Consumer Assessment of Healthcare Providers and Systems (CAHPS®) 2022 Virtual Research Meeting Summary: Assessing Patient Experience for Insights into Enhancing Equity in Healthcare

September 22, 2022

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This meeting explored how Consumer Assessment of Healthcare Providers and Systems (CAHPS®) surveys shed light on disparities in patient experience and how improved measurement can advance healthcare equity. Over 600 CAHPS survey users, researchers, healthcare organization leaders, patient advocates, policymakers, Federal partners, and the CAHPS Consortium attended.

Key Themes:

- There are many inequities across sociodemographic groups with respect to access to, and the quality of, health and healthcare services.
- Addressing and eliminating health inequities in patient experiences requires accurate measurement of differences in care experiences and reporting findings.
- Effectively addressing healthcare inequities requires improvements in data collection and data quality, and use of statistical techniques, such as stratified analyses to inform quality improvement efforts.
- Producing data that assess health equity and inform equity-targeted quality improvement requires both accurate identification of underserved groups and better response rates from those populations.
- Data should be collected only if there are specific plans to use them.

Key Issues:

- Disparities exist in the patient experience of racial and ethnic minorities, individuals with limited English proficiency, and sexual and gender minorities, people with disabilities, among others, but there are gaps in our understanding of different population groups.
- Two challenges in measuring the patient experience in these different groups are small sample sizes and low response rates.
- Many individuals have multiple characteristics.
- There is a need for disaggregated data to support a more granular look at subgroups.
- Provider education and training is needed to convey the benefits of collecting demographic data for quality improvement purposes, mitigating disparities in patient experience among minorities, and communicating sensitively with patients of different backgrounds.
- Measuring structural bias and structural barriers in healthcare requires complex methodologies to accurately identify, adopt, and implement equity improvement interventions.

Meeting Structure:
The meeting included a welcome session and four plenary sessions that highlighted research conducted by CAHPS grantees and other researchers. Presentations included the following topics:

- **Welcome and Overview**
- **Session 1:** Aiming for Equity in Patient Experience: What We Know about Disparities and Opportunities to Learn More
- **Session 2:** Improving the Participation of Diverse Populations in Patient Experience Surveys
- **Session 3:** Gathering Additional Information on Disparities in Patient Experience: Challenges and Strategies
- **Session 4:** Analyzing and Reporting CAHPS Survey Data to Assess and Improve Equity in Patient Experience
- **Concluding Remarks and Adjournment**

Welcome and Overview

Robert Valdez, Ph.D., MHSA, Director, AHRQ
Kamila Mistry, Ph.D., MPH, Associate Director, Office of Extramural Research, Education & Priority Populations, AHRQ
Caren Ginsberg, Ph.D., Director, CAHPS & SOPS, AHRQ

The Agency for Healthcare Research and Quality (AHRQ) regards advancing equity in healthcare as a top priority, aligning with its mission to produce scientific evidence that makes healthcare safe, high quality, equitable, and affordable. AHRQ acknowledges that structural racism is inherent throughout the healthcare system. The agency's 2021 National Healthcare Quality and Disparities Report highlights the misdiagnosis, overdiagnosis, and poor treatment and care management of people of color, all contributing to health inequities among populations.

Creating a more equitable system requires dismantling structural racism, which follows the President's Executive Order and the Department of Health and Human Services priorities. This requires that healthcare organizations assess entrenched practices and policies, engage in internal and external systems changes, and acknowledge structural barriers that compromise equity.

AHRQ and its CAHPS program have a sustained commitment to getting patient experience measurement right and improving health equity.

Session Summaries

The following summaries highlight key points from each of the four sessions, including: (1) what is known, (2) main conclusions, and (3) future research directions (**Figure 1**). Abstracts of all presentations in each session are available in Appendix A.

