Legacy Impact Report

Purchaser Business Group on Health
Patient Assessment Survey

AUGUST 2024

Patient
Assessment Survey

Executive Summary

The Patient Assessment Survey (PAS) program, operated by the Purchaser Business Group on Health (PBGH) for over two decades, has been a cornerstone in capturing and improving patient experience across California's health care system. PAS collected feedback from over 40,000 commercially insured patients within 176 provider organizations annually, providing crucial insights into patient interactions with health care providers. These metrics, including access to care, communication with providers and overall care ratings, have been instrumental in driving quality improvements and enhancing transparency in health care delivery.

Throughout its tenure, the PAS program has not only influenced individual provider performance but also contributed to broader initiatives such as the California Office of the Patient Advocate's (OPA) Report Card and the Integrated Healthcare Association (IHA)'s Align. Measure. Perform. (AMP) incentive payment design. The program's public reporting and accountability measures have led to consistent improvements in patient experience, with notable gains in overall care and doctor ratings over the years.

Public reporting and accountability for patient experience measurement drove steady improvements, averaging 1-3% gains each year. The program identified significant disparities in care, particularly for racial and ethnic minorities and non-English-speaking patients, with gaps in mental health and telehealth services being especially pronounced. These discoveries highlight the essential role PAS played in not only improving patient care but also in uncovering and addressing inequities within the health care system.

Despite its success, the PAS program was discontinued in July 2024 due to the removal of patient experience measurement from the AMP program, which made the initiative unsustainable without the necessary financial incentives for provider participation. PBGH remains committed to advocating for innovative and meaningful approaches to measuring healthcare quality, costs, experiences and outcomes.

Introduction

Patient experience within the health care delivery system is a crucial indicator of quality. It has been linked to multiple benefits for patients, including improved disease management, adherence to medication regimens, better quality of life and health outcomes. Recognizing the importance of patient experience to health care quality and outcomes, the Purchaser Business Group on Health (PBGH) has operated the Patient Assessment Survey (PAS) across California for more than 20 years. This survey captures and shares patient voices to ensure a more patient-centered system. The PAS program reflects the commitment of health plans, purchasers and provider organizations to the joint administration of a statewide patient experience survey in California.

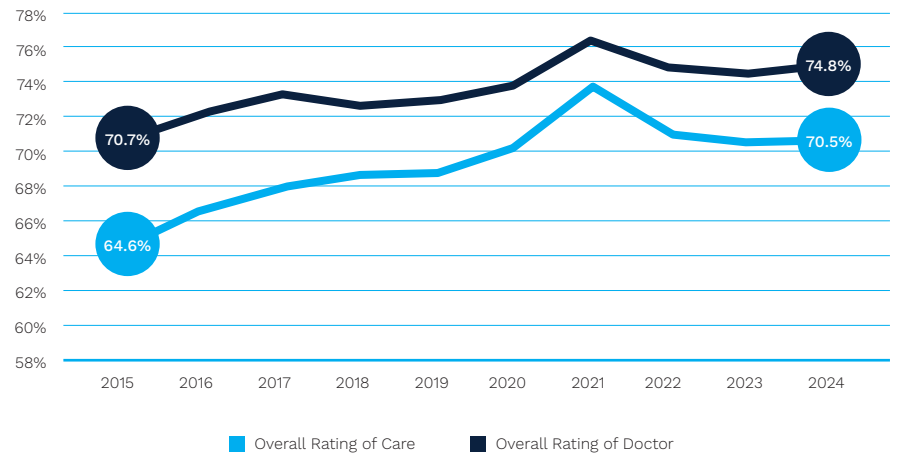
PAS is based on the Consumer Assessment of Healthcare Providers and Systems Clinician & Group Survey (CG-CAHPS), which is endorsed by the National Quality Forum and was developed by the Agency for Healthcare Research and Quality (AHRQ) and its research partners in the CAHPS consortium (see CAHPS overview for more details). PAS reports on patient experience with access, ease of specialty referral, communication with providers, experience with office staff and overall ratings of care and doctor. These metrics are important to patients and families but not otherwise systematically collected.

