

# ***The CAHPS Clinician & Group Survey: Update on Instrument Design, Implementation, and Comparative Data***

**June 23, 2009**

## **Presentation**

### **Introduction**

>> Greetings. And welcome. All participants are in a listen-only mode. If anyone should require operator assistance during the conference, press \*0 on your telephone keypad. It is now my pleasure to introduce your host, Carla Zema with the CAHPS User Network. Thank you, you may now begin.

>> Carla: Good afternoon and welcome to the CAHPS Clinician & Group, or C&G, Survey webcast, sponsored by AHRQ. This webcast will provide you with an update on instrument design and implementation as well as comparative data through the CAHPS Database. I am Carla Zema and I will be your moderator for the webcast, I'm with St. Vincent College and serve as a consultant to the CAHPS User Network. One of my privileges is to work with the CAHPS Instrument Development Team. Today you can listen to the webcast through streaming audio -- through your computer speakers -- or by telephone. If you experience any difficulties with streaming audio, please feel free to join us by phone at any time.

You may also experience a slight lag in the advance of the slides. This is dependent upon your computer speed and the type of Internet connection that you have.

As you may know CAHPS represents a family of surveys that asks consumers and patients about their experience with health care. The CAHPS surveys are about health care experiences at the ambulatory and facility level. At the ambulatory level, this includes not only medical groups and practices, but other ambulatory settings such as hospital outpatient clinics and public health clinics. While we did receive a few questions in advance of this webcast about our facility surveys, the focus of this webcast will be the ambulatory setting with the Clinician & Group Survey. Later on we'll provide you with information on how to join our Listserv so you can get notifications about future events that focus on this as well as our other surveys. We have a great lineup of speakers representing the CAHPS consortium as well as the CAHPS user.

Julie Brown is the lead for the RAND grantee team for the Instrument Development Team. She has been with the CAHPS Consortium 15 years and we are so grateful to have her with us today. She'll be updating us on the developments on the survey. There are exciting things going on since our last webcast in September.

Heather Britt is with us. Last September you heard from Michelle about the planned implementation of the visit-specific version of the Clinician & Group Survey in Minnesota through the Minnesota Community Measurement initiative. Heather is here today to share with you their experiences from the perspective of the medical groups, after having fielded the survey.

Michael Hornbostel is here to share with us the new Clinician and Group Database that will provide comparative data for this survey.

I have a couple housekeeping items. We've learned from our previous webcast that you really like and learn from our question and answer session at the end of the presentations and we love to hear from you. So we encourage you to submit your questions throughout the presentations. All you need to do is simply select questions from the navigation bar. You'll see a pop-up box and you type in your question in the text box and hit send. You also have the option to send your question in anonymously if you prefer. So again, send in your questions throughout the presentations and we'll address them all during the question and answer session. We love to hear from you so send in lots of questions and comments for us.

If you are unable to see the slides fully on your screen right now, you need to scroll to see the entire screen, this may be because you need to adjust your screen resolution and you can do that by adjusting your resolution to 1024 by 768. Each operating system is little different but you can do this by right-clicking on the desktop and selecting display modes or settings.

We hope you don't need us but if you need help during this webcast, you can select help on the upper right portion of your screen. If you're dialed into the telephone line to hear the audio, you can dial \*0. A common problem is not being able to hear the webcast through your computer speaker, so you can join us again by phone by dialing 1-877-445-9761 and entering 322108#.

Another common problem is having your computer freeze during the presentations. If you hit your F5 button this will refresh your screen and your Internet connection.

Remember that you may be experiencing a lag in the advancement of the slides due to your Internet connection speed. If that didn't work, you can try logging out and log back in to the webcast. If you need technical help and you're not dialed in, you can dial technical help, 1-866-490-5412. And if you have any problems you don't have to write all those numbers down. You'll see a series of tabs on your screen, that you can access all of the information that I just gave you.

So now let's hear from our speakers. First we have Julie Brown, again Julie is the lead on instrument development from the RAND grantee team and she brings 15 years of CAHPS experience to the team. And she's going to start by giving us a overview and update of the visit survey and this is the version of the Clinician &

Group Survey that focuses on the most recent visit but I'll turn it over to Julie Brown who will tell you all about it.