Figure 1: Research Meeting Session Summary Structure

Session 1: Aiming for Equity in Patient Experience: What We Know about Disparities and Opportunities to Learn More

This session reviewed what is known about disparities in patient experience, including differences among Medicare health plan enrollees and how those disparities have changed over time; differences among patients receiving hospice care; and differences among nonelderly Medicaid managed care health plan enrollees. The speakers in this session also discussed opportunities to assess disparities in patient experience for patients with disabilities as well as disparities related to sexual orientation and gender identity (SOGI).

1. Racial and Ethnic Disparities in the Care Experiences of People with Medicare

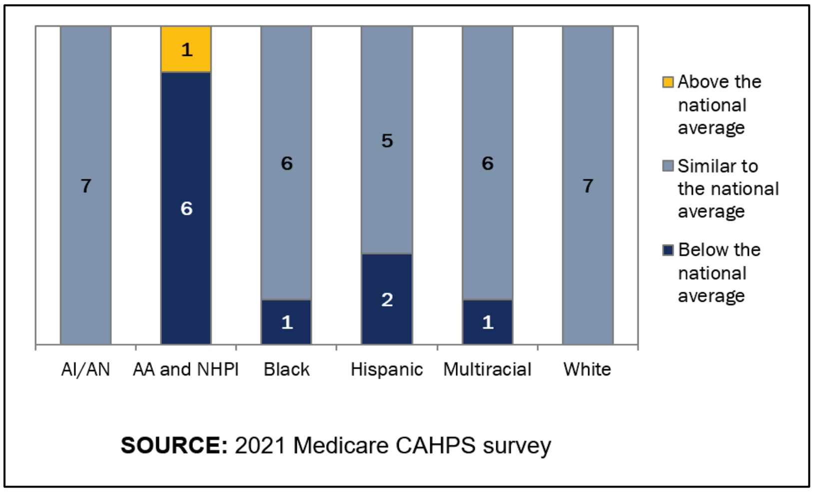
Steven Martino, Ph.D., Senior Behavioral Scientist, RAND Corporation

National data reveal racial and ethnic disparities in the experience of care among Medicare Advantage enrollees. For example, Asian American and Native Hawaiian and Other Pacific Islander, Black, and Hispanic people report care experiences below the national average for one or more CAHPS measures (Figure 2).

Looking at individuals' characteristics in combination (e.g., race and gender) can help provide more insight about one-dimensional disparity or reveal disparities that are not apparent when data are aggregated at a higher level.

Research is needed to identify drivers of underlying racial and ethnic disparities.

Figure 2: Racial and Ethnic Disparities on 7 Patient Experience Measures in 2021: Summary*



SOURCE: 2021 Medicare CAHPS survey

* Steven Martino, *Racial and Ethnic Disparities in the Care Experiences of People with Medicare*, September 22, 2022

2. Variation in Caregiver-Reported Hospice Care Experiences by Race and Ethnicity

Rebecca Anhang Price, Ph.D., Senior Policy Researcher, RAND Corporation

High-quality hospice care is patient- and family-centered. The CAHPS Hospice Care Survey is an effective tool for assessing the care experience.

The experience of care for Black and Hispanic patients is similar to or better than it is for White patients within the same hospices, except for the measure of Emotional and Spiritual Support. However, Black and Hispanic patients more often receive care from hospices that provide worse care experiences.

Findings suggest the importance of targeting the emotional and spiritual support of Black and Hispanic patients for quality improvement across all hospices, improving overall care experiences in hospices that serve higher proportions of Black and Hispanic patients, and increasing Black and Hispanic patients' access to high-performing hospices.

3. Racial and Ethnic Disparities in Patient Experience of Care Among Medicaid Managed Care Enrollees

Kevin Nguyen, Ph.D., Brown University

Medicaid managed care enrollees who are members of racial and ethnic minority groups have historically reported worse experiences than White enrollees.

In a recent study of nonelderly Medicaid managed care enrollees in thirty-seven states, researchers found that, compared with White enrollees, minority enrollees reported significantly worse care experiences. Disparities were largely attributable to worse experiences by race or ethnicity within the same plan.

