

**SUPPORTING STATEMENT FOR REQUEST FOR MODIFICATION OF -- 2900-0712  
NATION-WIDE CUSTOMER SATISFACTION SURVEYS**

**VA Form 10-1465-2, Inpatient short form; VA Form 10-1465-3, Ambulatory Care, long form;  
VA Form 10-1465-4, Ambulatory Care short form;**

**VA Form 10-1465-5, Clinician and Group Survey Patient Centered Medical Home, short form;  
10-1465-6, Clinician and Group Survey Patient Centered Medical Home, long form**

**A. JUSTIFICATION**

**1. Explain the circumstances that make the collection of information necessary. Identify legal or administrative requirements that necessitate the collection of information.**

The Survey of Health Experience of Patients (SHEP) has been developed to measure patient satisfaction in the Veterans Health Administration, and has been in use in its present form since 2008. The mission of the Veterans Health Administration (VHA) is to provide high quality medical care to eligible veterans. Executive Order 12862, dated September 11, 1993, calls for the establishment and implementation of customer service standards, and for agencies to “survey customers to determine the kind and quality of services they want and their level of satisfaction with current services”.

Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) is approved by the Office of Management and Budget (OMB) for use by the Center for Medicare and Medicaid Services (CMS), a U.S. government agency, for use in measuring patient satisfaction among patients of hospitals that accept Medicare reimbursement. The OMB Control number for this use is 0938-0981. The HCAHPS and a combination of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan and CAHPS Clinician and Group surveys were approved for use in SHEP.

Neither the CAHPS Health Plan survey, nor the CAHPS Clinician and Group survey is approved by OMB for use by government agencies. However, both of these ambulatory care surveys have undergone extensive testing and validation in a variety of populations. Their psychometric properties are well documented.

The short form, (10-1465-2) or core inpatient SHEP will be comprised of 53 questions. This form will be sent to 100% of each monthly sample. The short form inpatient SHEP will be comprised of three groups of questions with a total burden of 15 minutes:

1. Satisfaction - HCAHPS
2. Patient perceptions of safety and satisfaction with Environment of Care in hospital settings
3. Patient Complaints

The short form (10-1465-4), or core outpatient SHEP will be comprised of 45 questions with a burden of 20 minutes. This core version will be sent to 90% of each monthly sample, and will be comprised of:

1. Satisfaction – Questions from CAHPS Health Plan 4.0 and Clinician and Group Surveys
2. Patient perceptions of safety and satisfaction with Environment of Care in clinic settings
3. Patient Complaints

A long form of the outpatient SHEP (10-1465-3) will be mailed to 10% of the sample, and will consist of 70 questions with a burden of 25 minutes. The long form will contain:

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1. Satisfaction - Health Plan 4.0 and Clinician and Group Surveys
2. Patient perceptions of safety and satisfaction with Environment of Care in clinic settings
3. Patient Complaints
4. Functional outcomes (SF-12 (Veteran modification))
5. Healthy behaviors (Healthcare Effectiveness Data and Information Set (HEDIS) Smoking measures and Audit C)
6. Satisfaction with influenza vaccination (October through March)

A short form of the outpatient SHEP (10-1465-5) will be mailed to 40 % of the sample, and will consist of 54 questions with a burden of 20 minutes. The short form will contain:

1. Satisfaction - Clinician & Group Survey Patient Centered Medical Home survey
  - a. How well providers communicate with patients (6 items)
  - b. Helpful, courteous, and respectful office staff (2 items)
  - c. Patients' rating of the provider (1 item)
  - d. Providers pay attention to your mental or emotional health (3 items)
  - e. Providers support you in taking care of your own health (2 items)
  - f. Providers discuss medication decisions (3 items)

A long form of the outpatient SHEP (10-1465-6) will be mailed to 5 % of the sample, and will consist of 85 questions with a burden of 25 minutes. The long/short form will contain:

1. Satisfaction - Clinician & Group Survey Patient Centered Medical Home survey
  - a. How well providers communicate with patients (6 items)
  - b. Helpful, courteous, and respectful office staff (2 items)
  - c. Patients' rating of the provider (1 item)
  - d. Providers pay attention to your mental or emotional health (3 items)
  - e. Providers support you in taking care of your own health (2 items)
  - f. Providers discuss medication decisions (3 items)
2. Functional outcomes (SF-12 (Veteran modification))
3. Healthy behaviors (Healthcare Effectiveness Data and Information Set (HEDIS) Smoking measures and Audit C)
4. Satisfaction with influenza vaccination (October through March)