**CAHPS Clinician & Group Survey: An Overview**  
**Julie Brown, RAND**

>> Julie Brown: Thanks, Carla. Thank you for joining us; I appreciate this opportunity to give you an overview of the Clinician & Group Survey.

I want to start by telling you how the Clinician & Group Survey relates to other surveys. As Carla mentioned, our focus today is on the ambulatory care surveys. This is part of a suite of surveys designed to assess ambulatory care at several levels of delivery. We have surveys to assess consumer experience with health plans, dental plans, rural tribal health services, group practices or sites of care, individual clinicians or medical groups, and home health care agencies.

The ambulatory surveys and supporting materials for the survey administration are available in English as well as Spanish.

Like many other CAHPS surveys, it contains questions about topics or experiences for which the consumer is the best or only source of information. Survey questions include a specific reference period, for example, either the last 12 months or your most recent visit.

A CAHPS survey doesn't ask consumers about satisfaction. Instead, we ask consumers to report on their experience with care, using a never to always frequency scale. We also ask consumers to rate providers and to rate the care they receive, using a 0-10 rating scale.

How we provide a standardized measure: because it is a standardized survey, the Clinician & Group Survey promotes comparison. One may want to compare individual clinicians within a system of care, sites of care within or outside of a single system of care, or medical groups across systems of care. Such comparisons can be supported by the CAHPS Database, which you'll hear more about in this webcast.

The survey also supports trending; that is, reviewing performance of a specific clinician or group across different survey administrations.

Let me talk now about... you should be on the slide titled Clinician & Group Survey Starts with Core Measures. The basic building block of the Clinician & Group Survey is a set of items we call the core measures. There are 14 core measures which are organized into what we call composites. For the purposes of reporting, the composites group the items by topic. As you can see from the slide, there are survey questions on access, which are in the composite called getting appointments and health care when needed. Questions on interaction with clerks and receptionists in the office are in the composite called courteous and helpful office questions. (The

third topic is) how well doctors communicate. And of course the 0-10 rating of the doctor is a stand-alone item for the purposes of reporting.

To meet the operational and information needs of sponsors, we offer several survey tools you can use to collect the core survey measures. We have a survey with a 12-month reference period, with specific versions to assess adult primary care providers, adult specialist care, and child primary care providers. We have a survey that references a consumer's most recent visit, with a version to assess adult primary care.

Some of you may have attended our webcast last September in which we debuted a visit-specific version of the Clinician and Group Survey. Our current most recent visit version of the survey reflects further refinements of the survey we presented last September.

Specifically, the refinements to our recent visit survey version include asking consumers to report their experience in the last 12 months for some core measures, and their experience during their most recent visit for other core measures.

The decision to include both 12-month and most recent visit items into a single survey version was informed in part by a field test conducted by the Allina Health Care System. Heather Britt is here to share that experience with you. Heather?

**Reflections on Our Experience with the Visit-Specific Version of the Clinician & Group Survey**  
**Heather Britt, Allina**

>> Heather Britt: Thanks so much. I'm with the Center for Healthcare Innovation at Allina Hospitals and Clinics. We are the largest provider group in Minnesota and western Wisconsin and have had a fantastic time learning with the CAHPS team as we implemented measurement of patient experience statewide across our clinics and the clinics of lots of our peer medical groups.

I'm really delighted to be able to share with you what we've learned so far; I think we think of this as a journey and we are only partway there.

Next slide. I'm going to spend the next several minutes talking about three different aspects of our work to date. First, I'll talk about our experience in our statewide pilot test of the CAHPS Clinician & Group Visit-Specific Survey. Second, I'll share what we learned from our initial analysis of the special test that we did with the visit-specific version and the 12-month version. We did both of those surveys simultaneously in two of our largest clinics. And third, I'll close by discussing how the pilot test works, how what we've done fits with our current internal measurement work, and the strategy Allina has for how we'll be able to improve patient experience going forward. And I'm excited to hear the questions you'll have for me and other members of the panel as we get to the close of our session.

