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

Presented to: Patient-Reported Outcome & Experience Measures Forum
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Calgary, Alberta

Presented by:
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Co-chair, BC Patient Reported Experience Measures Steering Committee (BCPREMS)
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 ...
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) |
<table>
<thead>
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<tbody>
<tr>
<td>Respect for patient values &amp; preferences</td>
<td>Respect and Dignity</td>
<td>Respectful Partnerships</td>
</tr>
<tr>
<td>Information, Communication &amp; Education</td>
<td>Information Sharing</td>
<td>Evidence Based Care</td>
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<tr>
<td>Coordination of Care</td>
<td>Collaboration</td>
<td>Leadership</td>
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<tr>
<td>Involvement of Family</td>
<td>Participation</td>
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<td>Emotional Support</td>
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<td>Hearts &amp; Minds</td>
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<td>Physical Comfort</td>
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<td>Preparation for Discharge /Continuity &amp; Transitions in Care</td>
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<td>Reliable Care</td>
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<td>Access</td>
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Mandate of BC PREMS

To develop a coordinated, cost-efficient, and scientifically rigorous 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**

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

- **Data Collection**
  - Distributing surveys
  - Collecting completed responses/surveys

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

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

- **Sharing Results**
  - Dissemination of results to all stakeholders
  - Public Reporting

- **Action Planning**
  - 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

**Timeline**

- 2003 - 2010
- 2010 - present
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 1 million 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?

- Acute Inpatients (medical, surgical, pediatrics, maternity, rehab)
- Outpatient Cancer Care Patients (radiation, IV chemo, non-IV)
- Long-Term Care Families & Frequent Visitors
- Long-Term Care Residents
- Mental Health & Substance Use Clients
- Emergency Department Patients
- Mental Health & Substance Use Families/Supporters
<table>
<thead>
<tr>
<th>Year</th>
<th>Sector</th>
<th>Methodology</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>2003</td>
<td></td>
<td>Mail; Random sample 103 facilities</td>
<td>Point in time -- 3 months July 1st to September 30th, 2003</td>
</tr>
<tr>
<td>2007</td>
<td>Emergency</td>
<td>As above 111 facilities</td>
<td>Point in time -- 3 months February 1st – April 30th, 2007</td>
</tr>
<tr>
<td></td>
<td></td>
<td>As above 111 facilities</td>
<td>Continuous May 1st, 2007 to March 31, 2015</td>
</tr>
<tr>
<td>2004</td>
<td>Long Term Care</td>
<td>RESIDENTS: Interview; Census 102 facilities</td>
<td>Point in time -- Oct 2003 to March 2004</td>
</tr>
<tr>
<td></td>
<td></td>
<td>FAMILY/FREQUENT VISITOR: Mail; Census 102 facilities</td>
<td>All residents and their most frequent visitor (who was sometimes a family member, but not always) in directly funded and managed facilities</td>
</tr>
<tr>
<td>2005</td>
<td>Acute Inpts</td>
<td>Mail 80 hospitals</td>
<td>Point in time -- 3 or 6 months</td>
</tr>
</tbody>
</table>
| 2008   | Medical, Surgical, Maternity, Pediatrics Freestanding Rehab | I) June 1st to Nov 30th, 2005  
   | 2011/12 |                                            | II) Oct 1st to Dec 31st, 2008  
   |        |                                            | III) Oct 1st/11 to Mar 31/12 |
| 2006   | 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  
   | 2012/13 |                                            | 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
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<tbody>
<tr>
<td>Use of “ready to wear” tools; participation in validation of US tools for use in Canada/BC</td>
<td>BC custom questions developed and tested to augment “ready to wear” tools; addressed ethnicity, patient safety (harm, hand-washing, check ID before meds)</td>
<td>Intro of simultaneous continuous surveying in ED and PIT surveys in other sectors</td>
<td>Interest in combining PREMS &amp; PROMS</td>
</tr>
<tr>
<td>Copy cat processes as recommended by vendors and/or other jurisdictions</td>
<td>Alternate languages introduced (French, Chinese, Punjabi, German)</td>
<td>Analytical reports commissioned (CHSPR/UBC, survey research experts)</td>
<td>Decision to develop a survey instrument to address a gap in the literature and in practice--a tool for MH/Addictions family/supporters</td>
</tr>
<tr>
<td>Developed processes to meet privacy requirements of BC’s OIPC, including completion of PIA’s and exclusion of youth to meet privacy risks/requirements</td>
<td>Added web based response option via unique access codes to all surveys</td>
<td>“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)</td>
<td>Moving from data collection and reporting to focus on use of results to promote QI at the point of service</td>
</tr>
<tr>
<td>Results reported without weights (actual volumes NOT reflected)</td>
<td>Results weighted to reflect actual volumes (from facility level up)</td>
<td>Further customization of survey tools &amp; cognitive testing of new/changed items</td>
<td>Early adopter province in CIHI’s CPERS</td>
</tr>
<tr>
<td>Use of vendors’ standard reporting templates</td>
<td>“Made in BC” peer groups defined and national benchmarks adjusted to ours</td>
<td>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.</td>
<td>Focus on info at transition points/continuity across transitions in care</td>
</tr>
<tr>
<td>All surveys conducted as Point in Time (PIT) studies</td>
<td>Risk mitigation strategy developed and approved by OIPC to permit inclusion of youth</td>
<td>Change from proprietary to non-prop tools</td>
<td>Change from sector based to continuum based surveying</td>
</tr>
<tr>
<td></td>
<td>Narrative summary reports introduced</td>
<td>Change from sector based to continuum based surveying</td>
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</tbody>
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## BC adopts a Modular Approach to Measuring PX