Interventions are needed to mitigate racial and ethnic inequities in patient experiences, including the collection of comprehensive race and ethnicity data, the adoption of health equity performance metrics, plan-level enrollee engagement, and multisectoral initiatives to dismantle structural racism. Future research can also explore variations within Medicaid Managed Care plan disparities and identify which plans are doing well.

4. Disability Overview and Healthcare Disparities

Lisa Iezzoni, M.D., M.Sc., Professor of Medicine, Harvard Medical School, based at the Health Policy Research Center, Mongan Institute, Massachusetts General Hospital

Disability is a nearly universal phenomenon as it affects almost everyone at some point in life. Disability and race and ethnicity are intersectional.

Healthcare disparities exist among people with disabilities with patterns varying by the type of disability. Most physicians have the misperception that patients with disability have an overall worse quality of life than nondisabled patients.

Interventions are needed to educate providers so patients with disabilities do not need to prove to their doctor that they value the quality of their life to get equitable care.

5. Improving the Measurement of Sexual Orientation and Gender Identity (SOGI) in Federal Surveys: Challenges and Recommended Approaches

Sylvia Fisher, Ph.D., Senior Social Science Analyst, AHRQ

Sexual orientation (SO) and gender identity (GI) are core aspects of individuals' identity that affect their healthcare experiences and outcomes. Currently, however, no official SOGI measurement standards exist, resulting in knowledge gaps about sexual and gender minority populations and their needs. Inadequate or inaccurate measurement of SOGI can result in potential health disparities among individuals in under-represented demographic groups.

In March 2022, a National Academies of Sciences, Engineering, and Medicine (NASEM) consensus study team recommended questions to improve SOGI data collection. The proposed gender identity measure clearly distinguishes between sex assigned at birth and current gender, which allows for enumeration and cross-tabulation of cisgender and transgender people. Concerns about the limitations of the response options, however, include the absence of new and emerging identity terms (e.g., "non-binary"). Recommended question to assess sexual orientation has fewer concerns.

Research needs include obtaining appropriate methodological support for new response categories that better represent current and emerging SOGI terminology.

Session 2: Improving the Participation of Diverse Populations in Patient Experience Surveys

This session discussed approaches to patient experience surveys that ensure broad representation of sampled populations and address under-representation of minority populations. Topics include use of the Bayesian Improved Surname Geocoding (BISG) method and the effectiveness of various survey administration modes.

1. Improving the Participation of Diverse Populations in Patient Experience Surveys

Marc Elliott, Ph.D., Distinguished Chair in Statistics; Senior Principal Researcher, RAND Corporation

Many underserved groups, including racial and ethnic minority patients, often have low survey response rates. It is vital to encourage the participation of all racial and ethnic groups to ensure that patient experience survey results represent the surveyed population, fully capture the experiences of underserved groups, and adequately measure the impact of health equity and equity-targeted quality improvement efforts. Although race and ethnicity data are essential for monitoring response rates and representativeness, these data are often unavailable for nonrespondents.

Special methods are needed to measure race and ethnicity when valid self-reported data are not provided by respondents. The Bayesian Improved Surname Geocoding (BISG) and Modified BIFSG approaches can be used in any dataset with name and address data to compare racial and ethnic groups. Multimode approaches that include web, telephone, or both, and longer field periods (from 42 to 49 days) can improve response rates (Figure 3) and the representation of underserved racial and ethnic groups in patient experience surveys (not shown).

Census data requests, when fulfilled, will allow more detailed representation of Asian, Hispanic, and multiracial race and ethnicity. Full implementation of new web-first survey modes would provide additional information about the representation of underserved groups.

