Supporting Statement A for Emergency Room Patient Experiences with Care Survey

Contract Number: HHSM-500-2012-00059G

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Prepared for CMS

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RAND HEALTH

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EMERGENCY DEPARTMENT PATIENT EXPERIENCES WITH CARE SURVEY

Introduction

The Centers for Medicare & Medicaid Services (CMS) requests a one-year clearance from the Office of Management and Budget (OMB) under the Paperwork Reduction Act of 1995 to implement the Emergency Room Patient Experience Survey. This request for approval takes the OMB control number 0938-New.

Under Contract Number HHSM-500-2012-00059G, the project team will develop, field test, and analyze a patient experiences with care survey for patients with a recent emergency room visit. The survey will include both individuals admitted to the hospital following their emergency room visit and those discharged to the community (also known as "treat and release" emergency room visits).

A. Justification

A1. Necessity of Information Collection

The Centers for Medicare & Medicaid Services (CMS) has already implemented patient experience surveys in a number of settings including Medicare, Medicare Advantage, and Part D Prescription Drug Plans, hospitals, and home health agencies. Other Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys exist for hemodialysis facilities, nursing homes, and physician practices. However, the emergency room is a unique environment within the health care system, bridging the world of outpatient and inpatient care.

In particular, the emergency room is a pivotal arena for the provision of acute care services, handling 28 percent of all acute care visits in the U.S., half of all such visits by Medicaid and SCHIP beneficiaries, and nearly two-thirds of such visits among the uninsured. In addition, the emergency room is the portal of entry for nearly half of all hospital admissions for more than half of all hospital admissions involving Medicare beneficiaries. Further, under EMTALA – the Emergency Medical Treatment and Active Labor Act of 1986 – everyone who comes to an emergency room for care is entitled to a screening exam and stabilizing treatment (including hospitalization if needed) without regard for their ability to pay, making the emergency room a resource for those who may have no other place to receive care.

These unique aspects of emergency room care make existing CAHPS instruments only partially relevant for capturing patient experiences. The field test for which this Supporting Statement requests clearance is a required part of the process for certification of a patient experiences with care survey as a CAHPS survey, and ensures that items in the instrument perform well under real-world survey administration conditions and are appropriate for making objective comparisons between emergency rooms across the U.S.

A2. Purpose and Use of Information

This survey supports the six national priorities for improving care from the National Quality Strategy developed by the U.S. Department of Health and Human Services (HHS) that was called for under the Affordable Care Act to create national aims and priorities to guide local, state, and national efforts to improve the quality of health care. This strategy has established six priorities that support a three-part aim focusing on better care, better health, and lower costs through improvement. The six priorities include: making care safer by reducing harm caused by the delivery of care; ensuring that each person and family are engaged as partners in their care; promoting effective communication and coordination of care; promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease; working with communities to promote wide use of best practices to enable healthy living; and making quality care more affordable for individuals, families, employers, and governments by developing and spreading new health care delivery models. This survey will provide patient experiences with care data that enables making comparisons of emergency departments across the nation and promoting effective communication and coordination.

A3. Technological Collection Techniques

The survey vendor will collect the data via mail and telephone for two types of patients that have had a recent emergency room experience: patients discharged to the community and patients admitted to the hospital. Patients will be randomized to one of three data collection strategies – mail only, phone only, or a mixed mode of mail with phone follow-up to non-responders. Those randomized to the mail only condition will receive one copy of the survey via mail with a second survey mailed to non-responders three weeks after mailing one. Those randomized to the mixed mode condition will receive one mailing followed by phone attempts to non-responders. The mailed survey formatted for data scanning and data from all returned surveys will be scanned into an electronic data file. Computer Assisted Telephone Interviewing (CATI) will be used for the telephone administration (telephone only) group as well as the secondary mode of data collection for non- responders to a mailed request to complete the survey in the mixed mode group.

A4. Identifying Duplication

The emergency room patient experiences with care survey consists largely a set of newly developed items specific to the domains of the patient experience in an emergency room. A call for input on topics was published in Federal Register Volume 77, Number 232 (Monday, December 3, 2012). Items addressing communication, pain medication, and courteousness of staff are adapted from Hospital CAHPS and the Clinician and Group CAHPS item sets; they are edited for wording specific to the emergency room. The survey is being designed to gather only the necessary data that CMS needs for assessing emergency room patient experiences with care and should complement, not replace, data that providers are currently collecting that support improvement in patient-centered care.

Though hospitals and vendors might conduct individual site-specific surveys about patient experiences in the emergency department, there is no standardized instrument that currently exists.

A5. Impact on Small Businesses

Survey respondents are patients who have received care from an emergency room. The survey should not impact small businesses or other small entities.

A6. Consequences of Less Frequent Data Collection

This Supporting Statement requests clearance for a one-time data collection.

A7. Special Circumstances

There are no special circumstances associated with this information collection request.

A8. CMS Federal Register Notice

The 60-day Federal Register notice published on February 1, 2013 (78 FR 7434). Three comments were received. Our response has been added to this package.

A9. Respondent Payments or Gifts

This data collection will not include respondent incentive payments or gifts.

A10. Assurance of Confidentiality

Individuals contacted as part of this data collection will be assured of the confidentiality of their replies under 42 U.S.C. 1306, 20 CFR 401 and 422, 5 U.S.C. 552 (Freedom of Information Act), 5 U.S.C. 552a (Privacy Act of 1974), and OMB Circular A-130.

