Supporting Statement A for the Emergency Department Patient Experience of Care (EDPEC) Survey Mode Experiments

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Prepared for CMS

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EMERGENCY DEPARTMENT PATIENT EXPERIENCE OF CARE (EDPEC) SURVEY MODE EXPERIMENTS

Background

The Centers for Medicare & Medicaid Services (CMS) requests a three-year clearance from the Office of Management and Budget (OMB) under the Paperwork Reduction Act of 1995 to implement the experiments described herein to address questions about the feasibility of national implementation of the EDPEC Survey.

As the leading organization spearheading national implementation of patient experience of care surveys, the Centers for Medicare & Medicaid Services (CMS) has made considerable investments in developing and testing the Emergency Department Patient Experience of Care (EDPEC) Survey. This work comprises a key contribution that CMS makes to one of the six priorities included in the Department of Health and Human Services' National Quality Strategy – ensuring patient and family engagement in care – and thus to the implementation of the Affordable Care Act. Under Contract Number HHSM-500-2014-00421G, CMS now seeks to test methods for supporting possible national implementation of the EDPEC Survey and ensuring that it complements Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) efforts. The surveys will include patients admitted to the hospital following their emergency department visit and those visiting the emergency department who are discharged to the community (also known as "treat and release" emergency room visits).

This request seeks approval of 922.8 hours of respondent burden to assess patient experiences. These hours are required to (1) assess patient experiences at the respondent level; (2) provide sufficient response to generate emergency department-level estimates of experiences; (3) allow for a test of mode of inpatient survey administration (mail only; telephone only; combined mail/telephone; and interactive voice recognition IVR); (4) allow for a test of mode of discharged to community survey administration (feasibility of in ED distribution as compared to combined mail/telephone); (5) allow for a test of two different versions of a survey to be used in combination with HCAHPS with patients admitted to the hospital as a result of their ED visit; and (6) allow for an examination of the impact of proxy response on response rates and patterns.

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 Original Medicare, Medicare Advantage, and Part D Prescription Drug Plans, hospitals, home health agencies, in-center hemodialysis facilities and hospices. Other Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys exist for 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 department 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 department is the portal of entry for nearly half of all hospital admissions (Pines et al 2013). Further, under EMTALA – the Emergency Medical Treatment and Active Labor Act of 1986 – everyone who comes to an emergency department 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 department a resource for those who may have no other place to receive care.

The purpose of this current data collection is to test alternative methods for potentially implementing the EDPEC Survey, including ensuring that its implementation would not impact the reliability of hospital scores for the Hospital CAHPS (HCAHPS) survey.

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. In 2012, the Centers for Medicare & Medicaid Services (CMS) launched the development of the Emergency Department Patient Experience of Care (EDPEC) survey to measure the experiences of patients (18 and older) with emergency department care. The survey was developed by following the principles used to develop Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys. The EDPEC survey will provide patient experience with care data that enables comparisons of emergency department and support for improving the quality of patient experience in the emergency department.

In this Supporting Statement, we describe plans for the conduct of two experiments: one focused on patients admitted via the ED, using the EDPEC Survey admitted instruments; and one focused on patients who are discharged to the community, using the EDPEC Survey for this population. These experiments are designed to answer outstanding questions about the feasibility of national implementation of the EDPEC Survey.

A3. Technological Collection Techniques

Patients will be randomized to mode of data collection: mail only, telephone only, mail-telephone mixed mode, and touch-tone IVR only.

Those randomized to the mail only condition will receive two rounds of mailed surveys while those randomized to the mixed mode condition will receive one mailing followed by phone interviews. The mailed survey will be 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. CATI is used to assure that the survey items are administered in the required order and to minimize interviewer-error in the conduct of the survey by telephone.

IVR cases will be introduced to the IVR system by a live operator, and operators will be available to provide support and complete a survey when a patient does not wish to continue with IVR. IVR cases will receive up to 5 call attempts over more than one week. The touch-tone IVR protocol uses interactive voice response technology in which all survey participants receive the same audio recording of question text and response options and use the touch-tone keypad of their telephone to answer each question or request assistance from a live interviewer. IVR assures the survey items are administered in the required order, that survey items are "read" identically for each survey participant, and minimizes any error or bias introduced by the presence of a "live" interviewer.

A4. Identifying Duplication

The EDPEC Survey consists largely of a set of newly developed items specific to the domains of the patient experience in an emergency department. A call for input on topics was published in Federal Register Volume 77, Number 232 (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 department. The survey is designed to gather only the necessary data that CMS needs for assessing emergency department patient experiences with care and should complement, not replace, data that providers are currently collecting that support improvement inpatient-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 a hospital and/or an emergency department. 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 to determine the most appropriate methods for possible future national implementation of the survey.
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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 November 28, 2014 (79 FR 70870). No comments were received.