On an annual basis, PBGH collects patient experience ratings from over 40,000 commercially insured patients for 176 provider organizations within California. The results are risk-adjusted by age, gender, education level, race/ethnicity, primary language of respondent, self-reported physical health and self-reported mental health. PAS is the only such program to collect results using email and text messaging, along with mail and phone follow-up, leading to significantly higher response rates compared to industry standards. PBGH reports provider organization-level patient experience scores to provider organizations and health plans that are benchmarked with statewide percentiles, rankings, averages and 90th percentiles. Aggregated results are also available for Northern and Southern California regions. To support and prioritize quality improvement activities, key driver analyses identify and prioritize measures of provider performance that have the largest impact on the overall ratings. More details are available in the Appendix.

Additionally, PAS results have been reported as part of the State of California Office of the Patient Advocate (OPA) Report Card since its inception and were also part of IHA's AMP incentive payment design accounting for approximately 30% of the AMP Quality Composite Score.

Public reporting and accountability for patient experience measurement has driven steady improvements (on average 1 – 3% each year) over the past two decades. For example, the statewide average for Overall Rating of Care increased from 55.0% in 2006 to 73.5% in 2021, and Overall Rating of Doctor increased from 64.1% to 76.2% during that same time. And, looking at the recent ten-year trends, it is notable that the Overall Ratings of Care and Doctor improved steadily from 2015 to 2021. However, patient experience ratings decreased in 2022 and 2023 (reflecting experience in 2021 and 2022, respectively) likely due to post-pandemic frustration. Patient experience ratings during the pandemic (Measurement Year 2020/Reporting Year 2021) remained high due to what the PAS Steering Committee referred to as the "gratitude effect" in which patients were grateful for the ability to see a doctor regardless of the circumstances.

10-Year Trends of Overall Ratings of Care and Doctor



The PAS program is governed by a multi-stakeholder steering committee consisting of health plan and provider group clinical and quality improvement leadership and is currently co-chaired by representatives from Kaiser Foundation Health Plan and St. Joseph Heritage Healthcare. PBGH is grateful for the leadership, guidance and commitment from the steering committee, the members of which are listed in the Acknowledgements.

The PAS program is being sunset due to a recent decision by IHA to remove patient experience measurement from its AMP incentive payment program in response to industry concerns about cost and burdenpushback. Without payments to providers to collect and report the results, there is no business case to participate and the program is no longer sustainable.

This report describes the decades of commitment from providers, plans, PBGH and its partners to ensure that the patient voice is captured, the importance of measuring patient experience to achieve equitable health care and the impact on the industry by driving improvement and conducting innovative research to assess telehealth and access to behavioral health services.