Allina Hospitals and Clinics is a large integrated provider group system. We have 11 hospitals and over 90 clinics in our system currently. We care for about a million and a half individuals across Minnesota and Wisconsin. The Allina Medical Clinic is our largest medical (practice with) 40 of our clinics; (it) employs a little over 500 clinicians, and about 300 of those clinicians are in primary care.

As an organization broadly, we're focused on measurement to drive change, and we have specific areas that we pay attention to and orient towards: care or really clinical outcomes; service, meaning patient and family experiences; people, a focus on employee engagement and turnover; finance, healthy financial positioning compared with our peers; and growth, so appropriately transitioning our in-patient services to outpatient areas, and really rethinking our approach to primary care.

Our mission is one of the biggest reasons why we were interested in participating in this pilot, the patient experience work, to begin with. We are invested in the continuum of the patient's journey with health, as well as the specific work that we can do to help support that journey and make that journey as optimal as possible.

I want to acknowledge all of the peer groups that we had in Minnesota. Allina was only one of the partners in this broader patient experience work. Eight other medical groups across the state worked extensively with us and a group known as Minnesota Community Measurement, a nonprofit organization, funded in Minnesota by the insurers or payer community, really designed to focus on publicly reporting health care quality and performance information. They have a special focus on ambulatory segments or clinic segments of health care and are driven by the Institute of Medicine's idea that health care should be safe, effective, patient-centered, timely, efficient and equitable. So they're doing a purposeful long-range plan and work towards making sure that they're making data available to consumers and to patients in each one of those six areas.

They have a website that's available to consumers, also available to provider groups and others to view performance on clinical and patient experience outcomes—really for a variety of clinics across Minnesota.

Our effort from the beginning of this work was to pilot the collection of patient experience data through medical groups, and report those results out at the clinic level. As Minnesota Community Measurement began this work in late 2006-early 2007, they really made a conscious decision to spend time talking with individuals from the payer community and individuals from medical groups, to really understand the landscape and the appetite for measuring patient experience across the state.

Minnesota Community Measurement was also focused on building on the current momentum existing in Minnesota around public reporting of clinic performance on clinical measures. Diabetes optimal care and vascular optimal care are two of the best examples.

And medical groups were really clear in their message back to Minnesota Community Measurement that whatever approach we employed needed to be flexible, allow for the use of either of our current vendors, for our current internal processes to be continued. The process must focus on producing data useful for quality improvement. So while we were interested in public reporting, we were equally as invested in internal quality improvement efforts. And finally, the broad community really wanted to understand what would potentially be the long-term implications and potential impacts of this course of work.

For a whole lot of discussion, a whole lot of collaborative partnership work, we actually decided to go with what we call a medical group model, so medical groups are responsible for owning the cost and the implementation for this work, as opposed to looking to payers to do that work for us.

Each participating medical group assigned at least one individual, if not several individuals, to join a patient experience workgroup with Minnesota Community Measurement as the facilitator.

This workgroup was charged with developing specifications for the process, implementing the process, and shepherding this reporting process afterwards.

The CAHPS Database team was asked to join the team as both a set of experts to help guide the discussion and inform us and to direct us, as well as to be a neutral aggregator of data both from the standpoint of helping us get our data in order for reporting, but also offering to us this opportunity to sort of get our hands on external benchmarks that the community here is really seeking and certainly the community nationwide is seeking.

Conversations around the instrument implemented needed to be useful and usable for the purpose of quality improvement and led to this creation of the visit-specific version. That instrument focuses on, as Julie alluded to before, what we call access questions, experience with the physician and experiences with the staff, and references the most recent visit.

A sampling frame that we used that was pulled is really this most recent three-month window of visits available to us for the purposes of doing the survey.

Our implementation across the medical groups was purposefully flexible, with our specifications written with sufficient enough detail that each medical group could take it to their own current patient experience vendor and that we could use it internally to drive our internal survey process. Or medical groups could contract with a central vendor, particularly for those groups that didn't have an existing ongoing patient experience measurement activity underway.

As you can see, our timeline extended really from the fall of 2007, when our workgroup started convening, to the spring of 2009, when reports were released and

we had reports -- now out live on the Minnesota Community Measurement site -- for consumers and providers to be able to take a look at and compare performance across clinics.