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. 4,951 individuals visiting an emergency department will be surveyed in 2015.

There are three versions of the survey for patients admitted to the hospital: HCAHPS alone which is implemented at the national level (HCAHPS, Attachment 1), and two versions that will be administered as a supplement to the existing Hospital CAHPS survey. One of these versions has 18 additional ED-specific items (EDPEC for Admitted Patients: HCAHPS Add-on Version A, Attachment 2), and the other has 23 additional ED specific items version (EDPEC for Admitted Patients: HCAHPS Add-on Version B, Attachment 3). Versions are detailed in Exhibit 1 below.

The HCAHPS only version of the survey contains 32 items and is estimated to require in an average administration time of 8 minutes (at a pace of 4 items per minute) or 0.133 hours.

The EDPEC HCAHPS Add-on Versions A and B will be administered only to patients admitted through the emergency department, thus the core HCAHPS item *During this hospital stay, were you admitted to this hospital through the Emergency Room?* (Attachment 1, item 26) is not needed for the add-on versions. The HCAHPS portion of the EDPEC HCAHPS Add-on Versions A and B will therefore consist of a total of 31 items due to elimination of item 26.

The EDPEC HCAHPS Add-on Version A contains 49 items (31 HCAHPS core items and 18 ED-Specific Items) and is estimated to require in an average administration time of 12.25 minutes or .204 hours. The EDPEC HCAHPS Add-on Version B contains 54 items (31 HCAHPS core items and 23 ED-Specific Items) and is estimated to require in an average administration time of 13.5 minutes or .225 hours. See Attachments 1, 2, and 3 for copies of the surveys.

There is one version of the survey for patients who are discharged to the community (Attachment 4). The survey contains 43 items and is estimated to require in an average administration time of 10.75 minutes (at a pace of 4 items per minute) or .179 hours. See Attachment 4 for a copy of this survey.

Exhibit 1. Survey versions and item counts

Survey Version	Number of HCAHPS Core items	Number of ED-Specific Items	Total Survey Items	Average Time to Complete (minutes*)
HCAHPS**	32	0	32	8
EDPEC for Admitted Patients: HCAHPS Add-on Version A	31	18	49	12.25
EDPEC for Admitted Patients: HCAHPS Add-on Version B	31	23	54	13.5
EDPEC Discharged to Community	0	43	43	10.75

*Assumes a pace of 4 items per minute

** This survey instrument is currently approved by OMB under OCN 0938-0981 (CMS-10102) as part of the National Implementation of Hospital Consumer Assessment of Health Providers and Systems (HCAHPS). While we recognize OMB's approval, the burden proposed in this PRA package is for respondents randomized to complete the survey under this package's proposed mode experiment.

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 922.8 hours. The annual total cost burden is estimated to be $21,012.

Exhibit 2. Estimated annualized burden hours and cost

Survey Version	Number of Respondents	Number of Responses per Respondent	Hours per Response	Total Burden hours	Average Hourly Wage Rate*	Total Cost Burden
HCAHPS**	1467	1	.133	195.6	$22.77	$4,454
EDPEC for Admitted Patients: HCAHPS Add-on Version A	1454	1	.204	296.9	$22.77	$6,759
EDPEC for Admitted Patients: HCAHPS Add-on Version B	1454	1	.225	327.2	$22.77	$7,449
EDPEC Discharged to Community	576	1	.179	103.2	$22.77	$2,350
Total	4,951	1		922.8	$22.77	$21,012

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

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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 $729,313.

A15. Program Changes or Adjustments to Annual Burden

This is a new information collection request.

A16. Tabulation and Publication of Results

We anticipate that the analysis plan will include analyses needed 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 department-level reliability of items. We will compute these statistics overall, and separately by mode of administration (mail; telephone; mixed; IVR), inpatient HCAHPS Add-on Version A vs. HCAHPS Add-on Version B administration, inpatient add-on vs. HCAHPS only, and discharged to community in-ED distribution vs. mixed mode administration, computing mean scores for composites and global rating items. Additionally, we will explore response distributions by proxy allowed vs. not-allowed and item performance across instruments, proxy status, and modes.

In particular analyses will be conducted to examine mode effects on overall response, item response, and item distribution (mail only, telephone only, mixed mail/telephone, and IVR for the inpatient experiment; and mixed mail/telephone, in ED distribution for the discharged to community experiment). These analyses will allow for the development of appropriate adjustment factors that may potentially support the future use of the surveys.

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

Publication of Results: CMS may confidentially share emergency department-level estimates with emergency department administrators for quality improvement purposes. However, emergency department-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.

REFERENCES

Pines JM, Mutter RL, Zocchi MS. 2013. Variation in Emergency Department Admission Rates Across the United States. Medical Care Research and Review 70(2): 218-231.