Brief History and Evolution of PAS

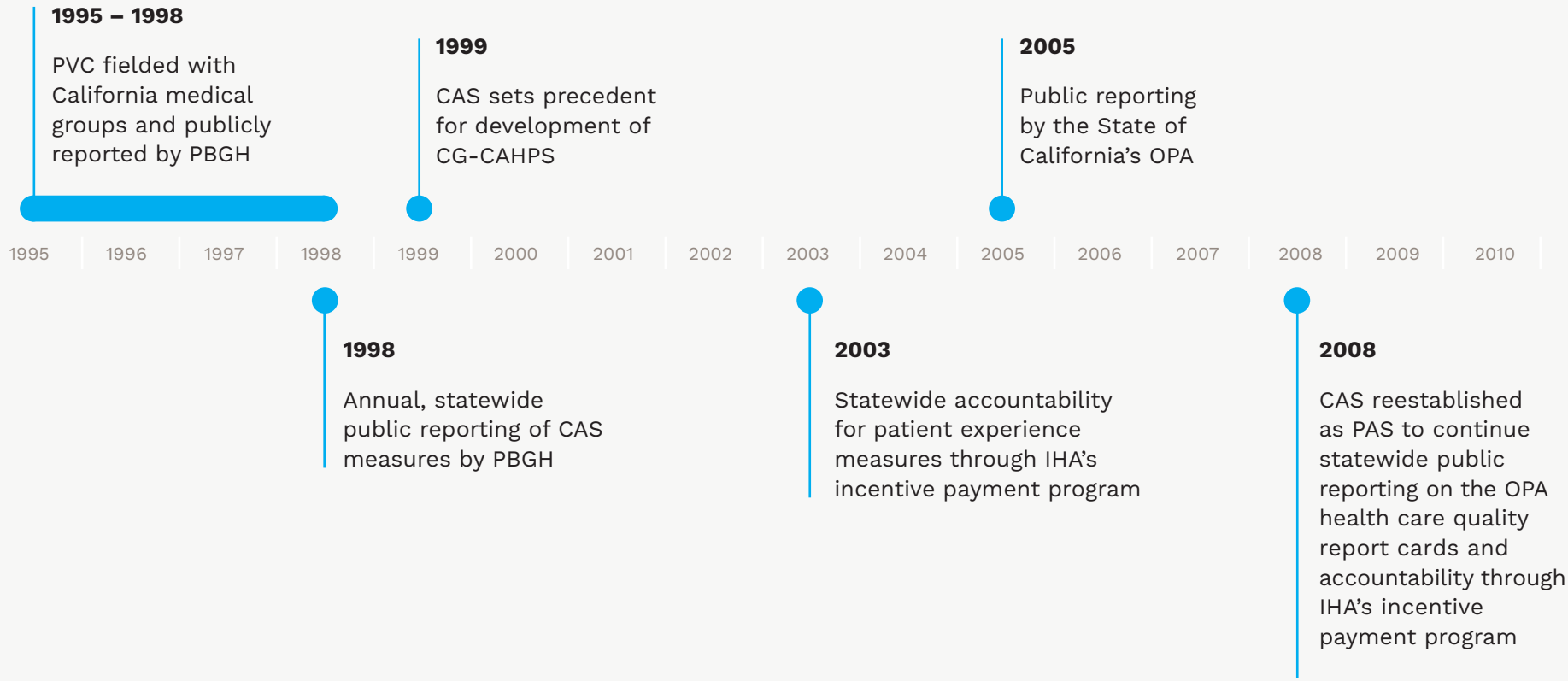
In 1995, PBGH developed the Physician Value Check (PVC) in partnership with the American Medical Group Association to collect patient-reported information about health status and certain aspects of patient experience with care. Results were publicly reported in 1996 and 1998 and early research analyzed the relationship between change in patient experience and quality of care, finding that less decline in experience was associated with better processes of care. PVC was renamed the Consumer Assessment Survey (CAS), which PBGH began administering annually in 1998. With the launch of CAS, medical groups and health plans committed to underwriting the costs of survey administration. In 1999, AHRQ began developing a tool to assess patients' experiences with medical groups and clinicians. At the time, PBGH had already developed CAS so worked closely with AHRQ and the CAHPS team. CAS served as the precedent for what later became known as CG-CAHPS, now the industry standard for surveying patient experience. In 2008, CAS was renamed PAS to distinguish it as a provider-level survey about "patients" rather than "consumers" or health plan members. The administration of PAS has continued to be funded by health plans and provider organizations throughout the program's tenure.

PBGH's Consumer Assessment Survey set a national standard for patient experience measurement and was paramount to the development of CG-CAHPS.