We learned a tremendous amount from the pilot study as all good pilot studies do, they instruct us, on both the benefits the work would afford us immediately and really down the road in the future, as well as the challenges that any patient experience measurement work and sort of strategic activity and specifically our methodology presented to us.

In the way of benefits, we learned first -- and I think this is something we all know intuitively, it's just more challenging I think sometimes in practice to put into play -- collaboration across groups leads to better outcomes. For us, it was a visit-specific tool that we could test and evaluate how well it offered us an opportunity for quality improvement based upon looking at those results.

Collaboration also led us to better learning; we began to understand really how our peers are using patient experience data, their internal culture around improvement and ways we could ultimately work together across medical groups to improve experiences for our communities of patients.

Flexibility was inherent in the process; it meant that more groups were initially willing to join into the pilot. It means everybody stayed until the end of the pilot, and Minnesota Community Measurement has a list of new groups who want to join for the 2010 fielding that we'll do for patient experience.

Including patient experience as part of the core measures included in public reporting for clinics is really, I think we ultimately believe, better for patients, especially since it serves as a comprehensible entry point into the world of public reporting and clinic selection. It's also for providers because we believe it's a concrete reminder that relationships, continuity and whole person knowledge are powerful predictors of outcomes and compliance.

In the way of challenges, we learned again a tremendous amount. Even though that time line seems long, when we look back at it, I think at every point throughout the process, we felt rather rushed. It seemed short, rapid, a whole lot more work than everyone conceptualized. Overwhelming to medical groups and particularly to our information systems folks, and other electronic health record folks internally who we had to rely upon for the purposes of selecting data sampling and those sorts of things.

Speaking of sampling, the approach that we use for sampling is more complicated than any of the medical groups are currently using for standing patient experience work. We did not de-duplicate across existing surveys, and I think we all faced some feedback from patients that was pretty frank about that. We'll likely aim for common

sampling approach in the future rather than expecting each group to do this in a way that's individual and unique.

Flexibility, while certainly a benefit, was a challenge because it meant that Minnesota Community Measurement was responsible for a substantial amount of quality control and review. I think a pilot means that deadlines are perceived as softer in the minds of the folks participating, as opposed to harder.

And letting each medical group decide to do sort of what it wanted with regard to implementation certainly multiplied the work for Minnesota Community Measurement and the CAHPS team broadly.

And for us, despite previous reporting experiences with clinical outcomes data, reporting patient experience at the clinical level was still challenging for us: lots of anxiety by the medical groups staff, about how they were going to be viewed and appear on this website, questions about what is the optimal presentation of that data, what's the optimal usability, both for consumers as well as for provider groups. And a real appreciation for the fact that we need to include consumers or patients really early in the process as we're thinking about reporting and sharing this information back.

And I think the end message ultimately for us is we're never done with this, it's a constant journey and we're sort of continuing to grow and to learn. So as Julie alluded to, one of the reasons I think why the ambulatory team nationally is making this transition to this instrument that has both a visit-specific aspect and a 12-month aspect, is a result of some of the testing that we were fortunate enough to be able to participate in.

So simultaneously to implementing that visit-specific survey, Allina implemented the 12-month Clinician & Group Survey in two clinics that are really large enough to have enough providers and enough of a patient volume to handle those two similarly drawn random samples. We wanted to understand how the two tools compared to each other, how they might differ in results and what we might learn by testing both at the same time. Again, as I said, we used similarly drawn samples, the same field period for both surveys -- and for the purposes of these two surveys, patients weren't surveyed twice. They got one or the other of these particular tools.

And the slide that you're seeing before you isn't meant to actually really show our results; it's meant to give you a sense for the direction that the results really were oriented. Results from the test of the two versions, the 12-month version and the visit-specific version, revealed that both instruments could show the variation across clinics, so we could see differences across these two different clinics that we were interested in examining.

Both instruments showed fairly similar patterns, so better performance in some areas, poorer performance in other areas.

And both highlighted that we needed to work really on the same core areas across these clinics, and I'll talk a little more about that in a moment.

Where the instruments differed was on the access questions, so our ability to get the kinds of appointments that we want when we need. The visit-specific version of the access questions was far less reliable than the 12-month version of the access questions.