Figure 3: 2021 HCAHPS Mode Experiment Response Rates*

Survey Administration Protocol	Response Rate
HCAHPS Legacy Modes	
Mail Only	22%
Phone Only	23%
Mail-Phone	**31%**
Web-first Modes	
Web-Mail	**29%**
Web-Phone	**30%**
Web-Mail-Phone	**36%**

* Marc Elliott, *Improving the Participation of Diverse Populations in Patient Experience Surveys*, September 22, 2022

Session 3: Gathering Additional Information on Disparities in Patient Experience: Challenges and Strategies

This session reviewed the development of new questions and measures of disparities in patient experience, the challenges of gathering this information, and possible solutions. The speakers in this session also discussed what can be learned through the NRC Health/MGB Community Insights Panel Study and the use of open-ended narrative items.

1. New Approaches to Understanding Inequities: Setting the Stage and Analyzing Narratives

Mark Schlesinger, Ph.D., Professor, Yale School of Public Health

Patient narrative responses to structured open-ended questions about patient experiences offer insights into inequities by revealing differences in experiences as well as experiences perceived as insensitive or unfair.

In an analysis of narrative responses from a survey of health plan enrollees, most of the differences in patient experience revealed by the narratives were within the communication domain. The differences across racial and ethnic groups in communication with one's doctor and emotional rapport with that doctor were substantial. Black and Asian respondents also provided significantly more actionable feedback compared to other racial groups.

Future work should focus on developing and testing open-ended questions that ask directly about unfair treatment.

2. NRC Health/MGB Community Insights Survey: Patient Voices on Race & Ethnicity Collection

Mitch Kellaway, Data Accuracy, Health Equity, Mass General Brigham

Incomplete patient race and ethnicity data pose a fundamental challenge to effectively identifying health disparities and assessing interventions intended to address them.

Using the NRC Health/MGB the Community Insights Panel, a survey obtaining patients' thoughts on race and ethnicity data collection, most respondents did not know or said they were not asked about race and ethnicity and most patients said they would provide these data. The main reason respondents reported declining to provide race and ethnicity data was that they do not understand how it would help with their healthcare.

Patient experience surveys should modify or introduce new data collection strategies, such as having clinicians, waiting room staff, or front desk staff ask (and re-ask) race and ethnicity questions. Other considerations include running a pilot where ethnicity is asked before race, performing staff re-education regarding not skipping race and ethnicity questions, proactively conveying the benefits of demographic data collection to patients, and exploring survey methods other than email.

3. MA & PDP CAHPS New Item Testing: Perceived Unfair Treatment

Joy Binion, M.S., Centers for Medicare & Medicaid Services (CMS)

CMS collects information about Medicare enrollees' experiences with, and ratings of, Medicare Advantage (MA-Only) plans, Medicare Advantage Prescription Drug (MA-PD) plans, and Prescription Drug Plans (PDP) via the Medicare CAHPS Survey. However, currently there is no explicit question to assess perceived unfair or insensitive treatment.

CMS is developing and testing a new survey item to ask about perceived unfair or insensitive treatment. After a literature review and two rounds of cognitive testing, the question is being field tested through October 2022. Preliminary results show that perceived unfair treatment related to health conditions, disability, and income were reported most often. Enrollees with limited income, Black enrollees, and female enrollees were especially likely to report unfair or insensitive treatment. However, the basis of the unfair treatment they reported didn't necessarily correspond to these characteristics.

Responses to the new question on perceived unfair treatment in care will continue to be analyzed for potential survey inclusion. This type of question may be tested in other CMS programs

Session 4: Analyzing and Reporting CAHPS Survey Data to Assess and Improve Equity in Patient Experience

This session discussed ways to report CAHPS survey data to identify and highlight disparities in patient experience, including stratified reporting and the use of analytical methods to assess the impact of interventions on different patient groups.

1. The Centers for Medicare & Medicaid Services' Office of Minority Health's (OMH) Stratified Reporting of Medicare CAHPS Measures for Medicare Advantage Enrollees

Jess Maksut, Ph.D., CMS Office of Minority Health (OMH)

Since 2016, CMS has been producing national and contract-level estimates of performance across the patient experience and clinical care domains of care quality for people enrolled in Medicare Advantage (MA) to address and eliminate health inequities. Stratified reporting offers useful information for guiding equity-centered quality improvement interventions and for monitoring health and drug plan performance.

