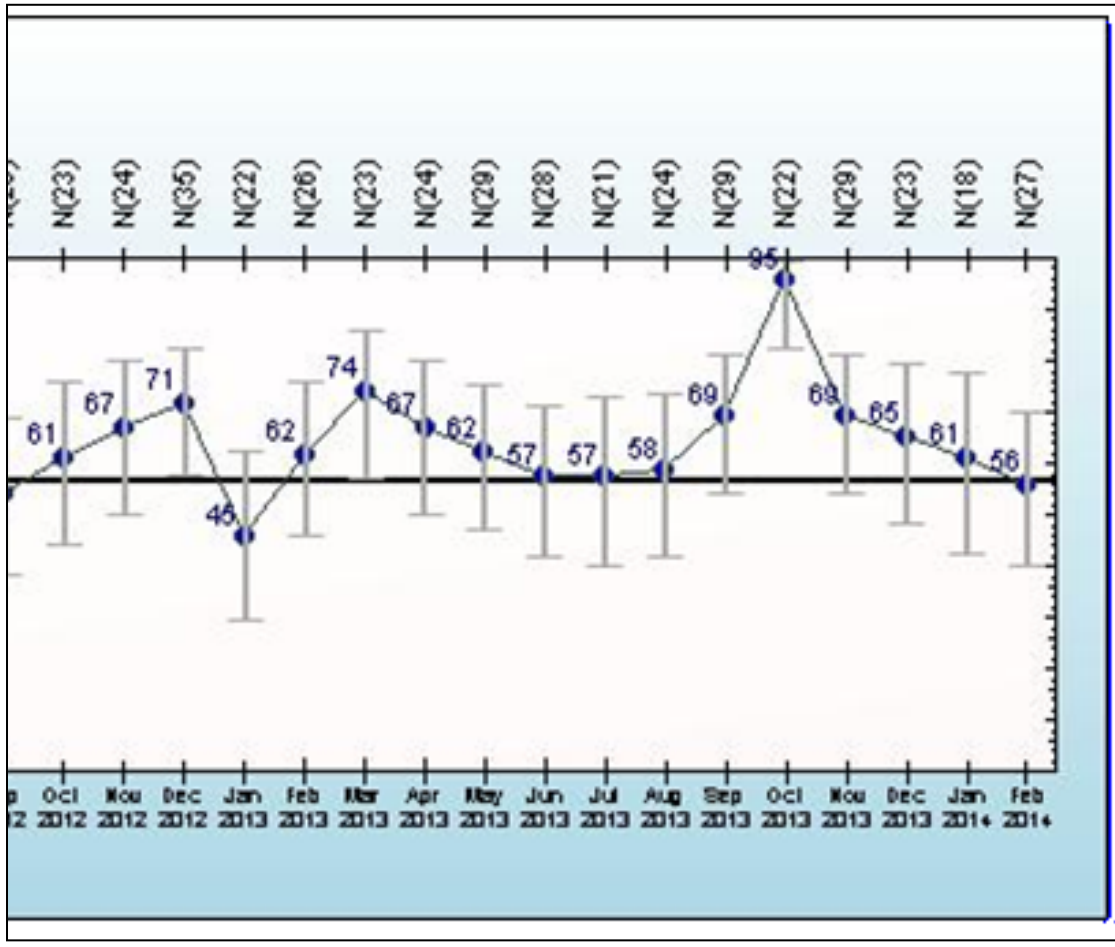


Comment [LP1]:

OBSERVATIONS: The score in February is not only WELL above the current long-term average (Avg = 49% positive), but also one of the highest scores to date! Great! That being said, neither of these observations are indicative of a sustained improvement for this question.

ACTIONS: Given the high results, we need to watch this indicator over the coming months to see if the scores remain very high, a positive trend emerges, or another sort of change happens.

“While you were in the Emergency Department, were you able to get all the services you needed?”



Comment [LP5]:

OBSERVATIONS: The score in February is the 4th consecutive month where the months scores have incrementally declined from the previous reporting period – this is indicative of a new negative trend (aka a sustained change) – that started as early as November 2013. All that being said, the scores for this indicator over the last year have all remained above average.

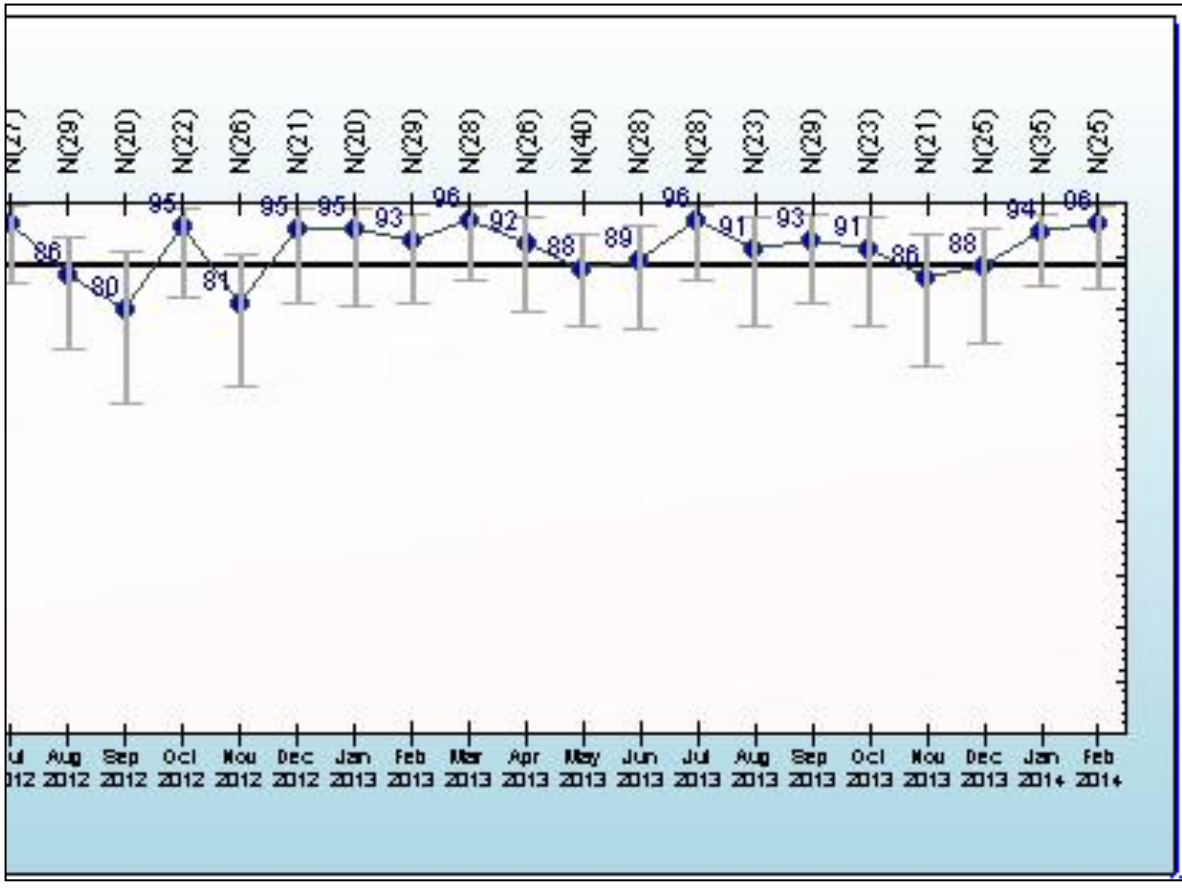
QUESTIONS: Given the positive scores over the last year or so for this indicator, do you think that this new negative trend is part of the general up/downs of experience of care in your ED or do you think that there is something specific that this change can be attributed to?