Each of these key elements of care will be collected concurrently on a monthly basis in separate surveys of two key patient populations, i.e., inpatients (recently discharged) and outpatients who have had a recent clinic visit (ambulatory care). Each sample size will be sufficient to allow for valid statistical results at the national, network and facility levels. Sample sizes for the non-satisfaction questions on the long form have been calculated to provide valid estimates at the network or national level only. Data for each survey will be analyzed and posted on the Office of Quality and Performance (OQP) Web Site for field use (quarterly for outpatients and semi-annually for inpatients), or posted as special reports. The intent is to develop relational data that will allow us to conduct powerful, selected, cohort analyses. De-identified, unadjusted survey results will be posted in the contractor's web page for rapid access by local VA facilities.

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### **2. Indicate how, by whom, and for what purposes the information is to be used; indicate actual use the agency has made of the information received from current collection.**

The overall purpose of the VHA Office of Quality and Performance SHEP Survey Program is to systematically obtain information from patients that can be used to identify problems or complaints that need attention and to improve the quality of health care services delivered to Veterans. Information obtained from the SHEP Program is one component of a larger Network Directors Performance Agreement system in VHA that culminates in the annual Network Performance Report. Results of each of the customer satisfaction surveys are made readily available to VA Central Office (VACO), Veterans Integrated Service Network (VISN), VHA field staff, and stakeholders as part of the Network Performance Report and via the VA Intranet. Data is used to demonstrate that VA is providing timely, high quality health care services to patients and to measure improvement toward the goal of matching or exceeding the non-VA external benchmark performance. Each VISN has designated a Quality Management Officer (QMO) that is responsible for acting as a resource for field staff for explanation of the data and for determining where opportunities for improvement of services exist.

- a. Customer Feedback information is provided to VA medical center staff, VACO management, and others interested in the quality of medical services provided to VA patients. The survey results for each center are used as a local management tool for assessing and improving the quality of services being provided to their patients.
- b. VACO management receives system-wide and VISN specific aggregated data, permitting longitudinal trend analysis of changes over time. Information obtained through this survey is useful at all levels to plan and redirect resources and efforts to improve or maintain a high quality of care to VA beneficiaries. If this information is not collected, vital feedback regarding patients' treatment by providers, related services, and patient-staff communication will not be available.

These voluntary customer service surveys fulfill the requirements of Executive Order 12862. A key requirement of Executive Order 12862 is for agencies to compare results of satisfaction surveys to comparable external referents. It is also a major goal of the current administration to pursue the goal of transparency regarding the efficacy of agencies.

In order for VHA to be able to achieve the goal of public reporting of inpatient veteran satisfaction data the survey sample creation, mailing protocols and data collection and analysis methods must mirror those outlined in CMS's "CAHPS Hospital Survey (HCAHPS) Quality Assurance Guidelines". In order to do this VHA must change the method of identifying eligible survey selectees and the mailing components of the survey for the Inpatient population. The CAHPS guidelines require identifying patients by Diagnostic Related Groups, or DRG codes, whereas VHA historically grouped patients by treating specialty, or bedsection. Further, CMS requires that the survey components consist of a first mailing of a survey questionnaire and cover letter, followed in approximately 21 days later with a repeat questionnaire to non-respondents. Historically VHA used a pre-notification letter, survey with cover letter, and follow-up postcard spaced by approximately seven days. .

The Survey of Health Experience of Patients (SHEP) has been developed to measure patient satisfaction in the Veterans Health Administration, and has been in use in its present form since 2008. The mission of the Veterans Health Administration (VHA) is to provide high quality medical care to eligible veterans. Executive Order 12862, dated September 11, 1993, calls for the establishment and implementation of customer service standards, and for agencies to "survey customers to determine the kind and quality of

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services they want and their level of satisfaction with current services". Further emphasized by the President's Executive Order 13571, on "Streamlining Service Delivery and Improving Customer Service," issued on April 27, 2011, VHA must work continuously to ensure that their programs are effective and meet their customers' needs. To this end, VHA is always seeking new and innovative ways to treat and otherwise care for our patients and those that support them.