In 1994, PBGH founded the California Cooperative Healthcare Reporting Initiative (CCHRI), a collaborative of health care purchasers, plans and providers, to measure and report on quality measures. Although the majority of CCHRI's efforts were focused on health plan-level measurement, the group recognized the importance for consumers to know whether medical groups or independent physician associations provided good access to medical treatment, how well physicians communicated with patients and whether physicians coordinated a patient's care. This insight led to the development of CAS. For eight years, CCHRI administered a patient experience survey (e.g., PAS) at the physician group-level, funded by health plans. CCHRI then launched several multi-payer claims aggregation projects to develop physician-level performance measures, including the California Better Quality Information Pilot for Medicare Beneficiaries in 2007 and the California Physician Performance Initiative in 2008. PBGH later founded a similar multi-stakeholder initiative, the California Healthcare Performance Information System, to develop and publicly report clinical quality measures at the individual physician and practice levels.

The PAS program was established as a PBGH initiative separate from CCHRI in 2001, with similar aims to publicly report for consumer use and to help health plans understand the underlying performance of their contracted medical groups, thereby improving their own ratings for National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) measures, Medicare Advantage Stars, Department of Managed Health Care (DMHC) requirements, etc. Early findings were instrumental in care delivery transformation, including the implementation of same-day appointment infrastructure and specialty care referral processes by medical groups. PAS was also the first quality measurement program to prompt Kaiser to report performance for its 12 operating regions, driving greater transparency in Kaiser's performance, which now reports for 15 regions on clinical performance.

The Evolution of Patient Experience Measurement at PBGH



Importance of Patient Experience Measurement

Research indicates that a better patient care experience is associated with patient engagement in self-care, greater adherence to recommended prevention and treatment processes, better clinical outcomes, improved patient safety within hospitals and reduced health care utilization.[1,2,3,4,5]

Studies have shown inequities in patient experience related to race and ethnicity. While most research in this area focuses on the Medicaid[6] space, analyses from PAS demonstrates these same inequities for Black, Hispanic and Asian patients, with inequities being even more pronounced for patients whose primary language is not English. Because positive patient experiences are linked to important clinical processes and better outcomes, improving how patients experience health care is an essential for addressing disparities across all health outcomes. If disparities in patient experience are not addressed, disparities in health outcomes will continue to perpetuate.

Stratification of PAS measures has revealed inequities in care experience based on race, ethnicity and primary language. Disparities in health outcomes will continue to perpetuate if disparities in patient experience are not addressed.

In addition, Massachusetts Health Quality Partners (MHQP) has produced results that show racial and ethnic disparities in patient experiences of care. This gap in patient experience mirrors the gap in patient outcomes, further emphasizing the importance of measuring and improving patient experience for Black, Hispanic and Asian patients to reduce disparities in outcomes.

PBGH has leveraged PAS to better understand the state of screening for mental health and access to mental health services in California. Data showed that Blacks and Native Americans reported 7-9% less ability to access care and patients across all racial and ethnic groups who are not English speakers were 9-10% less likely to be screened and obtain needed care. Non-English-speaking Asian patients were 19% less likely to report being asked about mental health symptoms and 10% less likely to get needed care. These differences are all highly significant, indicating a consistent pattern of less favorable ratings from racial and ethnic groups, particularly when English is not the primary language.

Relevance to National and California Stakeholders and Industry Initiatives

- Centers for Medicare & Medicaid Services (CMS) National Quality Strategy: The universal foundation for aligning measures across CMS includes CAHPS as the measure for Person-Centered Care, one of six domains within a total of 10 measures. Patient experience is also included in the CMS Meaningful Measures 2.0 and CMS Medicare Advantage Stars program.
- NCQA HEDIS/Accreditation: Patient experience measures are required for NCQA HEDIS and accreditation.
- PBGH's California Quality Collaborative and IHA Advanced Primary Care Measure Set: Patient experience is a core component of the Advanced Primary Care Measure Set developed through a multi-stakeholder process and supported by purchasers, focusing on patient experience of care and health outcomes.
- Health Plan CAHPS Measures: Measures within the area of "Getting Needed Care" are included in the DMHC Health Equity Set. Equivalent measures are collected at the medical group-level through PAS.
- Covered California Quality Transformation Initiative: Patient experience is part of this initiative, although it has less financial exposure for Qualified Health Plans (QHPs) due to the unavailability of data for all plans from CMS