The other areas of the survey, the questions about relationship and communication with doctor and communication with staff, the reliability was similar, so really this access area stood out as something that required attention and a little further understanding.

We reviewed these results, the patient experience workgroup of Minnesota Community Measurement. We sat down and tried to identify what might be an optimal solution to address the fact that medical groups are especially interested in quality improvement data that could be used sort of more real time to address behavior change and system support for patients experience. And I think sistering that with also wanting to measure, as reliably as possible, the sorts of things we were interested in measuring. So ultimately we decided that that the solution would be some sort of hybrid instrument. One that would focus on the 12-month time frame about the questions for access and would focus on the most recent visit for questions about the physician and about the staff.

We will field this hybrid instrument in May of 2010 when we do this survey again, across all the medical groups in Minnesota who are going to participate. We'll focus on visits by patient between January and March of next year and put the survey in the field in May.

As we debriefed from this first pilot test of measuring patient experience statewide in Minnesota we spent time responding to a survey that the Minnesota Community Measurement team put together in an effort to help us understand what the process was like, what everyone's experience was like and really what next steps would be. Some of the key take-aways from that survey are that -- and I think this is likely true for everyone across the country -- cost is a challenge that I think we'd underestimated. It's significant, and likely going to be a barrier over time in this work so we're just really trying to spend time thinking sort of thoughtfully and smart about how we're going to execute all of this going forward.

Whether or not to allow medical groups to continue forward with an internal process to collect data for public reporting is a challenge. We had lots of debates about this and we as a community have ultimately decided that we're uncomfortable with that. That folks will be expected to use really sort of a licensed certified vendor for this kind of work. There was a whole lot of strong support for this hybrid tool and an expectation that this would be the instrument we would be fielding going forward.

We talked about the kind of things we wanted to consider in the future: a Spanish version, a version for pediatrics, a version for specialists, something for non-physician providers. But I think we were trying to be reasonable about the number of changes that we were going to make between this year and next year. And for the purposes of what we're going to do in Minnesota, the only big change we're going to make is to include language about providers instead of physicians so that our instrument becomes a little more applicable to folks at mid-level versus solely those folks who are physicians.

We retained the option to include our own questions at the end of the survey sort of like the H-CAHPS models that lots of hospitals are incorporating across the country—so the ability for a group like Allina to add its Allina-only or special questions at the end of this instrument.

This is really critical to folks who want to make an ultimate transition to one instrument they're doing, not doing a couple of them. But still retaining some of those key questions that are important for their own internal trend lines they've been tracking for quite a while.

Integrating this measurement activity into internal measurement work already ongoing is something we all need to do. It's certainly possible, but I think we're finding that evolving, and that changing the machinery that is already up and running in large groups like the Allina Medical Clinic is a lot more challenging than what we thought.

As we consider the data that Allina received about its own performance on the visit-specific survey, we began to reflect on how this information aligned with what we knew from our internal survey process already, as well as how it highlighted new areas we needed to focus on. And actually, frankly think our physicians were excited to see some new things they could begin to sort of bite off and begin to do some work around.

Our results reinforced the fact we're strong at physician communication. This has been a core focus of the Allina Medical Clinic and we believe the results from the visit-specific survey are really additional validation of our method of giving feedback to physicians.

So the Allina Medical Clinic approach is to really meet with physicians throughout the year, share patient experience data with them at least quarterly, and ensure that leader physicians and opinion leader physicians in clinics have personal relationships with each of their fellow clinicians in a clinic, and really pay attention to patient experience as an important outcome that we are invested in measuring, understanding and doing better around.

Our results called attention to the fact that our work around access -- open access really -- what we've been investing in while promising still hasn't yielded the exceptional performance we'd hoped for. We've begun to understand that our efforts to implement open access still have to be extended. We also didn't perform nearly as well on staff communications as we'd hoped. And we had some signals from this, from the current kind of clinic organization questions that we have on our internal survey that we're sort of constantly fielding.

So the visit-specific survey data around staff communications offers us a really specific set of data to use in action with our staff. And it's something that we really were lacking prior to this work.