Comment [LP6]:

Patient Comment:

“4 times my husband needed emergency care related to his gout, but only once there was a doctor, able to do injections of steroid into joints.” (Feb 2014)

“How would you rate the courtesy of the Emergency Department staff?”



Comment [LP2]:
OBSERVATIONS: The score in February represents the 3rd consecutive month where the scores have increased incrementally from the previous month. While this is NOT yet indicative of a sustained improvement, if the score continues to show an increase in the March then a positive trend will have emerged.

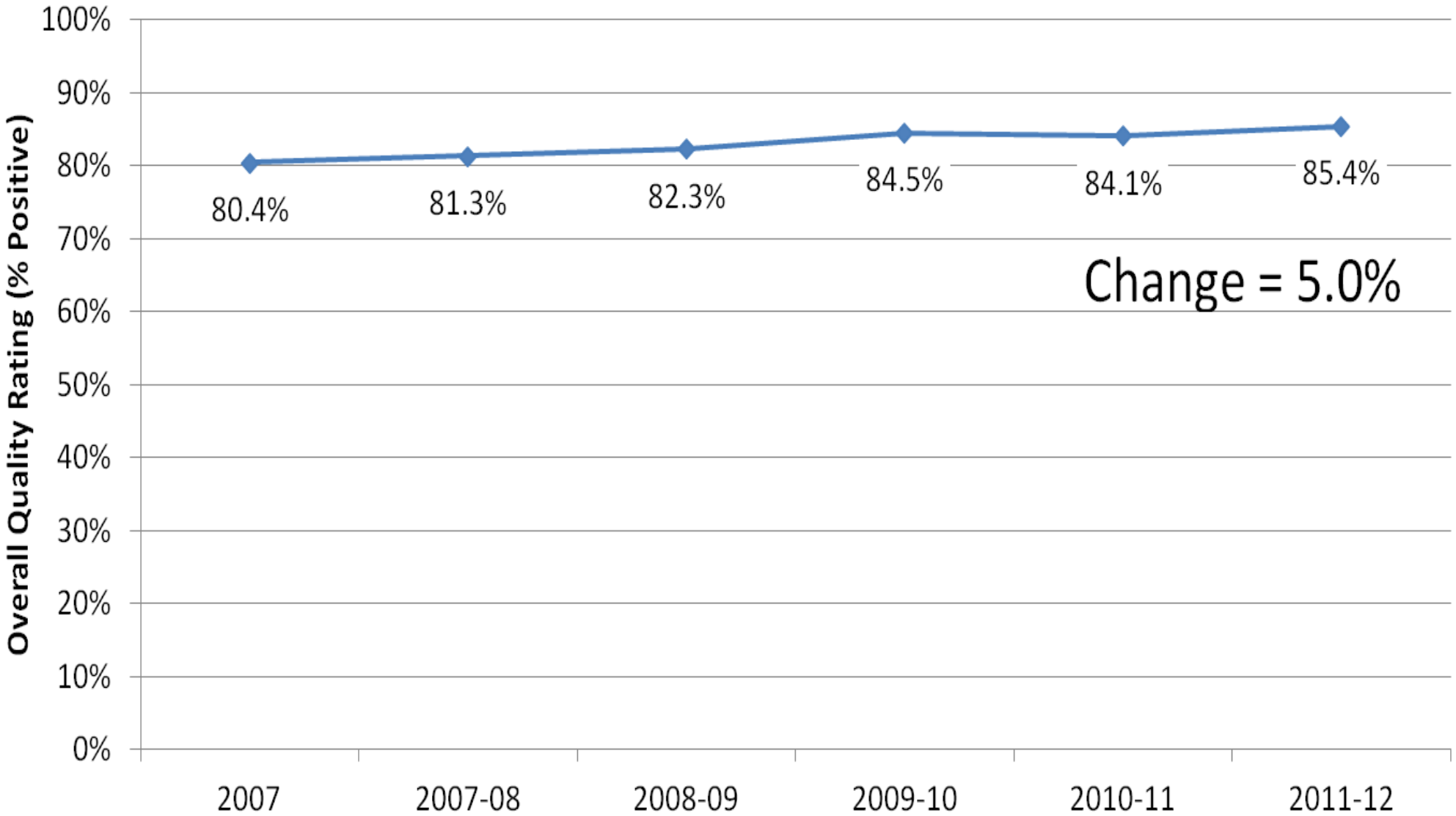
ACTIONS: Watch this indicator in March to see if a positive trend has emerged or not.

Comment [LP3]:
Patient Comments:
“I have been, been taken care of on a regular basis. The drs + nurses know my conditions and treat me very well.”

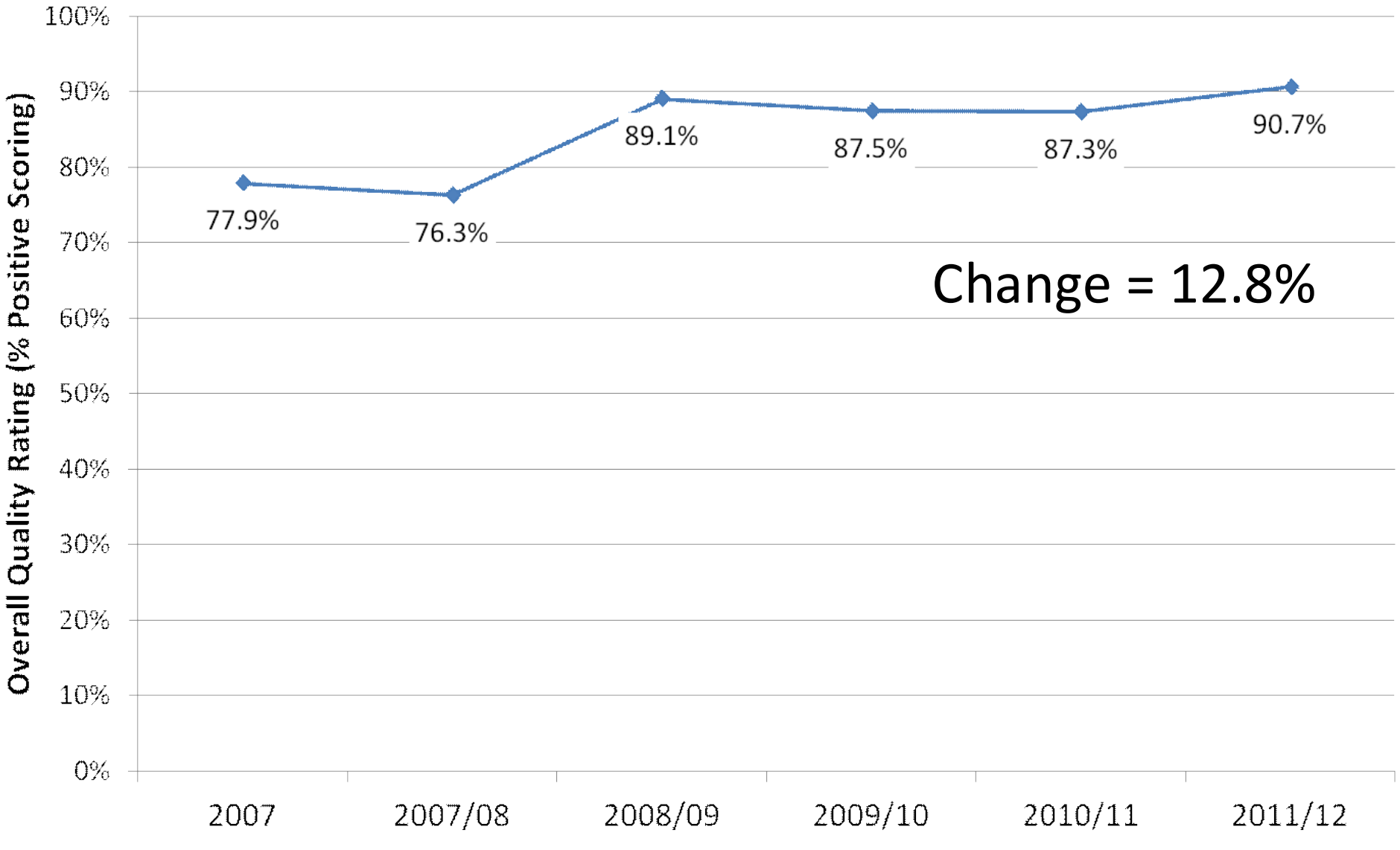
“The nurses were great. One went out of her way to advise me on post injury treatment and how to find a good physio near me.”