Other Innovative Research to Date

PBGH has leveraged the largest patient-level measurement of its type nationally to also identify and evaluate:

- Disparities in patient access to telehealth services
- Access to behavioral health providers and telehealth for behavioral health services

During the onset of the COVID-19 pandemic, PBGH developed a telehealth patient experience survey. The aims of this work were to understand the impact of telehealth on access and outcomes, identify opportunities for improving the quality of telehealth services and inform both provider and health plan telehealth programming. The PAS program surveyed patients from diverse backgrounds, including those with both commercial insurance and Medi-Cal/Medicaid coverage. Recognizing that telehealth can be essential to increased access to care, PBGH wanted to understand if access and comfort with technology, broadband or privacy might be concerns for a lower-income population.

Results from the survey showed that overall ratings and ratings about communication with the provider for telehealth were high but significantly lower for patients with Medi-Cal coverage. Patients using telephone rather than video rated all aspects of the visit less highly, which is reinforced by other studies showing that phone users face greater barriers to effective telehealth care. Notably, a much higher proportion of patients with Medi-Cal coverage used the phone (67%) compared to the commercial cohort (22%) and Medi-Cal enrollees were more likely to report inadequate pre-visit preparation by their provider. The greatest clinical concern suggested by these data was the lower rate of completing recommended follow-up care for those enrolled in Medi-Cal, indicating a link to less effective communication between the provider and the patient. Phone users in general were also less likely to get follow-up care.

In 2015, PBGH and MHQP partnered to field both the annual statewide surveys (comprised of ~46 questions) and a short-form survey (24 questions) in parallel to test methodology that could reduce survey administration costs and burden for respondents without sacrificing the scientific rigor of reported results. Overall, the short-form survey appeared to be a viable alternative to a longer form, such as the PAS or other CG-CAHPS surveys. Provider organizations were almost universally ranked similarly at the question item level. Testing of the composites found that the provider communication, patient engagement and ratings of care composites performed well, but the care coordination and access composites only performed well if all of the question items were included, which increased the survey length by three questions. Further testing would be needed to confirm if the composites can comparably score and rank providers.

Sunsetting the PAS Program and PBGH's Commitment to Next-Generation Measurement

The PAS program concluded on July 31, 2024. This decision followed IHA's removal of patient experience measurement from the AMP incentive payment program in response to industry pushback. Without payments to providers to collect and report the results, there was no business case for provider organizations to participate in the program, making the program unsustainable.

There are real costs to this decision. California stakeholders will lose access to:

- Statewide patient experience results and benchmarks
- Public transparency of patient experience results via OPA Report Cards
- Granularity of performance of provider organizations to understand the underlying performance and target improvement
- Stratification of patient experience measures for health equity insights

Despite the trillions of dollars spent on health care in the United States, the costs associated with collecting and sharing patient experience information were deemed prohibitive. The annual cost of collecting and reporting this data across California was under $2 million.

While provider organizations may use alternative survey mechanisms for quality improvement, they do not offer the standardization required for accountability. California stakeholders should be concerned about whether provider organizations will continue to prioritize patient experience in their improvement activities if results are not shared transparently. The lack of mandated accountability raises concerns about the continued prioritization of patient experience measures — the only metrics that capture the patient voice — signals that the industry may only hold itself accountable to transaction-based measures. Purchasers prioritize a health care delivery system that is patient-centric, one that measures and enhances health outcomes for their workers.

The measurement of U.S. health care lags behind patient needs and technological advancements and fails to reflect the priorities of those paying for and receiving care. Despite extensive thought leadership and numerous discussion forums, the implementation of necessary changes has yet to occur.

Former President & CEO of PBGH, David Lansky, Ph.D., stated in Health Affairs that a comprehensive overhaul of our measurement systems is overdue. PBGH joins him in calling for national leadership to adopt a completely new and meaningful approach to measuring health care quality, costs, experiences and outcomes. Given the substantial expenditures, we should expect a high-performing, effective system that prioritizes and meets patient needs — and can demonstrate that.