An analysis of national CAHPS composite measure scores for Medicare Advantage plans from 2009 through 2018 indicates both progress as well as growing inequities. Scores for the Getting Needed Care measure decreased at a steeper rate for Asian American and Native Hawaiian and other Pacific Islander enrollees than White enrollees, likely reflecting a growing inequity in access to care. On all four composite measures, scores improved more for Black enrollees than White enrollees. There was little change in the inequities between Hispanic and White enrollees for the Getting Needed Care, Getting Care Quickly, and Customer Service measures. Scores for Hispanic enrollees increased more than scores for White enrollees on the Annual Flu Vaccine measure. Patterns of small, mixed differences between women and men did not change appreciably.

Dramatic improvements for rural residents on the Annual Flu Vaccine measure eliminated a previously large inequity between rural and urban residents.

The CMS Health Equity Technical Assistance (TA) Program will continue to help support quality improvement partners, providers, and other CMS stakeholders (HealthEquityTA@cms.hhs.gov).

2. Using Analytical Methods to Assess the Impact of an Intervention on Different Patient Groups

Denise Quigley, Ph.D., Senior Policy Researcher; Professor, Pardee RAND Graduate School
Efrain Talamantes, M.D., MBA, M.Sc., Chief Operating Officer, AltaMed Health Services

Shadow coaching, or one-on-one peer provider counseling, has been shown to significantly improve provider behaviors and patient experience.

Based on an analysis of data from the CAHPS Clinician & Group Survey, shadow coaching achieved a statistically significant two-point (small-to-medium) improvement in the communication composite measure and the overall provider rating among English-preferring patients of coached providers. No evidence of a coaching effect was found for Spanish-preferring patients. Within each racial and ethnic group, mean reported experiences for non-English-preferring patients were worse than English-preferring patients.

Research should examine how shadow coaching and other provider-focused strategies could improve care for Spanish-preferring patients.

3. Discussant

Cara James, Ph.D., President and CEO, Grantmakers in Health (GIH)

The research presented in this and previous sessions highlights the persistence of disparities in patient experience data and the gaps in understanding certain populations, such as the lack of disaggregated data to be able to look more granularly at subgroups. Research also shows the many challenges regarding intersectionality (looking at multiple characteristics), low survey response rates, and variability across different settings.

While there is a good understanding of the current state of health equity, the next step is exploring how to advance it. Data need to be actionable and relevant to different entities and providers who are trying to advance health equity. Furthermore, there needs to be a better understanding of place-based disparities and drivers of disparities, which involves additional resources. Detailed data that support interventions and quality improvement are needed to move the needle forward and advance health equity.

Concluding Remarks and Adjournment

Susan Edgman-Levitan, PA, Executive Director, John D. Stoeckle Center for Primary Care Innovation; Co-Chair, Mass General Brigham Patient Experience Leaders Committee, Massachusetts General Hospital.
Caren Ginsberg, Ph.D., Director, CAHPS & SOPS, AHRQ

AHRQ is deeply committed to improving the experience of all patients through the collection of credible, reliable, and valid survey data. Insights gleaned from data presented in this Research Meeting will be used to improve measures that give voice to all patients and to improve data analysis and reporting to support critical improvement efforts.

This is the beginning of a new era of research on using patient experience research to reduce disparities. AHRQ gives thanks to the meeting planners, the presenters for sharing their research, and all meeting attendees who will use this knowledge to improve healthcare delivery.