<table>
<thead>
<tr>
<th>POPULATION</th>
<th>SURVEY INSTRUMENT</th>
<th>RESPONDENT POPULATION</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Acute Inpatients</strong></td>
<td>• core Picker Acute Inpatient Care tool validated for use in Cdn in 2003 with BC input</td>
<td>All patients sampled receive the core questions</td>
</tr>
<tr>
<td><strong>SUBPOPULATIONS</strong></td>
<td></td>
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<tr>
<td><strong>Maternity</strong></td>
<td>• 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 &quot;actionable&quot; items</td>
<td>Patients whose acute inpatient admission was related to a childbirth experience receive the core questions PLUS the Maternity module</td>
</tr>
<tr>
<td><strong>Pediatrics</strong></td>
<td>• BC module developed in 2005 as above with input from pediatric care providers • Items selected from Picker Cdn validated pediatric instrument</td>
<td>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</td>
</tr>
<tr>
<td><strong>Surgery</strong></td>
<td>• skip pattern introduced in 2008 survey • surgical questions selected from a NHS/UK validated tool by the BC SPR-SMC (Surgical Patient Registry Strategic Management Committee)</td>
<td>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</td>
</tr>
<tr>
<td>2008, 2011/12</td>
<td></td>
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<tr>
<td><strong>Rehabilitation</strong></td>
<td>• 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</td>
<td>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</td>
</tr>
<tr>
<td>2011/12</td>
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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!

**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
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.

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

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


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

Change = 5.0%
Lions Gate Hospital Emergency Department
Overall Quality Rating (% positive)
2007 to fiscal 2011/12

Change = 12.8%
Surrey Memorial Hospital Emergency Department
Overall Quality Rating (% positive)
2007 to fiscal 2011/12

Change = 14.3%
Victoria General Hospital Emergency Department
Overall Quality Rating (% positive)
2007 to fiscal 2011/12

Change = 12.2%
Cowichan Hospital Emergency Department
Overall Quality Rating (% positive)
2007 to fiscal 2011/12

Change = 10.6%
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%

PATIENT-CENTRED DIMENSIONS (2)