As such, VHA is undertaking a new initiative to implement a patient-centered medical home (PCMH) model at all VHA Primary Care sites which is referred to as Patient Aligned Care Teams (PACT). This initiative supports VHA's Universal Health Care Services Plan to redesign VHA healthcare delivery through increasing access, coordination, communication, and continuity of care. PACT provides accessible, coordinated, comprehensive, patient-centered care, and is managed by primary care providers with the active involvement of other clinical and non-clinical staff. PACT allows patients to have a more active role in their health care and is associated with increased quality improvement, patient satisfaction, and a decrease in hospital costs due to fewer hospital visits and readmissions. Currently VHA has no mechanism in place to measure the effectiveness of the PACT model from the patients' perspective.

To address a growing interest in assessing patient experience with the patient-centered medical home model, the CAHPS (Consumer Assessment of Healthcare Providers and Systems) Consortium has developed an expanded version of the Clinician & Group 12-Month Survey that incorporates the CAHPS Patient-Centered Medical Home Item Set. Although this survey could be used by any physician practice, it is expected to be especially useful for VHA facilities that have adopted features of PACT. The Agency for Healthcare Research and Quality released this expanded survey in October 2011. VHA wishes to adopt this member of the CAHPS family of survey instruments.

The Clinician & Group Survey Patient Centered Medical Home (C&G PCMH) survey includes standardized questions that assess key aspects of care like

- Getting timely appointments, care, and information (5 items)
- How well providers communicate with patients (6 items)
- Helpful, courteous, and respectful office staff (2 items)
- Patients' rating of the provider (1 item)
- Providers pay attention to your mental or emotional health (3 items)
- Providers support you in taking care of your own health (2 items)
- Providers discuss medication decisions (3 items)

In addition, adopting the C&G PCMH survey and the CAHPS Consortium survey methods will afford VHA the opportunity to participate in the CAHPS Benchmarking Database. The primary purpose of the CAHPS Database is to facilitate comparisons of CAHPS survey results by and among survey users. Currently, VHA does not have the ability to compare patient experiences with ambulatory care with the private sector or other non-VHA facilities.

Starting in late 2009, the CAHPS Team began developing the PCMH Item Set to improve the usefulness of the CAHPS Clinician & Group 12-Month Survey as a tool for assessing patients' experiences with the domains of primary care that define a medical home. The process of developing and testing the expanded 12-Month Survey with the PCMH items included multiple steps:

- Literature review.
- Input from a Technical Expert Panel and other stakeholders, in collaboration with the National Committee for Quality Assurance (NCQA).
- Focus groups.
- Cognitive testing in English and Spanish.

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- Development of a survey for field testing.
- Field testing by NCQA of the draft version of the expanded 12-Month Survey with PCMH items.
- Analysis of the field test results and refinement of the survey.

Given that the current outpatient SHEP instruments proved to be at least as reliable and valid for the VHA population as it was for the general public, we should expect no different from this new survey.

CAHPS sampling protocols also necessitate a change in how VHA defines eligibility for selection for the Inpatient survey. Historically no patient was eligible for reselection for a survey more than once in a 12-month period however, that is inconsistent with methods followed by CMS. CMS sampling protocols allow for reselection across months. By excluding patients already sampled in a 12-month period VHA may potentially introduce bias in the sample by excluding sicker patients. Different methodologies would could undermine the comparability of VHA and private sector data and impede public reporting of that data in 2011. An impact assessment was conducted using FY09 Inpatient data and it appears that allowing veterans that had multiple qualifying discharges in different months would result in a negligible increase in burden hours. There were a total of 385,000 unique patients in FY09; 19% had 2 or more discharges, (73,150); the sampling rate was 23% (16,824.5), and a 45% response rate (7,571); leaving approximately 7,600 patients of 650,000 discharges potentially eligible for re-responding (roughly 1%). The overall annual cap for inpatient surveys has remained at 150,000 per year.

VA Form 10-1465-3, Ambulatory Care, long form; VA Form 10-1465-4, Ambulatory Care short form have also been revised based on analysis of the first years data. The core portion of the survey has been reordered to be more consistent with the CAHPS Clinician and Group survey, and all non-CAHPS questions have been removed. The aim of reordering the survey questions is to improve the logical flow of the questions from a focus of 12-months of experience with VA care and service to focusing on the day of the visit of record that triggered eligibility for sample selection. The mailing components will remain unchanged, namely a pre-notification letter, survey with cover letter, and follow-up postcard spaced by approximately seven days.