See: http://www.chspr.ubc.ca/pubs/report/pursuit-quality-opportunities-improve-patient-experiences-british-columbia
The study looked at factors that drive patient ratings of quality…Factors such as staff courtesy, team work, comprehensive care and availability of nurses, appeared to be more important than wait times in influencing patient ratings.

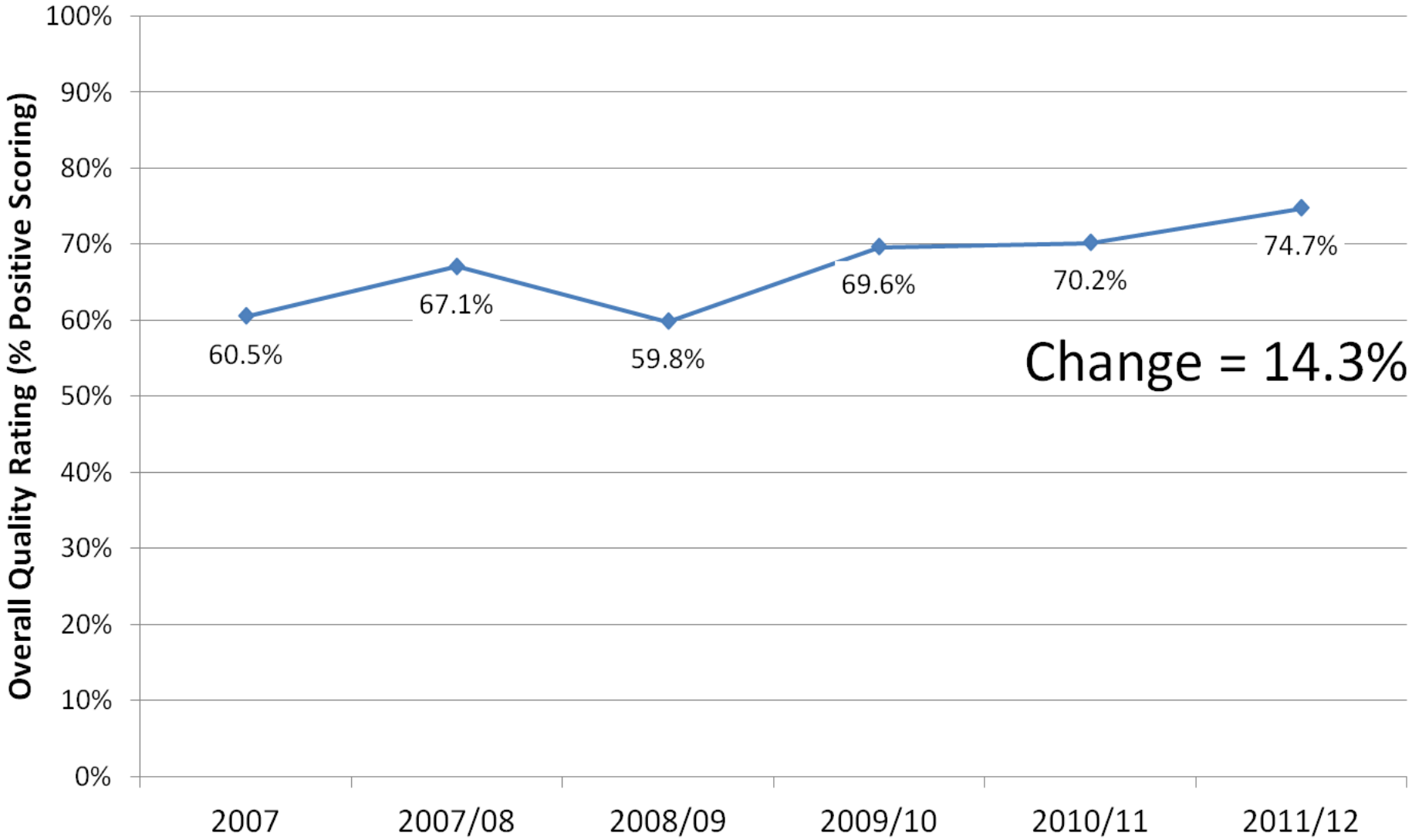
BC Decongestion Hospitals' Emergency Departments Overall Quality Rating (% positive) by Year



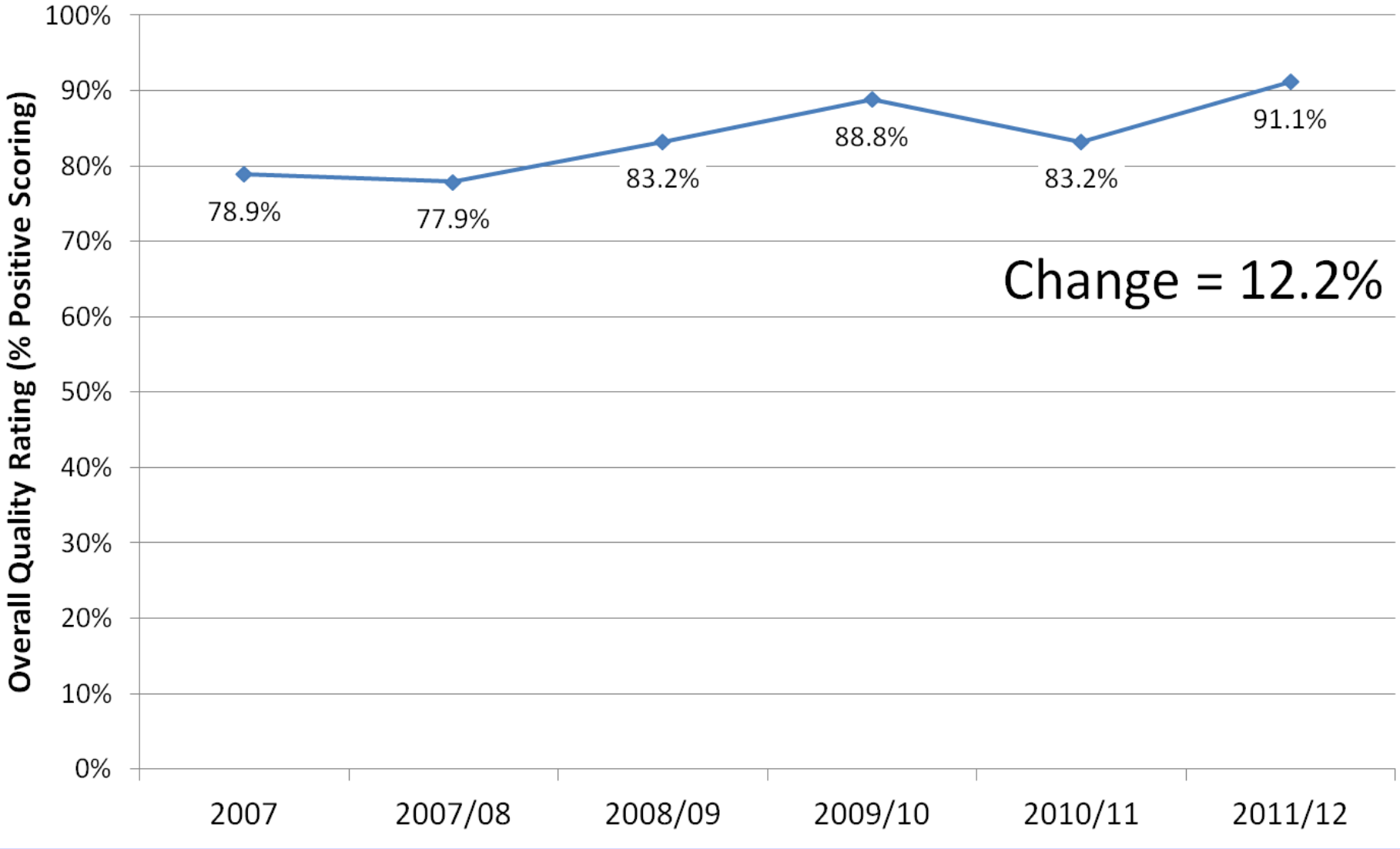
Lions Gate Hospital Emergency Department
Overall Quality Rating (% positive)
2007 to fiscal 2011/12



