

Summary of Changes in Reporting of Bereaved Family Survey Scores (Effective beginning Q1 FY16 reports which were sent out 4/1/2016):

The PROMISE Center, now known as the Veteran Experience Center, has refined the calculation and reporting of the Bereaved Family Survey scores. The purpose for these changes is to make more precise estimates of quality by adopting analytic and reporting practices that are used by other federal and private quality improvement and accountability organizations (e.g., Centers for Medicare and Medicaid Services – CMS; Agency for Healthcare Research and Quality - AHRQ). The changes described below will be fully implemented with the Quarter1 FY16 Reports.

Reporting of BFS scores using four-quarter cumulative scores. Historically, quarterly BFS reporting has been plagued by the small sample sizes in many facilities. Typically, a sample comprised of less than 30 responses is not large enough to provide stable estimates. Other national surveys address this problem by reporting scores from the most recent plus the previous 3 quarters. This is how the PROMISE/Veteran Experience Center now reports scores for both the quarterly PROMISE/Veteran Experience Center Reports and VSSC reports.

Accounting for potential nonresponse bias. A major concern in all survey administration is nonresponse bias, which occurs if survey non-respondents are different from respondents on key characteristics that are known to be associated with higher or lower scores. When nonresponse bias occurs, the sample may not be representative, leading to inaccurate outcome estimates. For example, next-of-kin who are spouses tend to rate the end-of-life quality of healthcare higher than NOK who are children of the decedent. If spouses respond to the BFS at higher rates than children of Veteran decedents (which they do), scores will be higher than if spouses and children respond at the same rate. Although low response rates raise concerns, nonresponse bias can exist even with higher response rates. We now minimize the effects of nonresponse bias by adjusting scores using well-established and widely used statistical methods.

Accounting for case-mix. In order to improve comparisons of BFS performance between facilities and VISNs, it is important to account for differences in case-mix. Case-mix in the context of the BFS refers to characteristics of Veterans and BFS respondents that are associated with BFS responses that are not under the control of the facility. For example, family members of patients with greater comorbidity burden (i.e., more chronic conditions) at the time of death report lower BFS scores. Therefore, facilities that treat less complex patients would be at an advantage when compared to a facility that treats more complex patients. Following similar procedures to CMS in the reporting of Consumer Assessment of Healthcare Providers and Systems (CAHPS) scores for hospital and hospice performance, statistical methods are now used to adjust reported BFS scores to reflect differences in case mix. These adjustments will result in BFS scores that will allow more equitable comparisons between facilities.

Alignment with VSSC reporting. Beginning December 30, 2015, the VSSC reporting schedule is now aligned with the PROMISE/Veteran Experience Center Quarterly report. That is, VSSC reporting will occur every quarter (December 30th, March 31st, June 30th, and September 30th) together with the PROMISE/Veteran Experience Center report. There are no longer interim VSSC reports. The scores on VSSC will now match those of the Veteran Experience Center.

Introduction to the Bereaved Family Survey PROMISE/Veteran Experience Center report

About the Bereaved Family Survey and PROMISE/Veteran Experience Center:

The PROMISE Center now known as the Veteran Experience Center, based at the Corporal Michael J. Crescenz Philadelphia VA Center for Health Equity Research and Promotion, is charged with collecting quality data to evaluate and guide the VA's Hospice and Palliative Care Program. A core element of this effort is the Bereaved Family Survey, which is administered to families of Veterans who have died in a VA facility.

About the performance measure:

The Bereaved Family Survey was a Pilot Performance Measure for the Office of Quality and Performance beginning in the first quarter of FY2010. One item of the survey was endorsed by the National Performance Measure Workgroup as an Emerging Measure beginning in FY2011. This item asks families to evaluate the overall care that the Veteran received in the last month of life, on a scale from "poor" to "excellent." The Measure is the adjusted proportion of families who report that care was "excellent."

The VISN-level benchmark for FY2016 is 58% with a stretch goal of 62% and was based on the 30th percentile of facilities scores (this is the performance level that 70% of the facilities are able to exceed).

To improve efficiency for FY2013 and beyond, the PROMISE/Veteran Experience Center moved from conducting the BFS through telephone survey to a mailed survey. The transition began in Q3FY12 with select VISNs and was completed in Q1FY13 when all VISNs were converted to a mail-out survey. The option to complete an online survey was added Q1FY15.

Additionally, in response to the field, a slight wording change to the survey was made for Q1FY13. The phrase "doctors and other staff" was replaced with "staff". The survey also now includes an explanatory statement as to who should be considered when thinking about "staff."

Disseminating reports within a VISN:

We recommend the following steps in sharing this report throughout a VISN:

- 1) The HPC Program Manager and Clinical Champion should review the report first and clarify questions/concerns with the PROMISE/Veteran Experience Center staff.
- 2) The Program Manager and Clinical Champion should share reports with clinical care leaders at each facility. At a minimum, this should include 2-3 members of that facility's interdisciplinary team. In addition, we recommend sharing the results with key facility leaders (e.g., the ACOS for GEC) whose support and input are valuable to hospice and palliative care initiatives.

Overview of methods used:

This report presents the results of surveys completed by the families of Veterans who died in VA facilities. In interpreting these tables and graphs, please note the following points:

- 1) The numbers in this report come from the results of interviews, mail and online surveys with Veterans' family members. The response rates vary considerably by facility and VISN, and currently range from 30 to 75 percent of eligible Veteran deaths.
- 2) Every graph or table, other than the Poor Pain Management table and graph, displays the adjusted proportion of family members who gave the best possible answer for that question. For the performance measure, the number presented is the adjusted proportion of family members who said that the Veteran received "Excellent" care. For all tables and graphs with the exception of the Poor Pain Management item, higher scores indicate better care. Lower scores are an indication of better care for the Poor Pain Management item ONLY (pain "Always" made the Veteran uncomfortable).
- 3) All scores have been adjusted to account for survey nonresponse bias as well as patient case mix.

A Guide to Interpreting the Data:

A few things to keep in mind when reviewing the report and interpreting the data:

- * First, look at the Performance Measure or “Overall” score. This provides a good overall measure of families' perceptions of quality.
- * Next, look at the individual items and supplemental data (survey and chart reviews). These items offer the most useful guidance for QI efforts.
- * Be cautious about interpreting scores based on fewer than 30 surveys. These results are not stable estimates of BFS scores. The written comments section is a particularly valuable source of information about the quality of care when sample sizes are small.
- * Be skeptical of results that don't fit with what you see clinically. If a score is surprising and it can't be explained, consider waiting for another quarter's data before you act.
- * Chart review items are meant to be diagnostic tools to help guide the development and implementation of quality improvement initiatives. They are not a good way to evaluate care on their own, but can be a useful adjunct to understanding how to improve specific areas of care. These data are not reported to the Office of Quality and Performance for performance measure purposes.
- * All scores have been adjusted to account for survey nonresponse bias as well as patient case mix.
- * The qualitative data reflect the Veteran's location of death. For example, the data for a Veteran who spent his last day of life in a hospice unit but the previous twenty days in an intensive care unit are assigned to the hospice unit. For that reason, please use caution when interpreting the qualitative data.