Given the enormous amount spent on US health care and the advances in technology, new and effective mechanisms for meaningful quality measurement and transparency are possible. PBGH looks forward to partnering with innovators committed to better measurement of health and health care and sharing results with all stakeholders to drive improvement.

"The current retrospective, transactional system for measuring and rewarding improvement is ineffective, expensive, burdensome, no longer credible, and does not measure health or the outcomes of health care. To achieve value-based care, and to ensure that care is more patient-focused, we need profound changes in how we capture and apply information about quality of care and health outcomes."

— David Lansky, Ph.D., Former President & CEO, PBGH

Acknowledgments

PBGH would like to acknowledge Rachel Brodie who led the PAS program since 2015. Rachel has provided the strategic leadership to manage and lead the program and methodological work for PAS as well as several other multi-stakeholder measurement and reporting initiatives that advance the quality of health care. PBGH also acknowledges several other former employees for their strategic leadership of pioneering performance measurement initiatives, including Cheryl Damberg, Ph.D. who developed and led the early research with PVC and CAS, Ted von Glahn who launched PAS, as well as the development of the OPA Report Cards, and David Hopkins, Ph.D. who launched and led CCHRI.

PBGH would also like to thank the Center for the Study of Services who served as survey administration vendor since 2001 and has been an incredibly collaborative partner. Jeff Burkeen, in particular, has provided invaluable expertise to the PAS program. PBGH would also like to acknowledge the statistical expertise led by the late Bill Rogers, Ph.D. whose guidance and dedication to the field continues to inspire us. Thank you also to Hong Chang, Ph.D. for designing and performing the program's more recent statistical analyses.

In addition, PBGH would like to acknowledge OPA, which shares PBGH's mission to improve health care quality through transparency and public reporting, featuring the PAS star ratings on their health care report cards since 2005. Thank you to IHA for prioritizing patient experience measures in the AMP program (formerly Pay-for-Performance) for decades in their shared commitment to measuring and holding provider organizations accountable for value-based health care.

PBGH thanks California Healthcare Foundation, Blue Shield of California and Health Net for sponsoring the telehealth survey research and issue brief and Arnold Ventures for sponsoring the short survey pilot joint project with MHQP. Thank you to the numerous health plans and provider organizations in California that have underwritten the PAS survey administration, many of which have also participated on the PAS Steering Committee over the years.

Thank you to the PAS Steering Committee, and particularly Chong Kim, Blake Hodges and Michelle Best, for their recent leadership as chairs. The committee met monthly to review updates to the survey instrument, revisions to the scoring and rating methodology and make decisions about research topics and supplemental questions. The most recent committee roster is below:

Michelle Best (Co-Chair), St. Joseph Heritage Healthcare
Blake Hodges (Co-Chair), Kaiser Foundation Health Plan
Frances Arce, Health Net of California
Deborah Austin, John Muir Health
Swati Awsare, Anthem Blue Cross/Elevance
Judy Baillie, Western Health Advantage
Raheleh Barznia, Blue Shield of California
Sondra Davis, Brown & Toland Physicians
Linda Deaktor, MedPoint Management
Maria Hancock, United Healthcare
Kelly Karaoglu, Aetna Healthcare of California
Priscilla Kwan, Chinese Community Health Care Association
Wendy Manna, Hill Physicians Medical Group
Rochelle McCauley, Southern California Kaiser Permanente Medical Group
Dr. Samuel Skootsky, UCLA Medical Group
Mary Swimley, Sutter Health
Fahreen Wahid, L.A. Care Health Plan

About Purchaser Business Group on Health (PBGH)