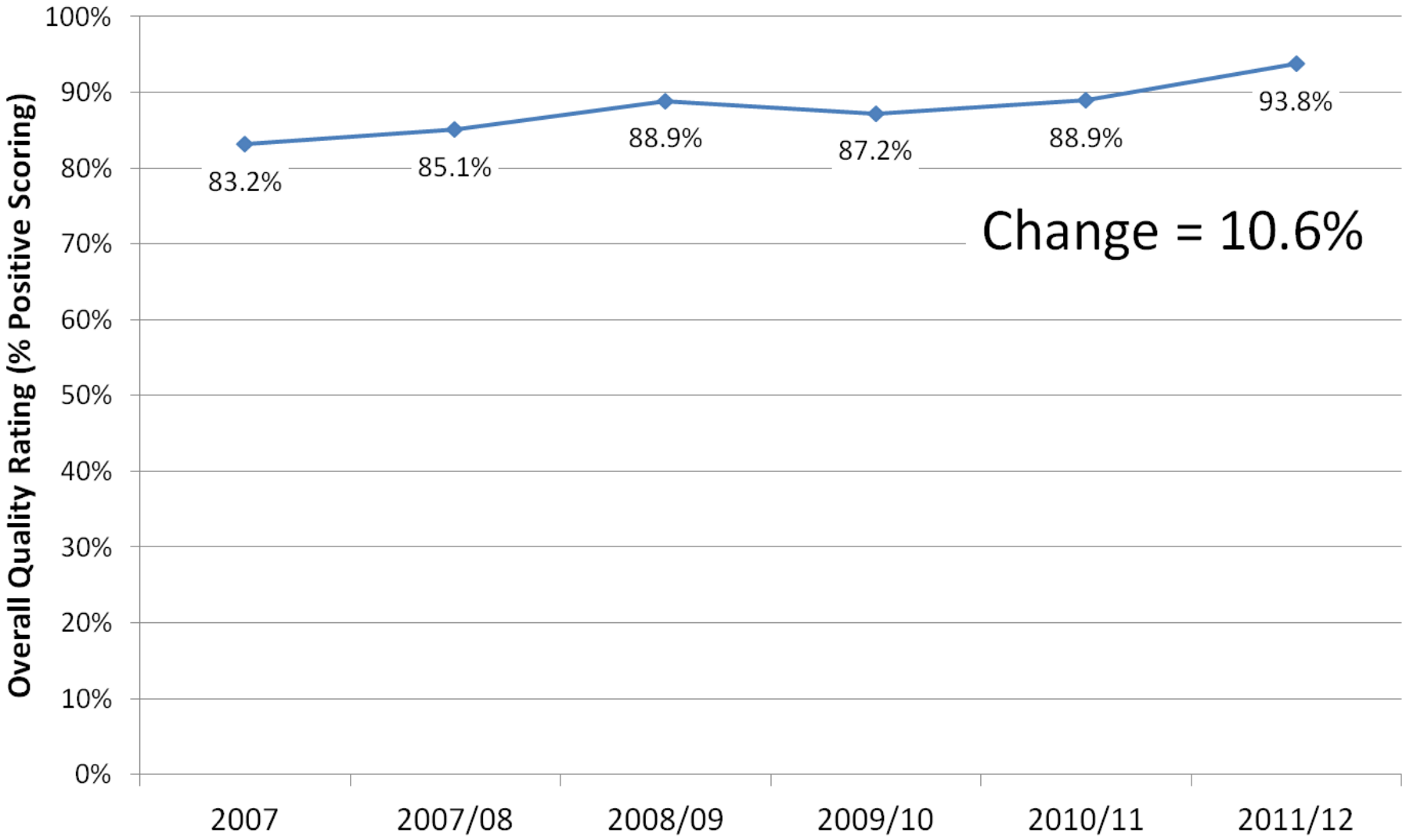
Surrey Memorial Hospital Emergency Department
Overall Quality Rating (% positive)
2007 to fiscal 2011/12



Victoria General Hospital Emergency Department
Overall Quality Rating (% positive)
2007 to fiscal 2011/12



Cowichan Hospital Emergency Department
Overall Quality Rating (% positive)
2007 to fiscal 2011/12



Storyboard Template - produced units, programs, facilities, HAs, and BC

Ministry of Health Logo OR
Health Authority Logo

DRAFT Sample Provincial Report

Experience of Outpatient Cancer Care Survey 2012
(June 15th, 2012 to December 15th, 2012)

Number of Respondents: 6,785 || Response Rate: 40.1%

For more information on the survey or for more detailed results, please contact THIS PERSON at THIS EMAIL AND PHONE NUMBER.

STRENTHS
(top 10 performing survey questions)

Survey Question	% Positive
Waited less than 30 mins from scheduled appt to radiation	95.3%
Treated w/ dignity and respect by providers	92.3%
Family/friends involved in care and treatment	92.1%
Waited less than 60 mins from scheduled appt to chemo	90.0%
Could trust providers w/ confidential info	**87.8%**
Knew who was in charge for each therapy	83.1%
Got services need in past 6 months	81.2%
Staff did everything to help w/ chemo side effects	80.7%
Staff did everything to make chemo wait comfortable	80.5%
Staff did everything to help w/ radiation side effects	80.0%

PATIENT-CENTRED DIMENSIONS (2)

Physical Comfort	**77.2%**
Coordination and Continuity of Care	**64.5%**
Information, Communication and Education	61.4%
Respect for Patient Preferences	74.1%
Emotional Support	53.1%
Access to Care	75.8%

97.0%

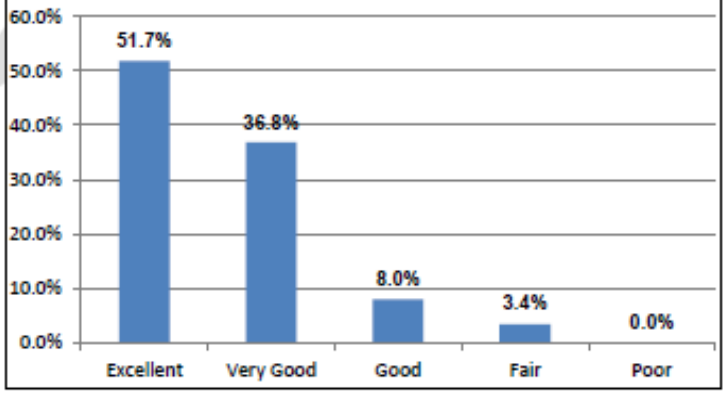
BC Overall Quality of Care (1)
(Good + Very Good + Excellent)