**3. Describe whether, and to what extent, the collection of information involves the use of automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, e.g. permitting electronic submission of responses, and the basis for the decision for adopting this means of collection. Also describe any consideration of using information technology to reduce burden.**

Since moving to the CAHPS surveys, VA is bound by their protocols. The only official mode of administration that is allowed for submission to the Hospital Compare website is paper and pencil surveys by mail, with an optional follow-up by telephone (OQP doesn't use the telephone follow-up option). CAHPS does not allow web-based surveys at this time, so there are no immediate plans for a web option.

**4. Describe effort to identify duplication. Show specifically why any similar information already available cannot be used or modified for use for the purposes described in Item 2 above.**

There is no information currently being systematically collected that can be used for this purpose. Although there are many small local patient satisfaction surveys largely focused on a specific part of the Medical Center, these do not permit system-wide and VISN specific aggregated data, or longitudinal trend analysis of changes over time. Furthermore, local surveys would not be a reliable basis from which to develop national policies, establish performance targets, or make reliable, valid non-VA comparisons, as required by the Executive Order.

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**5. If the collection of information impacts small businesses or other small entities, describe any methods used to minimize burden.**

No small businesses or other small entities are impacted by this information collection.

**6. Describe the consequences to Federal program or policy activities if the collection is not conducted or is conducted less frequently as well as any technical or legal obstacles to reducing burden.**

If VHA is unable to obtain a renewed clearance of the CAHPS-based instruments the collection of customer satisfaction information will cease. VHA would be unable to measure satisfaction with VHA healthcare, and would therefore become noncompliant with Executive order 12862.

Less frequent collection would reduce the VHA's ability to both effectively track progress toward national and local performance goals, and identify potential negative trends in a timely fashion, at all levels of the system.

**7. Explain any special circumstances that would cause an information collection to be conducted more often than quarterly or require respondents to prepare written responses to a collection of information in fewer than 30 days after receipt of it; submit more than an original and two copies of any document; retain records, other than health, medical, government contract, grant-in-aid, or tax records for more than three years; in connection with a statistical survey that is not designed to produce valid and reliable results that can be generalized to the universe of study and require the use of a statistical data classification that has not been reviewed and approved by OMB.**

VHA facilities need up-to-date results to manage the customer service programs for facilities, therefore SHEP is collected monthly on a rolling basis. There are no such special circumstances requiring responses in fewer than 30 days. OQP ensures that no individual is eligible for random selection in any survey project more often than once in any calendar month. This is consistent with CAHPS protocol. Eligibility for selection is determined by several factors, so eligibility does not guarantee selection into any given sample, and participation in the survey is completely voluntary.

**8. a. If applicable, provide a copy and identify the date and page number of publication in the Federal Register of the sponsor's notice, required by 5 CFR 1320.8(d), soliciting comments on the information collection prior to submission to OMB. Summarize public comments received in response to that notice and describe actions taken by the sponsor in responses to these comments. Specifically address comments received on cost and hour burden.**

The notice of Proposed Information Collection Activity was published in the Federal Register on January 17, 2012, page 2349. We received no comments in response to this notice.

**b. Describe efforts to consult with persons outside the agency to obtain their views on the availability of data, frequency of collection, clarity of instructions and record keeping, disclosure or reporting format, and on the data elements to be recorded, disclosed or reported. Explain any circumstances that preclude consultation every three years with representatives of those from whom information is to be obtained.**

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Considerable input on the use of HCAHPS has been obtained from the Agency for Healthcare Research and Quality (AHRQ) and from other federal healthcare agencies now using HCAHPS and CAHPS, such as CMS and DOD. In addition, input has been obtained from Synovate Corporation.

**9. Explain any decision to provide any payment or gift to respondents, other than remuneration of contractors or grantees.**

No payment or gift is provided to respondents.

**10. Describe any assurance of privacy, to the extent permitted by law, provided to respondents and the basis for the assurance in statute, regulation, or agency policy.**

Each patient who participates is assured privacy to the extent to the law. It is recognized that the survey must be completely voluntary in order to provide reliable results. Survey instructions to patients specify and underscore that responding to the survey is completely voluntary, private to the extent to the law, and will have no effect on entitlement to or eligibility for VA healthcare benefits, and that the form does not need to be signed. The patient completes the questionnaire anonymously (giving neither name nor social security number) and returns it to the contractor collecting data for OQP. All returned survey documents are destroyed once the dataset created from those documents has been validated. In the many years that the VA has been conducting similar types of surveys, there has never been a single complaint by a veteran concerning a violation of this pledge. Since the responses are not individually identifiable, there is no need to store or process these forms in accordance with the Privacy Act. Nonetheless, the VA adheres to U.S.C. 38, Section 5705, Confidentiality of Medical Quality-Assurance Records.