Appendix A: Presentation Abstracts

Session 1: Aiming for Equity in Patient Experience: What We Know about Disparities and Opportunities to Learn More

Racial and Ethnic Disparities in the Care Experiences of People with Medicare

Steven Martino, Ph.D., Senior Behavioral Scientist, RAND Corporation

This presentation reviewed research that RAND has performed for the Centers for Medicare & Medicaid Services to help identify and track gaps in care quality and incentivize efforts to advance health equity. The focus of the presentation was on racial and ethnic disparities in experiences of care in Medicare Advantage. Data presented were from the 2021 Medicare CAHPS Survey. The research team used these data to investigate overall racial and ethnic disparities nationally, and to investigate racial and ethnic disparities within strata defined by sex and rurality. Important measurement, study design, and statistical considerations that need to be made when investigating racial and ethnic disparities in quality of care were also discussed.

Variation in Caregiver-Reported Hospice Care Experiences by Race and Ethnicity

Rebecca Anhang Price, Ph.D., Senior Policy Researcher, RAND Corporation

High-quality hospice care is patient- and family-centered care and can be assessed by care experience surveys. Researchers used CAHPS Hospice Survey data from 464,064 caregivers of Black, Hispanic, and White hospice patients from July 2020-December 2021 to examine how hospice care experiences differ by patients’ race and ethnicity, and whether differences reflect differential care experiences within the same hospices versus differential concentration of patients between hospices. Researchers found that care experiences for Black and Hispanic patients are similar or better than for White patients within the same hospices, except for Emotional and Spiritual Support. However, Black and Hispanic patients more often receive care from hospices that provide worse care experiences. Findings suggest the importance of targeting the emotional and spiritual support of Black and Hispanic patients for quality improvement across all hospices; improving overall care experiences in hospices that serve higher proportions of Black and Hispanic patients; and increasing Black and Hispanic patients’ access to high-performing hospices.

Racial and Ethnic Disparities in Patient Experience of Care Among Medicaid Managed Care Enrollees

Kevin Nguyen, Ph.D., Brown University

Medicaid managed care enrollees who are members of racial and ethnic minority groups have historically reported worse care experiences than White enrollees. Using 2014–18 data on 242,274 nonelderly Medicaid managed care enrollees in thirty-seven states, researchers examined racial and ethnic disparities in four patient experience metrics. Compared with White enrollees, minority enrollees reported significantly worse care experiences. Overall adjusted disparities for Black enrollees ranged between 1.5 and 4.5 percentage points (PPs) on a 0–100 scale; 1.6–3.9 PPs for Hispanic or Latino enrollees; and 9.0–17.4 PPs for Asian American, Native Hawaiian, or other Pacific Islander enrollees. Disparities were largely attributable to worse experiences by race or ethnicity within the same plan. Interventions to mitigate racial and ethnic inequities in care experiences include the collection of comprehensive race and ethnicity data, the adoption of health equity performance metrics, plan-level enrollee engagement, and multisectoral initiatives to dismantle structural racism.

Disability Overview and Healthcare Disparities

Lisa Iezzoni, M.D., M.Sc., Professor of Medicine, Harvard Medical School, based at the Health Policy Research Center, Mongan Institute, Massachusetts General Hospital

Although disability is nearly universal across the lifespan, people with disabilities experience health and healthcare disparities. Disabilities are diverse; disparity patterns vary by disability type. Compared with white persons, people who are racial and ethnic minorities have higher disability rates, potentially compounding disparities. People with disabilities have been stigmatized for millennia; during the eugenics period in early 20th century America, they were targeted with sterilization and other brutalities. The complicity of healthcare professionals in this malfeasance left a legacy of distrust among some disabled people. Today, the social model views disability as resulting from societies that fail to accommodate people who perform basic functions in different ways, making disability a human rights issue. The Americans with Disabilities Act and other disability civil rights laws require healthcare professionals to provide equitable care to disabled people. Many providers are unaware of their legal obligations, and disability disparities persist.