AREAS FOR IMPROVEMENT
(bottom 10 performing survey questions)

Survey Question	% Positive
Put in touch w/ provider to help with anxieties and fears	24.2%
Enough info re: possible relationship changes	**27.6%**
Enough info re: possible emotional changes	**33.9%**
Put in touch w/ provider to help with anxiety/fears at diagnosis	35.0%
Enough info re: possible changes in sexual activity	39.8%
Enough info re: possible changes in work/activities	44.2%
Providers aware of medical history	47.6%
Explained wait for first treatment appt	51.2%
Enough info re: possible energy level changes	51.9%
Knew next step in care	52.7%

"The entire staff of the Cancer Clinic at Alpha Hospital are outstanding. The people who give the radiation treatments are dedicated and professional, with outstanding people skills which they apply in a friendly, thoughtful way. Patients were shown respect + understanding with a feeling of quiet optimism."

"Overall, how would you rate the quality of care at Alpha Hospital in the past 6 months?"
Results by Response Option



"I have seen 5 oncologists in the past 6 mos. One hardly spoke + the last 2 had no idea of my medical history - could not answer any of my questions. If you do not manage your own care - you will become a statistic. The cancer unit nurses are well informed about medications but offer no emotional support. Who does??"

(1) Percent (%) Positive scores are calculated by summing responses to survey questions that are considered positive.
(2) Dimension scores are calculated by summing positive responses for each Q within the dimension then dividing the total number of responses to all Qs in that dimension.
(3) Patient-centred and their corresponding scores **highlighted in blue** represent survey questions with a high correlation to the Overall Quality of Care score

Now, a look forward …

….a(nother) change in direction

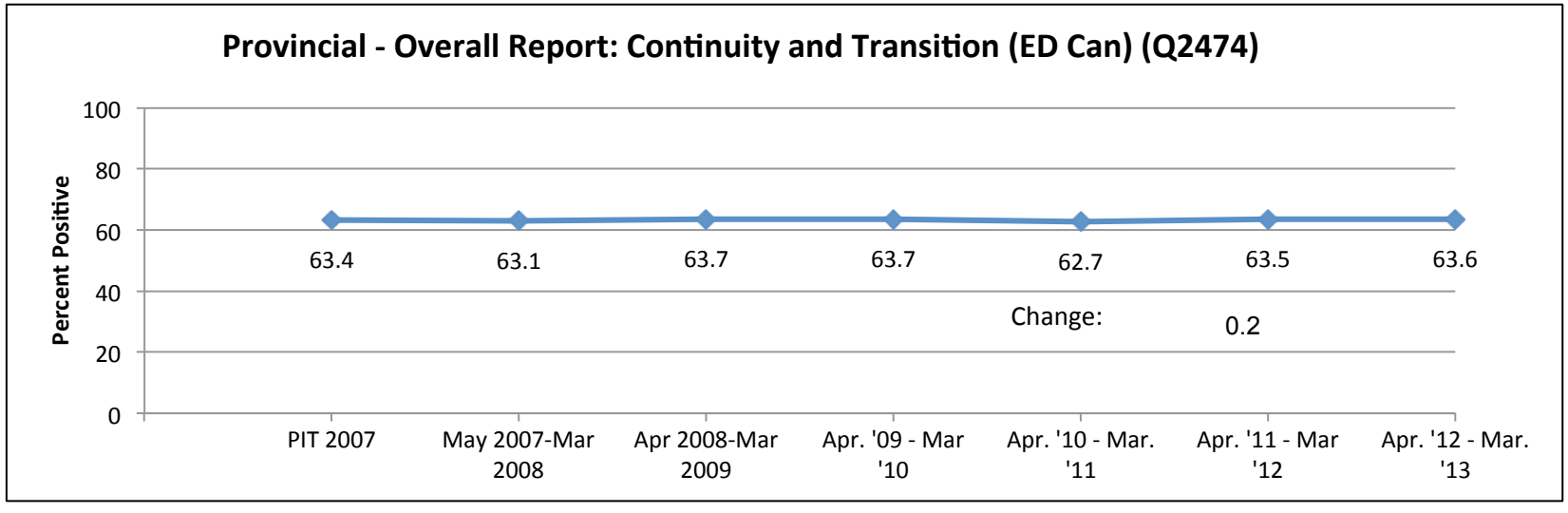
Definition of Patient experience …

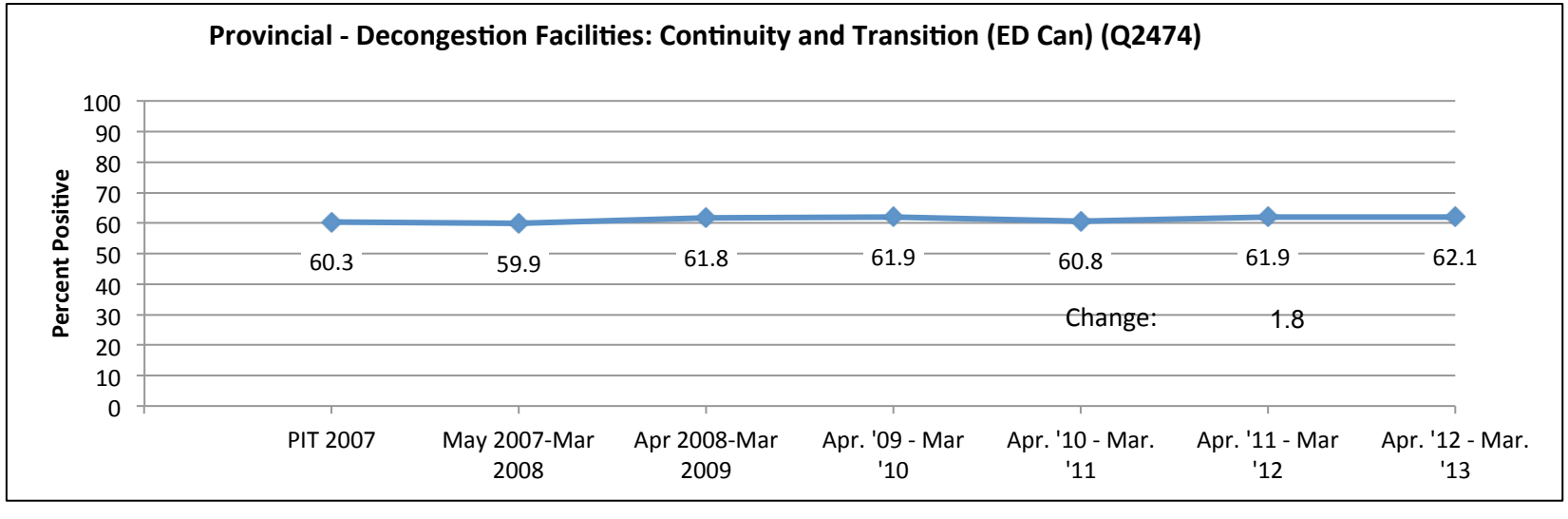
"The sum of all interactions, shaped by an organization's culture, that influence patient perceptions across the continuum of care."