**11. Provide additional justification for any questions of a sensitive nature, such as sexual behavior and attitudes, religious beliefs, and other matters that are commonly considered private; include specific uses to be made of the information, the explanation to be given to persons from whom the information is requested, and any steps to be taken to obtain their consent.**

There are no questions asked of a sensitive nature concerning topics such as sexual behavior, religious beliefs, or similar type subjects.

**12. Estimate of the hour burden of the collection of information:**

a. Annual respondent burden is computed on this basis as follows:

FORM NUMBER	RESPONDENTS	FREQUENCY OF RESPONSES	% ELEC	BURDEN	HOURS
10-1465-2	75,000	1	0	15	18,750
10-1465-3	23,524	1	0	25	9,802
10-1465-4	126,700	1	0	20	42,233
10-1465-5	80,000	1	0	15	20,000
10-1465-6	8,000	1	0	25	3,333
	<b>313,224</b>	<b>313,224</b>			<b>94,118</b>

Assumes Survey will begin with January encounters

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**b. Provide estimates of annual cost to respondents for the hour burdens for collections of information. The cost of contracting out or paying outside parties for information collection activities should not be included here. Instead, this cost should be included in Item 14.**

The cost to the respondents for completing these forms is \$1,411,770 (94,118 hours X \$15 per hour). We do not require any additional record keeping.

**13. Provide an estimate of the total annual cost burden to respondents or record keepers resulting from the collection of information. (Do not include the cost of any hour burden shown in Items 12 and 14).**

- a. There IS no capital, start-up, operation or maintenance costs.
- b. Cost estimates are not expected to vary widely. The only cost is that for the time of the respondent.
- c. There are no anticipated capital start-up cost components or requests to provide information.

**14. Provide estimates of annual cost to the Federal Government. Also, provide a description of the method used to estimate cost, which should include quantification of hours, operation expenses (such as equipment, overhead, printing, and support staff), and any other expense that would not have been incurred without this collection of information. Agencies also may aggregate cost estimates from Items 12, 13, and 14 in a single table.**

The cost to the Government is \$12,065,619.02 to the vendor for printing, mailing, and collecting the data.

**15. Explain the reason for any program changes or adjustments reported in Items 13 or 14 of OMB 83-I**

The program change is due to the inclusion of VA Forms 10-1465-5 and 10-1465-6, respectively the C&G PCMH short and long forms. The increase in burden hours is 23,333. However, VHA reduced the amount of SHEP Outpatient Short form surveys (10-1465-4) mailed, such that there will be a net decrease of 25,340 burden hours.

VHA is undertaking a new initiative to implement a patient-centered medical home model of care at all VHA Primary Care sites, and is referred to as Patient Aligned Care Teams (PACT). This initiative supports VHA's Universal Health Care Services Plan to redesign VHA healthcare delivery through increasing access, coordination, communication, and continuity of care. PACT provides accessible, coordinated, comprehensive, patient-centered care, and is managed by primary care providers with the active involvement of other clinical and non-clinical staff. PACT allows patients to have a more active role in their health care and is associated with increased quality improvement, patient satisfaction, and a decrease in hospital costs due to fewer hospital visits and readmissions. Currently VHA has no mechanism in place to measure the effectiveness of the PACT model from the patients' perspective. The inclusion of these 2 new forms will fill that void.

**16. For collections of information whose results will be published, outline plans for tabulation and publication. Address any complex analytical techniques that will be used. Provide the time**



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**schedule for the entire project, including beginning and ending dates of the collection of information, completion of report, publication dates, and other actions.**

Results of the customer satisfaction surveys are made readily available to VACO, VISN, VHA field staff, and stakeholders via the VA Intranet and in executive summary reports. Upon request, information will be made available to concerned program officials, OMB, Congress, Veterans' Service Organizations (VSO), the news media, and interested citizens through the Freedom of Information Officer.

**17. If seeking approval to omit the expiration date for OMB approval of the information collection, explain the reasons that display would be inappropriate.**

We are not seeking to omit the expiration date from survey forms. Expiration dates will be placed on the forms upon receipt of OMB approval, and its associated expiration date.

**18. Explain each exception to the certification statement identified in Item 19, "Certification for Paperwork Reduction Act Submissions," of OMB 83-I.**

There are no exceptions.