A11. Sensitive Questions

The survey does not include any questions of a sensitive nature.

A12. Burden of Information Collection

Exhibit 1 shows the estimated annualized burden for the respondents' time to participate in this data collection. The emergency room patient experiences with care survey will be administered to 3,600 individuals in 2013. There are three versions of the survey: one for patients discharged to the community (Attachment A), one stand-alone version for patients admitted to the hospital (Attachment B), and a version for patients admitted to the hospital that will be administered as a supplement to the existing Hospital CAHPS survey (Attachment C).

The discharge version of the survey contains 63 items and is estimated to require in an average administration time of 14 minutes in English (at a pace of 4.5 items per minute) and 16.8 minutes in Spanish (assuming 20% more words in the Spanish translation), for an average response time of 14.7 minutes or .245 hours. The stand-alone version of the survey for admitted patients contains 57 items and is estimated to require in an average administration time of 12.7 minutes in English and 15.24 minutes in Spanish, for an average response time of 13.33 minutes or .222 hours. The version of the survey that will be administered as a supplement to the existing Hospital CAHPS items for admitted patients contains 39 items and is estimated to require in an average administration time of 8.7 minutes in English and 10.44 minutes in Spanish, for an average response time of 9.13 minutes or .152 hours. See Attachments A, B, and C for copies of the surveys. These burden and pace estimates are based on CMS' experience with surveys of similar length that were fielded with Medicare beneficiaries. As indicated below, the annual total burden hours are estimated to be 799 hours.

Exhibit 1. Estimated annualized burden hours

Survey Version	Number of Respondents	Number of responses per respondent	Hours per response	Total Burden hours
Emergency room patient experiences with care survey – discharged to community	2160	1	.245	529.2
Emergency room patient experiences with care survey – admitted to hospital (stand-alone)	720	1	.222	159.8
Emergency room patient experiences with care survey – admitted to hospital (Hospital CAHPS supplement)	720	1	.152	109.5
Total	3600	1	.222	799

Exhibit 2 shows the survey participants' cost burden associated with their time to complete a survey. The annual total cost burden is estimated to be $18, 193.

Exhibit 2. Estimated annualized cost burden

Form Name	Number of Respondents	Total Burden hours	Average Hourly Wage Rate*	Total Cost Burden
Emergency room patient experiences with care survey	3,600	799	$22.77	$18, 193
Total	3,600	799	$22.77	$18, 193

*Based upon mean hourly wages, "National Compensation Survey: All United States December 2009 – January 2011," U.S. Department of Labor, Bureau of Labor Statistics.

A13. Capital Costs

Survey participants will incur no capital costs as a result of participation.

A14. Cost to the Federal Government

The total cost to the Federal Government is $1,265,149.

A15. Program Changes or Adjustments to Annual Burden

This is a new information collection request. This request seeks approval of 799 hours of respondent burden to assess patient experiences with the emergency room. These hours are required to (1) assess patient experiences at the respondent level; (2) provide sufficient response to generate emergency room-level estimates of experiences; (3) allow for a test of mode of survey administration (mail only; telephone only; and mixed mail with telephone follow-up to non responders); and (4) allow for an assessment of the impact of a stand-alone emergency room survey vs. emergency room survey questions administered as a supplement to Hospital CAHPS.

A16. Tabulation and Publication of Results

We anticipate that the analysis plan will include analyses needed to refine the survey instrument and those to support improved sampling, implementation, and data collection processes. Such analyses fall into the following fundamental categories: psychometric analysis (including a mode experiment); weighting; case mix adjustment; and analyses of data quality and composite development.

(1) Psychometric Evaluation. Analyses will include evaluation of item missing data, item distribution (including ceiling and floor effects), and assessment of emergency room-level reliability of items. We will compute these statistics overall, and separately by mode of administration (mail; telephone; mixed), and stand-alone vs. supplement administration, and language, computing mean scores for composites and global rating items.

In particular analyses will be conducted to examine mode effects on overall response, item response, and item distribution – mail only, telephone only, and mixed

mail/telephone in order to prepare recommendations for field procedures in the event of future national implementation.

(2) Weighting. Analyses will include the calculation of (a) *Sampling weights* to reflect the probability that each patient is selected for the survey; (b) *nonrespons*e weights to reflect the probability that a sampled patient responds to the survey; and (c) *poststratification* weights to make the characteristics of the respondent sample more similar to the overall population.

(3) Case-mix adjustment and nonresponse. In consultation with CMS, we will consider mixed effect regression models of performance measures for emergency rooms. This approach uses linear models in which the dependent variable is a CAHPS score and the independent variables are case-mix adjusters, with controls for unit (e.g., emergency room) effects. These models would include fixed effects for patient-mix adjustors, such as self-reported overall health, mental health, age, and education.

Publication of Results: CMS may confidentially share emergency room-level estimates with emergency room administrators for quality improvement purposes. However, emergency room-level data from this survey will not be made publicly available to Medicare beneficiaries or the general public.

A17. Display of OMB Expiration Date

The expiration date for OMB approval of this information collection will be displayed on the survey.

A18. Exceptions to the Certification Statement

There are no exceptions to the certification statement identified in item 19 of OMB Form 83-I associated with this data collection effort.