The Beryl Institute

The Rationale for our focus on *Continuity across Transitions in Care*:

The short story: Continuity and transition scores are flat!!

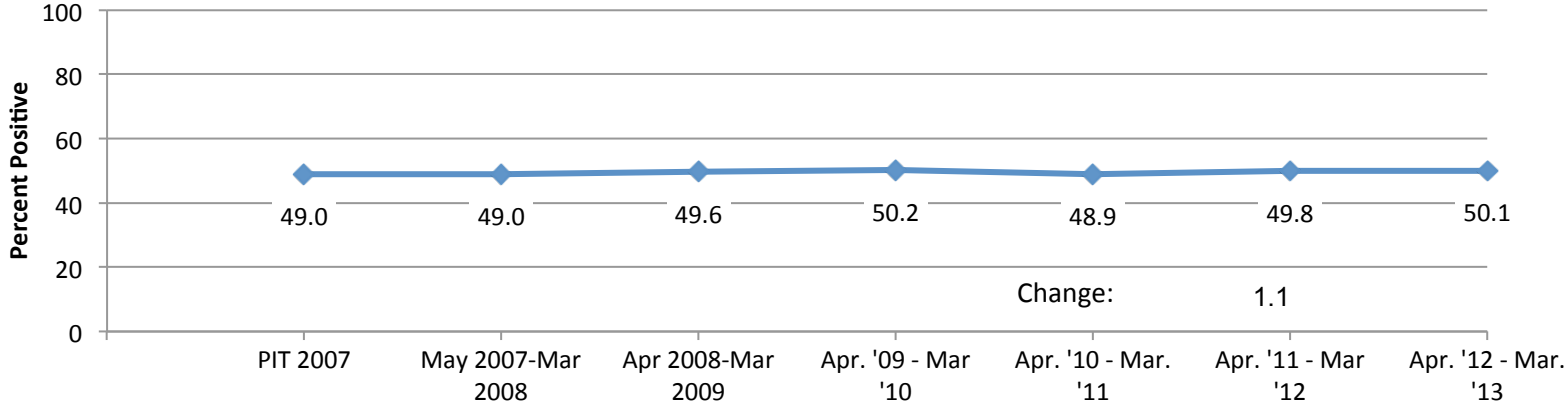




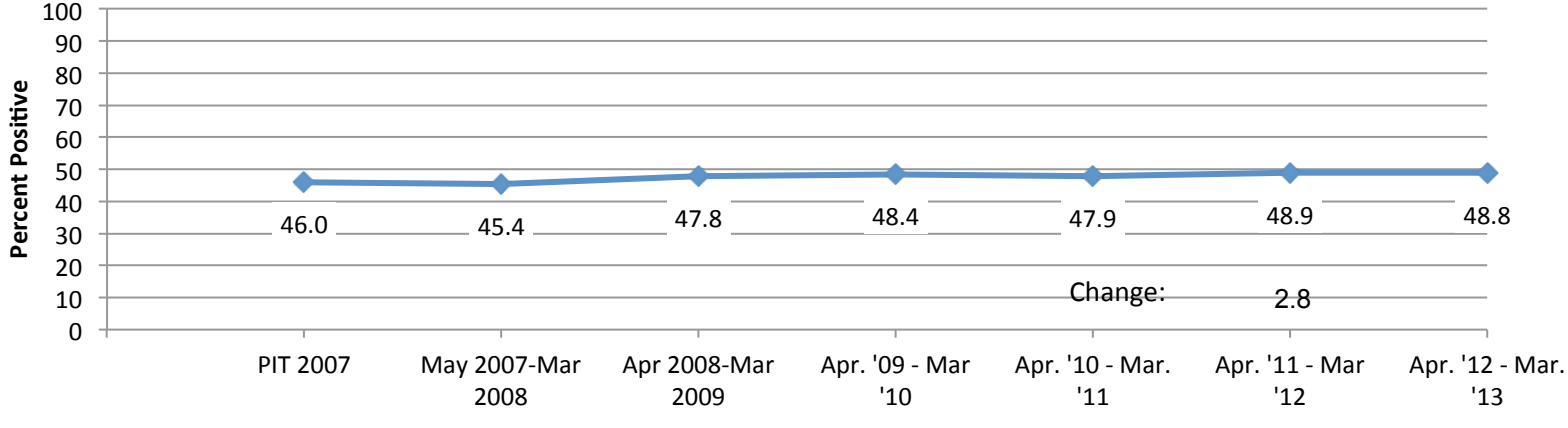
ED explained danger signals

Were you told what danger signals about your illness or injury to watch out for when you got home?

Provincial - Overall Report: ED explained danger signals to watch for (Q14919)



Provincial - Decongestion Facilities: ED explained danger signals to watch for (Q14919)



"Did they tell you when you could resume your usual activities, such as when to go back to work or drive a car?"

Sub-Sector	2005	2008	2011/12
All Sectors Combined	47.5%	45.8%	44.5%
Pediatrics	54.5%	55.8%	60.0%
Maternity	43.4%	44.7%	48.0%
Rehab	N/A	N/A	32.7%
Inpatients	47.9%	45.7%	43.6%

- This question is in the **CONTINUITY & TRANSITION** Dimension
- Lowest performing item in BC …
- 4 of 5 items in this Dimension show a decline for Med/Surg Inpatients and Rehab is lowest of all subsectors

BC's Vision for 2014 (and beyond!)

Availability of information from the perspective of patients about the quality of their care that follows their journey across the care continuum.

This includes:

- Ambulance Care/Transfer Services → ED
- Emergency Department Care → Acute IP
- Emergency Dept Care → Home/Home Care
- Acute Inpatient Care → Home/Home Care

Findings from the Literature (Dec 2013)*

- Continuity of care is an active area of interest
- Since 2011: Move from setting / condition specific to multidimensional tools (i.e., tools covering multiple transitions and types of patients)
  - Multidimensional usually means primary and outpatient physician specialist care with limited inclusion of hospital care (generally with no differentiation between ED and AC)
  - Absolutely no mention of ambulance / transfer service
- Conclusion, this field is young
  - Several tools are still undergoing development
  - Most have limited use / testing
- Language is an issue: Not all tools have been tested in English
- Promising questions, but no "ready to wear" tools
- Most of the domains that have been found fit into the three types of continuity: relational, informational, and managerial

*** A Review of the Literature: Measuring the Patient Experience Across a Continuum of Care Transitions**
By: Faye Schmidt, Ph.D. For: BC PREMS and the BC Continuum of Care Surveying Consultation Group
December 12th, 2013

***CONTINUITY ACROSS TRANSITIONS OF CARE** is the experience of consistent, connected, coordinated care that…*

Relational Continuity (BC PREMS, 2014)	**Informational Continuity** (BC PREMS, 2014)	**Managerial Continuity** (BC PREMS, 2014)
Includes meaningful relationships: **Builds confidence and trust between the patient and his/her key support person(s) and care provider(s)**	**Is supportive of information sharing:** **Ensures the information needs of the patient and, where appropriate his/her family/ supporter(s) are met. Ensures timely and accurate flow of relevant information to the patients' key care**	**Is managed over time, place and providers:** **Ensures the experience of the patient is seamless across: changing care needs, care providers, time, and settings.**

Conceptual Map of Items assigned to type of continuity

	Relational Continuity	Informational Continuity	Managerial Continuity	Other
Items in the core US HCAHPS Tool:		Items: 19, 20		Items: 18, 23 (Info on transition type)
Items of Cdn content added to US HCAHPS Tool:	Items: 35, 36	Items: 24, 27, 30, 37, 38, 39	Items: 25, 28, 29, 30, 31, 32	
New BC items to be added to the US/Cdn HCAHPS Tool:	Items: 45, 47	Items: 42, 43, 44, 46, 48, 49, 50, 52, 53	Items: 45, 46, 48, 49, 51, 52, 54	

BC PREMS' Workplan 2014/15

Decision # 1

BC to be one of 5 Early Adopter provinces funding CIHI's CPERS (Cdn Patient Experiences Reporting System) that will begin accepting data in April 2015.