<table>
<thead>
<tr>
<th>Survey Question</th>
<th>Physical Comfort</th>
<th>Coordination and Continuity of Care</th>
<th>Information, Communication and Education</th>
<th>Respect for Patient Preferences</th>
<th>Emotional Support</th>
<th>Access to Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Waited less than 30 mins from scheduled appt to radiation</td>
<td>85.3%</td>
<td>77.2%</td>
<td>64.5%</td>
<td>61.4%</td>
<td>74.1%</td>
<td>53.1%</td>
</tr>
<tr>
<td>Treated w/ dignity and respect by providers</td>
<td>92.3%</td>
<td>77.2%</td>
<td>64.5%</td>
<td>61.4%</td>
<td>74.1%</td>
<td>53.1%</td>
</tr>
<tr>
<td>Family/friends involved in care and treatment</td>
<td>92.1%</td>
<td>77.2%</td>
<td>64.5%</td>
<td>61.4%</td>
<td>74.1%</td>
<td>53.1%</td>
</tr>
<tr>
<td>Waited less than 60 mins from scheduled appt to chemo</td>
<td>90.0%</td>
<td>77.2%</td>
<td>64.5%</td>
<td>61.4%</td>
<td>74.1%</td>
<td>53.1%</td>
</tr>
<tr>
<td>Could trust providers w/ confidential info</td>
<td>87.8%</td>
<td>77.2%</td>
<td>64.5%</td>
<td>61.4%</td>
<td>74.1%</td>
<td>53.1%</td>
</tr>
<tr>
<td>Knew who was in charge for each therapy</td>
<td>83.1%</td>
<td>77.2%</td>
<td>64.5%</td>
<td>61.4%</td>
<td>74.1%</td>
<td>53.1%</td>
</tr>
<tr>
<td>Got services need in past 6 months</td>
<td>81.2%</td>
<td>77.2%</td>
<td>64.5%</td>
<td>61.4%</td>
<td>74.1%</td>
<td>53.1%</td>
</tr>
<tr>
<td>Staff did everything to help w/ chemo side effects</td>
<td>80.7%</td>
<td>77.2%</td>
<td>64.5%</td>
<td>61.4%</td>
<td>74.1%</td>
<td>53.1%</td>
</tr>
<tr>
<td>Staff did everything to make chemo wait comfortable</td>
<td>80.5%</td>
<td>77.2%</td>
<td>64.5%</td>
<td>61.4%</td>
<td>74.1%</td>
<td>53.1%</td>
</tr>
<tr>
<td>Staff did everything to help w/ radiation side effects</td>
<td>80.0%</td>
<td>77.2%</td>
<td>64.5%</td>
<td>61.4%</td>
<td>74.1%</td>
<td>53.1%</td>
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AREAS FOR IMPROVEMENT (bottom 10 performing survey questions)

<table>
<thead>
<tr>
<th>Survey Question</th>
<th>Physical Comfort</th>
<th>Coordination and Continuity of Care</th>
<th>Information, Communication and Education</th>
<th>Respect for Patient Preferences</th>
<th>Emotional Support</th>
<th>Access to Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Put in touch w/ provider to help with anxieties and fears</td>
<td>24.2%</td>
<td>77.2%</td>
<td>64.5%</td>
<td>61.4%</td>
<td>74.1%</td>
<td>53.1%</td>
</tr>
<tr>
<td>Enough info re: possible relationship changes</td>
<td>27.6%</td>
<td>77.2%</td>
<td>64.5%</td>
<td>61.4%</td>
<td>74.1%</td>
<td>53.1%</td>
</tr>
<tr>
<td>Enough info re possible emotional changes</td>
<td>29.1%</td>
<td>77.2%</td>
<td>64.5%</td>
<td>61.4%</td>
<td>74.1%</td>
<td>53.1%</td>
</tr>
<tr>
<td>Put in touch w/ provider to help with anxiety/fears at diagnosis</td>
<td>35.0%</td>
<td>77.2%</td>
<td>64.5%</td>
<td>61.4%</td>
<td>74.1%</td>
<td>53.1%</td>
</tr>
<tr>
<td>Enough info re: possible changes in sexual activity</td>
<td>38.8%</td>
<td>77.2%</td>
<td>64.5%</td>
<td>61.4%</td>
<td>74.1%</td>
<td>53.1%</td>
</tr>
<tr>
<td>Enough info re: possible changes in work/activities</td>
<td>44.2%</td>
<td>77.2%</td>
<td>64.5%</td>
<td>61.4%</td>
<td>74.1%</td>
<td>53.1%</td>
</tr>
<tr>
<td>Providers aware of medical history</td>
<td>47.6%</td>
<td>77.2%</td>
<td>64.5%</td>
<td>61.4%</td>
<td>74.1%</td>
<td>53.1%</td>
</tr>
<tr>
<td>Explained wait for first treatment appt</td>
<td>51.2%</td>
<td>77.2%</td>
<td>64.5%</td>
<td>61.4%</td>
<td>74.1%</td>
<td>53.1%</td>
</tr>
<tr>
<td>Enough info re: possible energy level changes</td>
<td>51.6%</td>
<td>77.2%</td>
<td>64.5%</td>
<td>61.4%</td>
<td>74.1%</td>
<td>53.1%</td>
</tr>
<tr>
<td>Knew next step in care</td>
<td>52.7%</td>
<td>77.2%</td>
<td>64.5%</td>
<td>61.4%</td>
<td>74.1%</td>
<td>53.1%</td>
</tr>
</tbody>
</table>

