BRITISH COLUMBIA (BC) 2018 EMERGENCY DEPARTMENT SURVEY AT A GLANCE

THE SURVEY

The ED 2018 survey asked patients about their health-related quality of life and their experiences with the quality of the care and services received as a patient in one of 108 Emergency Departments in BC. Patients who visited an Emergency Department between January 1st, 2018 and March 31st, 2018 were eligible to receive a survey consisting of items from the following Patient-Reported Experience Measures (PREMs) and Patient-Reported Outcome Measures (PROMs), as well as narrative comments. The survey was completed by 14,076 patients.

PREMs:

- The Emergency Department Patient Experiences with Care Survey (EDPEC)

Two versions:

  - Discharged to Community Instrument (35 questions)
  - Standalone Instrument (for patients admitted to hospital following ED visit; 2 questions)

- "Made-in-BC" Questions & Modules

Topics include:

  - Patient experience with ambulance transport, IV therapy, emotional support, respect for culture and traditions, safety, continuity across transitions in care, & need for home support following discharge (at request of the Office of the Seniors Advocate).

The survey instrument will be available in the Tech Report Appendix

***PROMs:**

- Veteran's Rand 12 (VR-12) Item Health Survey
  - Includes 8 principles of health domains: general health perceptions, physical functioning, role limitations due to physical problems, role limitations due to emotional problems, bodily pain, energy-fatigue, social functioning, and mental health.
- EUROQOL's EQ5D-5L
  - Assesses 5 dimensions of quality of life: mobility, self-care, usual activities, pain/discomfort, and anxiety/depression

** Scoring protocols for the VR-12 are currently in preparation. The EQ5D data was collected for the purpose of a side-by-side research study and should not currently be reported on.*

The Survey Codebook will be available in the Tech Report Appendix

SAMPLING PLAN

1 *Data Submission*

HAs/affiliates sent patient records to the data collection vendor, R. A. Malatest and Associates, twice per month for 4 months (Jan – Mar 2018). Malatest drew a random sample from the patient records. Sampling occurred from the "valid" sample (i.e., after exclusions).

To ensure the representativeness of the sample, a random sample of units with large discharge volumes, and a census sample of units with small discharge volumes were carried out.

The Tech Report will contain more details on Survey Methodology.

2 *Patient Notification*

Notification/invitation letters were sent to sampled patients within 1 week of receiving discharge records from the HAs, notifying patietns they have been selected to participate in a phone survey. The cover letter included a unique access code and URL for those who preferred to complete the survey online.

3 *Survey Administration*

Malatest surveyors conducted phone-based interviews (Computer-Assisted Telephone Interview (CAT)). Phone interviews used questionnaire scripts, prompts, and responses to FAQs.

4 *Data Collation*

Patients' survey responses were entered into a secure database and collated by the survey vendor. Aggregated results and reports are currently being developed and will be released in early 2019.

The Tech Report will contain details regarding the coding scheme for patient comments.

ANALYSIS & REPORTING

Survey Weights

What: A number value assigned to a participant's response that indicates how much "weight" should be given to the response relative to other responses.

Why: Large surveys often use sampling designs that result in disproportionate representation of the population.

When & How: Weighting should be done when pooling results from two groups (e.g., facilities) that are disproportionately represented. The ED 2018 weights provided have been computed based on facility volume. It is possible to also weight based on other factors (e.g., individual –level weights based on demographic factors). Consult with the **PCM weighting primer** for more info.

Refer to the Toolkit or Tech Report for more information about how weights were calculated.

Missing Data

What: A non-response to a planned observation in a survey.

Why: Missing data might occur when there are no data for a person (unit non-response) or when some answers for a respondent are unknown (item non-response). The reason for the missing data can be completely random, random, or not random.

When & How: Missing data should be dealt with whenever the aim of the analysis is to make an inference about a target population. If not dealt with, it could lead to biased estimates of population values. Potential ways of dealing with missing data include imputation techniques and alternative estimators. The key driver analysis computed with the ED 2018 data and the scoring of the VR-12 involved the use of multiple imputation. Consult with the **PCM missing data primer** for more info.

Reports

Provincial, subsector (including Aboriginal report), health authority, and facility level reports and storyboards will be created. All reports have at minimum 2 main sections: Key Findings and Frequency Tables. Unit-level reports also includ patient comments which are presented by content theme and valence.

Key Findings include: (a) global rating question scores; (b) key driver question scores [based on correlational analyses]; (c) top 10 top and bottom scoring questions; and (d) dimension scores.

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