Decision # 2

BC will transition from:

NRC+Picker Acute Inpatient and ED PREMS surveys (proprietary)

to

CPES-IC and ED CAHPS surveys (public domain)

(to be fielded with VR-12 PROMS)

BC PREMS' Workplan 2014/15

Decision # 3

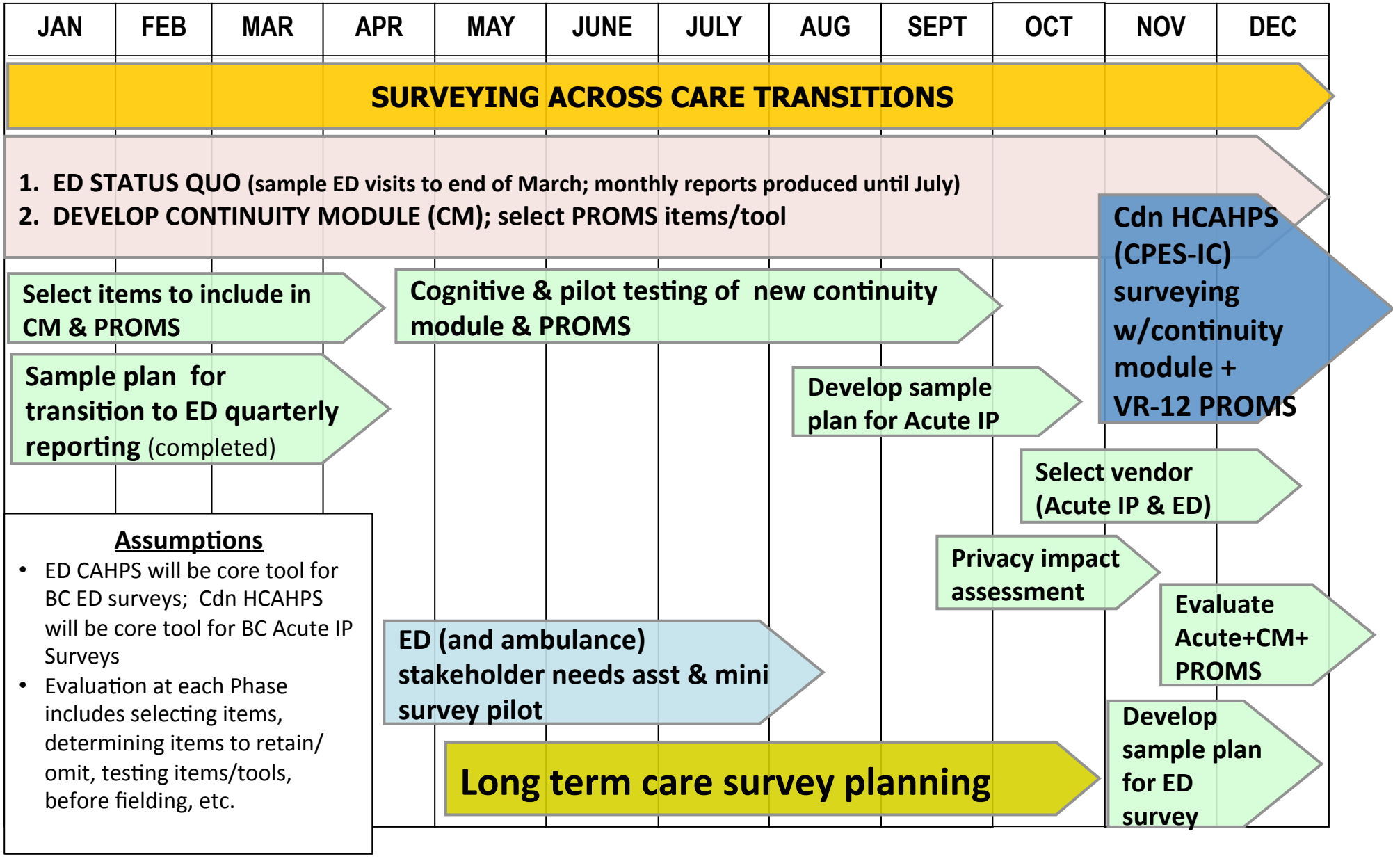
BC to develop a "*continuity across transitions in care*" module and field it with *VR-12 PROMS*.

Cognitively test and pilot test tools with BC Continuity module and VR-12 PROMS before fielding ***(Underway)***

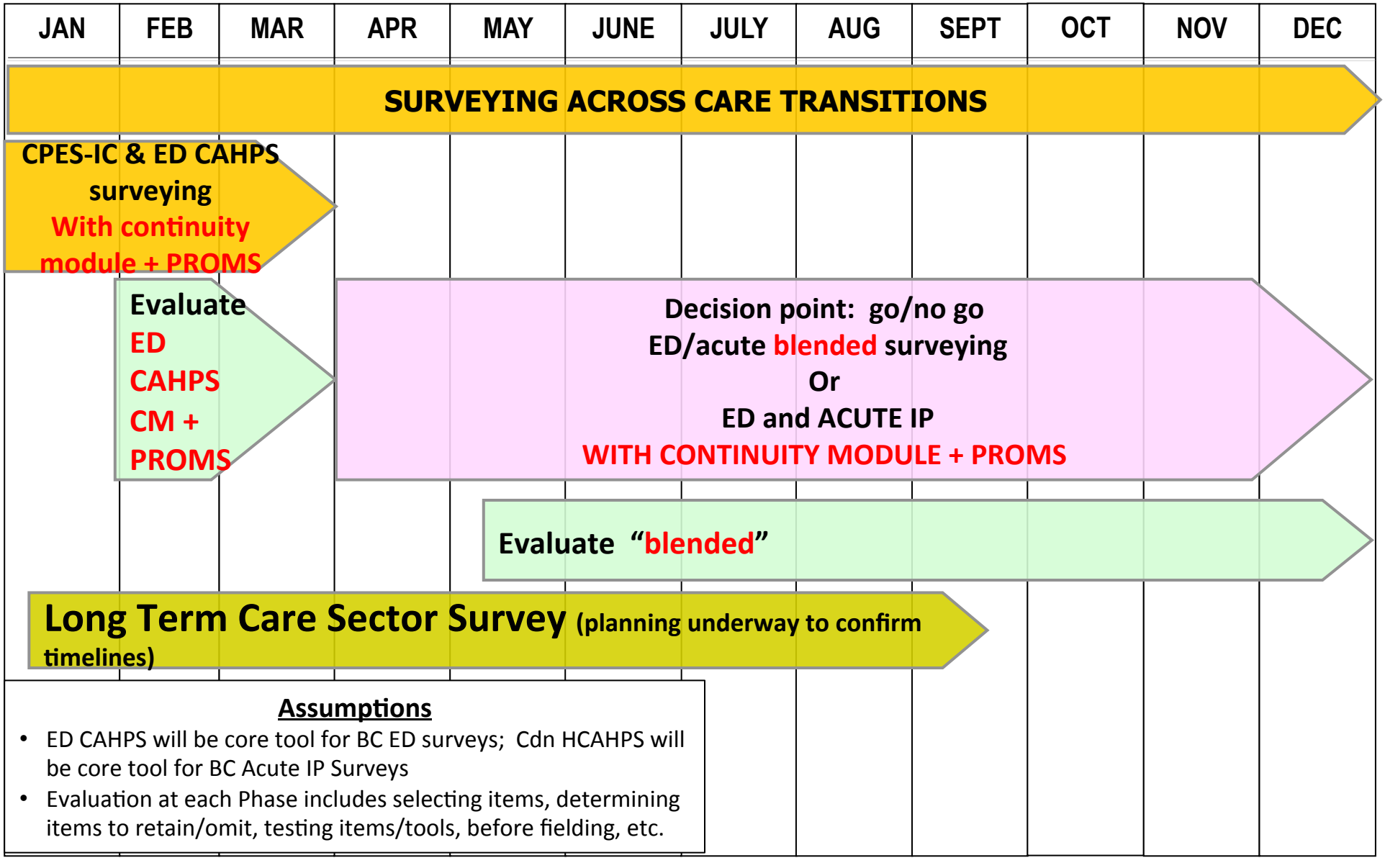
Evaluate at each phase before making go/no decision about proceeding to next