Quality and performance improvement is a major emphasis at Allina as it is at most large health care institutions across the country. We have a special focus on improvement in the key that we mention so the care initiative, employee engagement, financial health and appropriate growth. For Allina Medical Clinic, the leadership team uses a specific what they call formula to implement improvement efforts. First they really aim to understand the basic science so they look to the peer reviewed literature, those folks who have extensive experience in an area of interest, to inform what our approach should be.

So we spent a lot of time taking a look particularly for patient experience at the literature that talks about building relationships, trust, whole person knowledge, and making it possible so that patients can see their preferred regular provider at any point along their care journey.

Second, we strive to thoughtfully design the systems that will support improvements in quality. So really thinking about how are we going to design those reporting systems, the personnel systems, disease registries, the scheduling systems, so taking the time to carefully craft those systems so that they are appropriately supportive of initiatives. Then we focus on process improvement, internally we induce the -- for health care improvement for, and plan cycle part of that approach.

We actually expect that every one of our clinic managers is engaging in this sort of behavior and activity and improvement work on a fairly constant and ongoing basis.

Finally, and I think it has taken us a while to understand, but we fully appreciate the importance of engaging our front line clinicians and staff in changes, as well as the value of leadership, the Allina Medical Clinic team, in creating a platform for change and investment and improvement over time.

We're now considering how to evolve both measurements around patient experience as well as the strategies it employs to improve patient experience. So we're taking a look at the amount of data we generate for patient experience. We have internal reports that are available monthly for clinics and quarterly for providers.

We're asking ourselves: Is this data overload, especially at the clinic level? What's the minimum count of responses that are helpful for action and decision making? And at what intervals?

We'll participate in the use of the hybrid survey tool in early 2010 and then consider how to integrate this tool with our current internal process so that we're not surveying twice to obtain similar information.

And as I alluded to before, we're likely adding questions important to us for trending purposes onto the back end of that Clinician & Group Survey.

We'll also take advantage of the increasing amount of external benchmark data that will be available in our state as well as across the country. In particular, to help our highest performing clinics continue to strive. We're a large enough group that we have a fairly substantial amount of variability across our 40-plus clinics.

But especially for those clinics that are our top performers, they're interested in knowing how folks are doing outside of the Allina Medical Clinic, both within the state of Minnesota as well as across the country, and how they might continually strive for better performance.

To call attention to new issues that have been highlighted for us at the Clinician & Group Survey, we're going to use this public reporting -- so everything is out on the website -- as what we call internal burning platform and call-to action that will allow us to renew our efforts towards addressing open access and addressing staff communication.

And we have begun a focus on the support we offer outside the clinic visit--so after-visit summaries, additional support for self-management, specific plans for transitions out of the hospital, including nurse calls, measures reconciliation, immediate follow-up visits in the clinics. So we're really trying to think about beyond those frankly few moments that a provider and a patient have with each other; what other supports do we need to be offering?

And as I said, we'll continue our efforts towards full open access for our patients both to a regular clinician and ultimately to the entire electronic health record. We're also attempting to integrate agenda setting tools into the electronic communication and other interaction we have with patients prior to visits and following visits so that we're really closing the loop with providers and patients in a way that is thoughtful.

At Allina, exceptional performance around quality measurements is an expectation. It's actually not something that is part of our internal compensation model, so we find that healthy challenging of clinicians and staff as well as healthy peer pressure coupled with an understanding that our work is about providing the best care for patients results in the kind of improvement we hope for.

Our participation in the Minnesota pilot test around patient experience has taught us a number of lessons that we'll internally use and use for patient benefit.

That's it for me, thanks so much, and I think it's time for me to hand it back over to Julie.

**CAHPS Clinician & Group Survey: New Survey Developments**  
**Julie Brown, RAND**

>> Julie Brown: Thanks, Heather. That was really interesting and I see there are lots of questions.

I want to remind participants that as Carla mentioned we're going to have a Q&A session following Mike's presentation. I've come back on to follow up my overview with a summary of new developments in the CAHPS Clinician & Group Survey. First slide, please.

One of the new developments I want to share with you is that we are developing what we call a provider neutral version of the Clinician & Group Survey. As I mentioned in my earlier overview, the core measures can be fielded with a 12-month reference or can include a reference to the consumer's most recent visit. In addition, our focus to date has been on assessing the care provided by physicians, that is primary care providers and specialists.