Improving the Measurement of Sexual Orientation and Gender Identity (SOGI) in Federal Surveys: Challenges and Recommended Approaches

Sylvia Fisher, Ph.D., Senior Social Science Analyst, AHRQ

Sexual orientation (SO) and gender identity (GI) are core aspects of individuals’ identity that affect outcomes and experiences with discrimination. The availability of accurate SOGI information is integral to the success of broader efforts to increase diversity, equity, inclusion, and accessibility for underserved sexual and gender minority (SGM) populations. Currently, however, no official SOGI measurement standards exist, resulting in knowledge gaps about SGM populations and their needs. Measurement of SOGI concepts is complex and complicated partly by variations among newly emerging identities. Recent federal initiatives are underway to support improved SOGI data collection across multiple federal agencies to help address disparities and promote equity among SGM populations. After thoroughly reviewing the SOGI measurement literature, the National Academies consensus study team recently recommended a set of questions to advance improved SOGI data collection. This presentation highlighted these varied initiatives, along with suggestions for future research, to promote discussion about this important topic.

Session 2: Improving the Participation of Diverse Populations in Patient Experience Surveys

Improving the Participation of Diverse Populations in Patient Experience Surveys

Marc Elliott, Ph.D., Distinguished Chair in Statistics; Senior Principal Researcher, RAND Corporation

Many underserved groups, including racial and ethnic minority patients, have low survey response rates. Improving their response rates can ensure that their experiences are better represented and inform efforts to improve equity in patient experience. Measuring response rates by race and ethnicity is challenging when information on race and ethnicity is unavailable for nonrespondents. This presentation described how randomized experiments (e.g., the 2021 HCAHPS mode experiment) can help with de-identified patient data and how indirect estimation (i.e., applying Modified Bayesian Improved Surname and Geocoding (MBISG) to Medicare CAHPS data) can help in other situations with linkable data for which race and ethnicity is not known. Results indicated that multimode approaches that include web, telephone, or both, and longer field and response periods greatly improved representation of underserved groups. In particular, a Web-Mail-Phone survey mode and other two-phase modes, (Web-Phone, Mail-Phone, Web-Mail) were most effective at improving HCAHPS response rates for underrepresented groups. In addition, extending a 6-week data collection interval by one week substantially improved response rates and representation for underserved groups. In one application of MBISG, the response rates to a Mail-Phone protocol were estimated to be 9-12 percentage points lower for minority Medicare enrollees than for White enrollees. A second application estimated that 6.6% of Black, 4.7% of Asian American and Native Hawaiian/Pacific Islander, and 3.2% of White survey respondents did not report their race and ethnicity on the Medicare Advantage & Prescription Drug Plan (MA & PDP) CAHPS Survey.

Session 3: Gathering Additional Information on Disparities in Patient Experience: Challenges and Strategies

New Approaches to Understanding Inequities: Setting the Stage and Analyzing Narratives

Mark Schlesinger, Ph.D., Professor, Yale School of Public Health

New methods for identifying, understanding, and rectifying inequities based on patients' experiences can be categorized by their approach to inquiring about experience (general versus unfair experiences) and their methods for identifying inequities (cross-group comparison versus content of individuals' responses). This presentation reviewed recent research drawing on volunteered narratives within this framework and introduced new findings from CAHPS-based research to develop narrative item sets for health plan surveys. Using data from 573 enrollees in a well-established, high-performing health plan, this study demonstrates: (a) the importance of assessing health equity beyond dyadic cross-group disparities, (b) the parallels and divergences between narrative accounts and responses to CAHPS closed-ended questions, (c) racial and ethnic differences in both problematic experiences and exposure to exemplary providers, and (d) the potential for elicited narratives to collect actionable data from respondents of all ethnic and racial backgrounds, providing insights and evidence useful for reducing health inequities in the future.