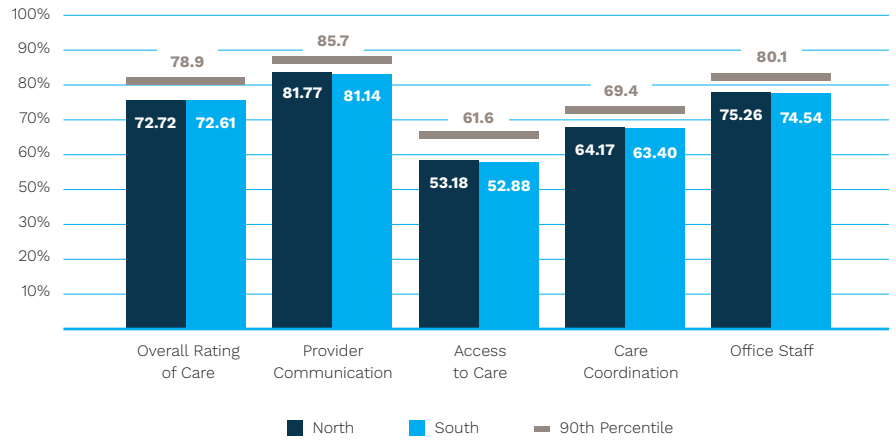
Purchaser Business Group on Health (PBGH) is a nonprofit coalition representing nearly 40 private employers and public entities across the U.S. that collectively spend $350 billion annually purchasing health care services for more than 21 million Americans and their families. PBGH has a 30-year track record of incubating new, disruptive operational programs in partnership with large employers and other health care purchasers. Our initiatives are designed to test innovative methods and scale successful approaches that lower health care costs and increase quality across the U.S.

Appendix | Most Recent PAS Results and Trends

PBGH reports patient experience scores to provider organizations and health plans that are benchmarked with statewide percentiles, rankings, averages and 90th percentiles. Aggregated results are also available for Northern and Southern California regions. To support and prioritize quality improvement activities, key driver analyses identify and prioritize measures (with drill down to individual questions) of provider performance that have the largest impact on the overall ratings.

Statewide Reporting Year (RY) 2024 PAS results for the composite scores

	Overall			
	North	South	Statewide Average	90th Percentile
Overall Rating of Care	72.72%	72.61%	72.64%	78.9%
Provider Communication	81.77%	81.14%	81.33%	85.7%
Access to Care	53.18%	52.88%	52.96%	61.6%
Care Coordination	64.17%	63.40%	63.62%	69.4%
Office Staff	75.26%	74.54%	74.75%	80.1%



More detailed results, including the statewide and regional scores for the question items that comprise each composite:

Composite or Question	Statewide Scores		Regional Scores	
	Average	90th Percentile	Northern CA Average	Souther CA Average
Ratings Composite				
Composite Score	**72.6%**	**78.9%**	**72.7%**	**72.6%**
Overall rating of provider (PCP & specialist)	74.8%	80.7%	75.5%	74.6%
Overall rating of provider (PCP)	74.6%	83.0%	73.3%	75.1%
Overall rating of provider (specialist)	75.1%	82.0%	77.7%	74.0%
Overall rating of health care	70.5%	77.7%	69.9%	70.7%
Provider Communication				
Composite Score	**81.3%**	**85.7%**	**81.8%**	**81.1%**
Provider explanations easy to understand	81.2%	85.2%	81.7%	81.0%
Provider listens carefully	81.9%	86.4%	82.3%	81.7%
Provider shows respect	85.8%	90.0%	86.3%	85.6%
Provider spends enough time	76.5%	81.8%	76.8%	76.3%
Access to Care				
Composite Score	**53.0%**	**61.6%**	**53.2%**	**52.9%**
Timely appt. for care needed right away	51.8%	61.3%	52.3%	51.6%
Timely appt. for check-up or routine care	55.6%	65.3%	56.3%	55.3%
Same day response to office hours contact	51.5%	60.8%	50.9%	51.7%
Care Coordination				
Composite Score	**63.6%**	**69.4%**	**64.2%**	**63.4%**
Provider knows important medical history	73.7%	79.2%	74.2%	73.6%
Office followed up on test results	65.6%	73.4%	67.2%	64.9%
Discussed all Rx medicines	58.0%	65.9%	56.3%	58.7%
Provider informed about other care	57.2%	65.2%	59.0%	56.4%
Office Staff				
Composite Score	**74.8%**	**80.1%**	**75.3%**	**74.5%**
Clerks and receptionists helpful	68.6%	74.8%	69.4%	68.2%
Clerks and receptionists respectful	80.9%	86.3%	81.1%	80.9%