- Field 1st : Acute IP (CPES-IC)
- Field 2nd: Emergency (ED CAHPS/PES)
- Field 3rd: Blended

BC PREMS' Workplan 2014



BC PREMS' Workplan 2015



Assumptions

- ED CAHPS will be core tool for BC ED surveys; Cdn HCAHPS will be core tool for BC Acute IP Surveys
- Evaluation at each Phase includes selecting items, determining items to retain/omit, testing items/tools, before fielding, etc.

More Learnings from BC!

Urban myth #1

Longer surveys = Lower response rates

Urban myth #2:

Real time data = More action on results

Urban myth #3:

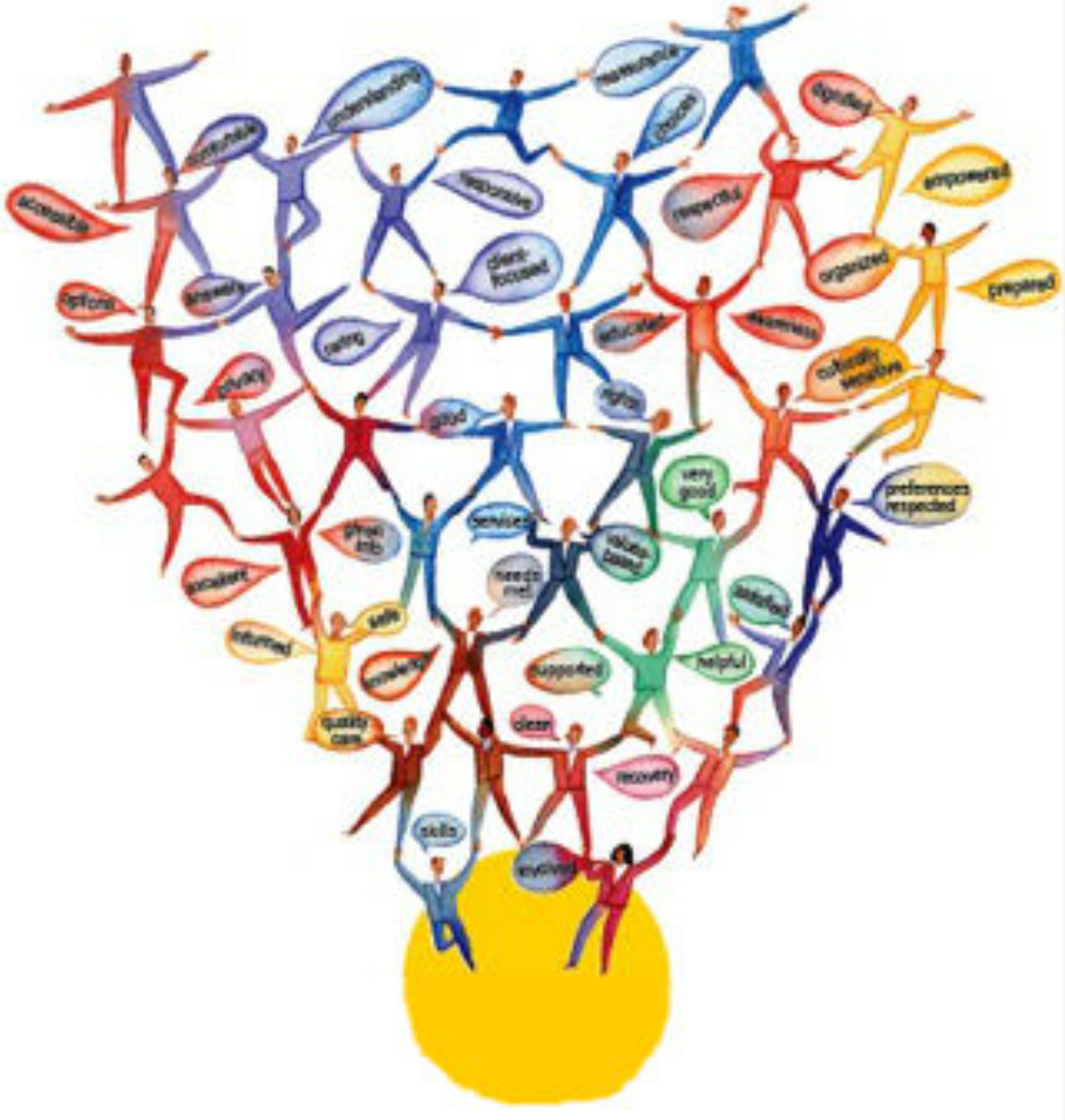
The voice of the patient =

Qualitative, not quantitative data

What are we most proud of?

- **Engagement of patients and professionals in expert Consultation Groups to plan every aspect of every survey in BC**
- **Development of questions, modules, and survey instruments that focus on:**
  - The patient perspective on patient safety (HH, Meds/MedRec, Harm)
  - Self-reported ethnicity, including work with NH on Aboriginal q's and reports
  - Development of Made in BC modules and surveys, e.g. the patient perspective on how well we address Emotional Distress and Support for Outpatient Cancer Care; Family/Supporter experience while a loved one is receiving short stay Mental Health & Substance Use Care; the patient perspective on stigma
  - The patient and provider perspective on Surgery, Maternity, Pediatrics, Rehab
- **Development of indicators that are added to Health Authority Balanced Scorecards, including Mission indicators for faithbased facilities**
- **Development of processes to permit return of raw data WITH identifiers for all surveys (June 2011); by March 2015 all PREMS data will be centrally hosted (BC MoH HealthIdeas platform)**
- **Building of capacity to use baseline data to develop real time patient and family feedback for QI that … translating data into information, and information into action**
- **Engagement of non-clinicians to extract patient records…biweekly (>17M records since 2003)**

Using the Patient's Experience to Transform Healthcare.



1. Measuring patient experience is NOT an amateur sport.
2. Measuring patient experience is a science…and an art.
3. Patients are integral in survey design, defining what is important and ensuring that questions measure what we intend them to measure.
4. Patient experience reports should be available as readily and frequently as other management reports.
5. Like accountability for patient safety, accountability for positive patient experience should rest with everyone.
6. Without accountability frameworks, action on results takes a back seat to other issues.
7. Improving the performance of one location will not improve the system as a whole.

Questions, discussion…

For more information….

Lena Cuthbertson

Provincial Director, Patient-Centred Performance Measurement & Improvement

Co-chair, BC Patient Reported Experience Measures Steering Committee

lcuthbertson@providencehealth.bc.ca

Link to BC PREMS survey results:

http://www.health.gov.bc.ca/socsec/surveys.html