However, the Ambulatory CAHPS team is currently developing a core survey tool to assess experience with a broader range of primary care providers—a range that includes nurse practitioners and physician assistants. If testing goes well, this may result in a provider neutral survey tool to assess any type of primary care provider.

We're working to begin qualitative testing of the survey and anticipate having a beta instrument available in English and in Spanish by the end of this year. But I promise we'll keep you posted on our progress.

Hopefully, I've made it clear that the Clinician & Group Survey consists of core measures that remain constant across any version of the survey. But because needs and systems of care may vary, we have a pool of survey questions that you can shop to identify survey questions to supplement the core measures. We call these supplemental items.

As you can see on the slide, there's quite a range of topics available in the supplemental items. The CAHPS goal in providing you with supplemental items was (a) to share items that cover topics that are important to consumers and sponsors, and (b) to share items that have had some level of qualitative and quantitative testing and that have met a minimum standard in our psychometric analyses.

Unlike core measures that are relevant to the experience of all consumers, supplemental items may only apply to a subset of consumers, such as consumers

who use translation services, or consumers who are faced with decisions or options for treatment.

Supplemental items can also provide more detailed or drill-down information to support quality improvement efforts. One way to think about it is that the core measures promote standardization and the supplemental items allow for customization.

The survey and reporting kit for the Clinician & Group Survey contains information on the placement and use of the supplemental items.

We develop and test additional supplemental items to address changes in the health care delivery system, to foster improvement in measuring patient-centered care or to meet additional information needs of the CAHPS user community.

We have three sets of supplemental items for the Clinician & Group Survey under construction and I'm going to preview them for you.

The first set of new supplemental items covers health literacy. The goal or purpose of this effort was to develop, test and deliver survey questions that assess consumer perspectives on how well the health professional they encounter communicates health information. A consumer's ability to understand and act upon the health information he or she receives can have a direct impact on health outcome.

As you might expect, the supplemental items on health literacy assess specific types of communication. The items expand the core measures on patient-provider interaction; the supplemental set also includes communication about health problems or concerns, measures of disease self-management, communication about medications, communication about test results, and communication about forms that are filled out.

The supplemental items on health literacy were recently field tested and analysis of that data is ongoing, as is refinement of the measures. You can expect public release of this item via the AHRQ CAHPS website in fall 2009.

The second set of new supplemental items is called patient assessment of cultural competency. You may have seen presentations on these items at the December 2008 User Group Meeting.

Funded in part by the Commonwealth Fund, the goal of this effort was to develop items that measured the consumer's assessment of the cultural competence of the care they received. Culturally competent care is defined as care that is responsive to diversity and factors such as language, beliefs, attitude and behaviors that affect health and health care. It is an important component of the delivery of patient-centered care.

The supplemental items on cultural competency also expand core measures on patient-provider interaction and assess oral communication between the patient and provider, preventive care, use of alternative medicine, equitable treatment, trust in the provider, and language barriers.

As with health literacy, the supplemental items on cultural competency have been field tested and refinement of the measures is ongoing and should be completed by the end of the calendar year. We anticipate public release of the items via the CAHPS website in 2010.

Turning now to the third set of supplemental items, the Health Information Technology Item Set. This item set focuses on consumer experience with health information technology. Specifically, health information technology encountered as consumers seek access to, and use health care.

I think we can all agree that health information technology or HIT is a major issue on the national agenda. As HIT rolls out across ambulatory delivery care systems, it is important to assess how it affects consumers' experience of care.

The supplemental items on HIT introduce some new topics to the CAHPS Clinician & Group Survey: patients access to and use of online personal health information, e-mail communication or web messaging with providers or medical offices, experience with electronic prescribing and physician use of a computer during an office visit.

In terms of the timeline for release of this item set, the HIT team has identified several partners to participate in field testing this fall. We expect analysis of that data and the resulting refinement to the supplemental measures to continue into next year.

Based on that timeline, we anticipate public release of this item set via the CAHPS website in summer of 2010.

Thanks again for giving me this opportunity to share our new developments for the CAHPS Clinician & Group Survey.