For provider organizations, PAS also provided reports that show the scores, reliability, comparison to regional and statewide benchmarks and trending.

Composite Scores

	Ratings Composite	Provider Communication	Access to Care	Care Coordination	Office Staff
Provider Organization	73.9%	81.3%	63.4%	56.4%	74.6%
90th Percentile	79.0%	85.8%	61.7%	69.5%	80.2%
Statewide Average	72.6%	81.3%	53.0%	63.6%	74.8%

Key driver analyses identify and prioritize measures (with drill down to individual questions) of provider performance that have the largest impact on the overall ratings for quality improvement purposes.

Key Driver Analysis

Question	Your Adjusted Score	Room for Improvement	90th Percentile Score	Improvement Opportulity in Ratings Composite if Question Performs at 90th Percentile
Provider spends enough time	70.0%	12.4%	82.4%	5.1%
Provider listens carefully	78.6%	7.9%	86.4%	2.3%
Provider knows important medical history	71.9%	7.8%	79.7%	1.0%
Provider discussed all Rx meds	52.2%	12.5%	64.7%	0.7%
Provider informed about other care	55.5%	9.7%	65.3%	0.7%

NA: Group is already at or above the 90 percentile score for this question.

Endnotes

1 Anhang Price R, Elliott MN, Zaslavsky AM, Hays RD, Lehrman WG, Rybowski L, Edgman-Levitan S, Cleary PD. Examining the role of patient experience surveys in measuring health care quality. Med Care Res Rev. 2014 Oct;71(5):522-54. doi: 10.1177/1077558714541480. Epub 2014 Jul 15. PMID: 25027409; PMCID: PMC4349195.

2 Doyle C, Lennox L, Bell D. A systematic review of evidence on the links between patient experience and clinical safety and effectiveness. BMJ Open 2013;3:e001570. doi:10.1136/bmjopen-2012-001570

3 Sequist TD, Schneider EC, Anastario M, Odigie EG, Marshall R, Rogers WH, Safran DG. Quality monitoring of physicians: linking patients' experiences of care to clinical quality and outcomes. J Gen Intern Med. 2008 Nov;23(11):1784-90. doi: 10.1007/s11606-008-0760-4. Epub 2008 Aug 28. PMID: 18752026; PMCID: PMC2585686.

4 Anhang Price R, Elliott MN, Zaslavsky AM, Hays RD, Lehrman WG, Rybowski L, Edgman-Levitan S, Cleary PD. Examining the role of patient experience surveys in measuring health care quality. Med Care Res Rev. 2014 Oct;71(5):522-54. doi: 10.1177/1077558714541480. Epub 2014 Jul 15. PMID: 25027409; PMCID: PMC4349195.

5 Zolnierek KB, Dimatteo MR. Physician communication and patient adherence to treatment: a meta-analysis. Med Care. 2009 Aug;47(8):826-34. doi: 10.1097/MLR.0b013e31819a5acc. PMID: 19584762; PMCID: PMC2728700.

6 Kevin H. Nguyen, Ira B. Wilson, Anya R. Wallack, and Amal N. Trivedi. Racial And Ethnic Disparities In Patient Experience Of Care Among Nonelderly Medicaid Managed Care Enrollees. Health Aff. doi: 10.1377/hlthaff.2021.01331 HEALTH AFFAIRS 41, NO. 2 (2022): 256–264.