Use of the Beneficiary Satisfaction Survey Results for Quality Improvement

Quality Improvement Organizations (QIOs) in each state are tasked with receiving and processing quality of care complaints from Medicare Beneficiaries and their representatives. The Centers for Medicare and Medicaid Services (CMS) has collected data about Beneficiary satisfaction with the process of filing a quality of care complaint. These data have been used by CMS and the QIOs to institute improvements in the systems and handling of complaints, making the process more Beneficiary and Family centered. Below we outline some of the ways that the Beneficiary Satisfaction Survey data have been used to improve the quality of care provided to Beneficiaries.

CMS use of data for systems and process improvement:
CMS has used the Beneficiary Satisfaction Survey as one of the measures of QIO contract performance. Historically QIOs have been required to achieve 80 percent satisfaction for complaints process ratings. Formal evaluation feedback has been provided to QIOs mid-way through the contract and again at the end of the contract. QIO performance on the established measures is a key factor considered when awarding subsequent contracts.

CMS conducted analysis of the drivers of beneficiary satisfaction including:

- Satisfaction with beneficiary interactions with their case manager.
- Satisfaction with QIO responsiveness.
- Satisfaction with the resolution of the concern.

In response to this analysis, new processes for complaint resolution were introduced permitting Mediation and Facilitated Resolution to be used for some types of complaints. Mediation and Facilitated Resolution provided the Beneficiary with more opportunities to be involved in the process and lead to a more clear understanding of the steps toward resolution. Beneficiaries whose complaints were resolved using Mediation or Facilitated Resolution were subsequently found to report higher levels of satisfaction with the process than Beneficiaries whose complaints were resolved with a traditional medical record review.

More recently, Immediate Advocacy was introduced for those cases where medical record review was not necessary. Immediate Advocacy is an informal process used by the QIO to quickly resolve an oral complaint. In this process, the QIO makes immediate or direct contact with a provider and/or practitioner for the beneficiary. Using data from the forthcoming Beneficiary Satisfaction Surveys, CMS will be able to discern if beneficiary satisfaction levels vary for those receiving Immediate Advocacy as compared to traditional medical record review.

In addition to implementing policy and process changes, CMS has facilitated ongoing QIO quality improvement by providing QIOs with access to survey results on a monthly basis. As annual analyses are conducted, these findings are also provided to the QIOs to support improvement activities. Scores and data results for each of the QIOs were compared to each other to identify variation. With this information, CMS facilitated regular calls as well as in-person sessions at QIO conferences to share findings from the surveys and analysis. High performing QIOs were invited to share their success stories with the QIO community.

QIO use of data for ongoing process and quality improvement:
Because QIOs have had nearly real-time access to the results from the Beneficiary Satisfaction Survey, they have been able to institute on-going quality improvement activities. QIOs reported accessing Beneficiary Satisfaction data regularly and implementing internal changes including the following:

- Monthly meetings to review data findings and share these with the Analysts who interact directly with the Beneficiaries.
- Quarterly meetings to review the survey open-ended comments and identify trends that could be translated into improvement practices.
- Supplemental trainings and preparation of reminder materials for Analyst and other QIO staff who interact with Beneficiaries. Trainings and materials have focused on improving communication by encouraging the use of patient-centered language and collaborative approaches.
- Adapted intake process to provide a thorough explanation of the complaint resolution process, steps, and expected length of time to complete.
- Modified letters to Beneficiaries to improve understanding of the steps involved in the review process and provide further detail on the case findings.
- Increased font size on letters to improve readability for Medicare Beneficiaries.
- Developed supplemental written materials for Beneficiaries to help answer common questions and provide a listing of state-specific resources.
- Increased outreach to Beneficiaries during the review process – typically by telephone to "touch base" and provide status updates to the Beneficiary.
- Provided the Beneficiary with a direct telephone number to reach the Analyst assigned to complete the review.
- Provided more community resource information to Beneficiaries – an expansion of holistic patient-centered care.
- Made an additional call to Beneficiaries after the case is closed to answer any further follow-up questions.