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

- Excellent: 51.7%
- Very Good: 36.8%
- Good: 8.0%
- Fair: 3.4%
- Poor: 0.0%

97.0%
BC Overall Quality of Care (1)
(Good + Very Good + Excellent)

“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??”

“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.”

(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(ther) change in direction
The Beryl Institute

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!!

![Graph showing continuity and transition scores](image)
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?”

<table>
<thead>
<tr>
<th>Sub-Sector</th>
<th>2005</th>
<th>2008</th>
<th>2011/12</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Sectors Combined</td>
<td>47.5%</td>
<td>45.8%</td>
<td>44.5%</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>54.5%</td>
<td>55.8%</td>
<td>60.0%</td>
</tr>
<tr>
<td>Maternity</td>
<td>43.4%</td>
<td>44.7%</td>
<td>48.0%</td>
</tr>
<tr>
<td>Rehab</td>
<td>N/A</td>
<td>N/A</td>
<td>32.7%</td>
</tr>
<tr>
<td>Inpatients</td>
<td>47.9%</td>
<td>45.7%</td>
<td>43.6%</td>
</tr>
</tbody>
</table>

- 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...

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Includes meaningful relationships:</td>
<td>Is supportive of information sharing:</td>
<td>Is managed over time, place and providers:</td>
</tr>
<tr>
<td>Builds confidence and trust between the patient and his/her key support person(s) and care provider(s)</td>
<td>Ensures the information needs of the patient and, where appropriate his/her family/sponsor(s) are met. Ensures timely and accurate flow of relevant information to the patients’ key care providers.</td>
<td>Ensures the experience of the patient is seamless across: changing care needs, care providers, time, and settings.</td>
</tr>
</tbody>
</table>
## Conceptual Map of Items assigned to type of continuity

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

**SURVEYING ACROSS CARE TRANSITIONS**

1. ED STATUS QUO (sample ED visits to end of March; monthly reports produced until July)
2. DEVELOP CONTINUITY MODULE (CM); select PROMS items/tool
   - **Select items to include in CM & PROMS**
   - **Sample plan for transition to ED quarterly reporting** (completed)
   - **Cognitive & pilot testing of new continuity module & PROMS**
   - **Develop sample plan for Acute IP**
   - **Select vendor (Acute IP & ED)**
   - **Privacy impact assessment**
   - **Evaluate Acute+CM+PROMS**
   - **Develop sample plan for ED survey**

**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.

**Long term care survey planning**

**Cdn HCAHPS (CPES-IC) surveying w/continuity module + VR-12 PROMS**
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.

Long Term Care Sector Survey (planning underway to confirm timelines)

Surveying across care transitions

CPES-IC & ED CAHPS
- Surveying with continuity module + PROMS

Evaluate
- ED CAHPS CM + PROMS

Decision point: go/no go
- ED/acute blended surveying
  - Or
  - ED and ACUTE IP WITH CONTINUITY MODULE + PROMS

Evaluate “blended”
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 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)
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