Community Insights Survey: Patient Voices on Race & Ethnicity Collection

Mitch Kellaway, Data Accuracy, Health Equity, Mass General Brigham

Incomplete patient race and ethnicity data pose a fundamental challenge to effectively identifying health disparities and assessing interventions intended to address them. Having seen early success in efforts to reduce data incompleteness, the Mass General Brigham (MGB) healthcare system has observed lower completion rates for ethnicity data than race data. To learn about barriers and opportunities for improvement, an NRC Health/ MGB Community Insights survey collected feedback from 1,390 patients on their experiences with being asked for ethnicity and race, preferred methods of data collection and question order, and reasons they might decline to answer either question. The session covered survey rationale, consideration of how race and ethnicity may qualitatively differ as question categories, insights from where responses vary among patients of different racial/ethnic identities, limitations within the respondent group, and how findings may inform Mass General Brigham's data collection strategies and patient surveys in the future.

MA & PDP CAHPS New Item Testing: Perceived Unfair Treatment

Joy Binion, M.S., Centers for Medicare & Medicaid Services (CMS)

To expand its focus on diversity and equity, the Centers for Medicare & Medicaid Services (CMS) has developed and is currently field testing a new question on the Medicare Advantage (MA) and Prescription Drug Plan (PDP) CAHPS survey to assess perceived unfair or insensitive treatment based on certain enrollee attributes such as health condition, disability, race, and income. Knowing how enrollees perceived their treatment will give MA and PDP contracts better insight into their enrollees' experiences to inform and target quality improvement initiatives. CMS developed the question based on a review of existing literature and input from multiple rounds of cognitive testing with Medicare participants. This question is being tested as part of a broader field test that is assessing additional potential survey updates, including adding the web mode of data collection to the current mixed mode (mail with telephone follow-up). This presentation summarized cognitive testing findings and preliminary field test findings related to this question.

Session 4: Analyzing and Reporting CAHPS Survey Data to Assess and Improve Equity in Patient Experience

The Centers for Medicare & Medicaid Services' Office of Minority Health's Stratified Reporting of Medicare CAHPS Measures for Medicare Advantage Enrollees

Jess Maksut, Ph.D., CMS Office of Minority Health (OMH)

This presentation described the history and purpose of the Centers for Medicare & Medicaid Services' Office of Minority Health's (CMS OMH) partnership with the RAND Corporation to produce publicly available annual reports with national- and contract-level estimates of quality of care delivered to Medicare Advantage (MA) enrollees stratified by race and ethnicity, sex, urban/rural status, and dual eligibility/Low-Income Subsidy eligibility status. These stratified reports, which include a number of patient experience indicators captured via Medicare CAHPS surveys, support CMS OMH's mission, vision, and the *CMS Framework for Health Equity 2022-2032*. MA contracts and other partner groups can leverage the information in the stratified reports on the nature and extent of health and healthcare disparities to identify meaningful opportunities to develop and implement health equity-centered and culturally and linguistically appropriate quality improvement interventions and strategies.

Using Analytical Methods to Assess the Impact of an Intervention on Different Patient Groups

Denise Quigley, Ph.D., Senior Policy Researcher; Professor, Pardee RAND Graduate School
Efrain Talamantes, M.D., MBA, M.Sc., Chief Operating Officer, AltaMed Health Services

Shadow coaching has been shown to significantly improve provider behaviors and patient experience, but its differential effect on English- versus Spanish-preferring patients is unknown. This presentation reviewed study findings that assessed the impact of coaching on patient experience for English- and Spanish-preferring patients. Researchers analyzed 2012-2019 CAHPS Clinician & Group Survey 2.0 data from patients at a large, urban Federally Qualified Health Center. One-third of the patients were Spanish-preferring. Researchers fit mixed-effects regression models with random provider effects (level of treatment assignment), fixed effects for time (linear spline for time with a knot or “jump” at coaching date), patient characteristics, and site indicators, stratified by language. Results showed a statistically significant 2-point (small-to-medium) jump in the CAHPS communication composite measure and the overall provider rating among English-preferring patients of coached providers. No evidence of a coaching effect was found for Spanish-preferring patients. The study concluded that selection and training of providers seeing Spanish-preferring patients should be refined to extend the benefits of coaching to Spanish-preferring patients.

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