**Introduction for Michael Hornbostel**  
**Carla Zema, Moderator**

>> Thanks so much Julie. As you heard from Heather and as we hear from a lot of our users, many of our users are really interested in comparison data for benchmarking purposes. And so Michael Hornbostel will now tell us about the CAHPS Database.

**Participating in the Clinician & Group Component of the CAHPS Database**  
**Michael Hornbostel, Westat**

>> Michael Hornbostel: Thank you, Carla. Hello, my name is Michael Hornbostel and I'm the Clinician & Group Manager for the CAHPS Database at Westat. Today I'm presenting an overview about participating in the Clinician & Group component of the CAHPS Database.

The CAHPS Database has been a national repository of data from the CAHPS family of surveys. The two applications of the CAHPS Database are benchmarking and research to evaluate health system performance and support quality improvement research on consumers' quality.

This project and its products are funded by AHRQ, and administered by Westat through the CAHPS User Network.

For those participating who are not participating with the CAHPS Database, and the components we support, they include health plan, hospital and now clinician and group surveys. Since 1998, the CAHPS Health Plan Survey Database has collected 3.4 million records and created 11 Annual Chartbooks. Since 2006, the CAHPS Hospital Survey Database has received almost a million records and created three Annual Chartbooks.

Currently, we intend on the CAHPS Clinician & Group Survey Database being as large as the others.

Some of the products are the Online Reporting System, Annual Chartbooks, customized sponsor reports, research files, as well as support to AHRQ's National Healthcare Disparities and Quality Report. And we also have created some special analyses and reports.

The Clinician & Group Database is being developed in response to user demand. We've been working with key organizations to provide guidance and to receive feedback. Some of those organizations include survey vendors, health plans and medical groups, Aligning Forces for Quality and national medical boards, and many more.

Our goal is to support clinician and group versions and users with standardized submission specifications.

There are many benefits to participating; all the products and services are free, and participation is open to all survey users. The public has access to comparative results through the Online Reporting System, while users who participate get more. I'll explain more on that in a minute.

There are a variety of ways that the CAHPS Database supports participants. We have data submissions specifications, an online data submissions system, our

custom analysis and reports and the User Network, as well as, our e-mail and phone technical support.

About the Online Reporting System I mentioned before, the CAHPS Health Plan, Hospital, and Clinician & Group Surveys will all be supported in the Online Reporting System. There's a public portal available for everyone with summary level data, similar to the Chartbooks.

Participants receive password-protected portal access that display results compared to summary level data.

Some of the Clinician & Group comparative data we plan to report includes survey type, such as 12-month versus visit-specific population, adult, pediatric, geographic location, physician specialty, size of group or practice, ownership and affiliation of group or practice. Then all products of the CAHPS Database protect the identity of the participant. No entity can be identified through the Online Reporting System.

Here you will see a sample of the Online Reporting System's public portal—available to everyone with summary level data, similar to the Chartbooks.

The comparative data will display individual items, as well as composites. All the comparative data in the Online Reporting System can be downloaded into Excel files or printed.

The next image is the same report; however, highlighted in red, it displays the participant's results which can be accessed through the password-protected portal. Organizations that participate will receive this password-protected portal.

Voluntarily submitting data to the CAHPS Database is a simple process that involves six steps: register an account, sign and fax the data use agreement, submit a questionnaire, upload data files, and you'll receive final approval by e-mail. We'll be testing the system in July with volunteers; then in September, we plan to open the system to the public. Data submissions will be accepted on a rolling basis. Data can be submitted within certain dates which fall into one reporting period or another. The Clinician & Group Database will be updated routinely, segmented by calendar year. Please visit the Online Reporting System through the address provided, and select comparative data.

Currently, the plan data is available but Hospital and Clinician & Group will follow later this year. Please contact us with any questions you might have about Clinician & Group and the CAHPS Database. Remember our technical support is a free resource to all organizations. Below is our e-mail address and phone number. Anyone interested participating in the CAHPS Database, please provide your name and e-mail address and we will be contacting you.

I'll turn it over to Carla. Thank you.

## **Question and Answer Session**

>> Carla: It's really exciting to see that database coming together. I know we've seen a lot of interest in it.

Okay, at this time we're going to open it up for questions and answers. We've received a lot of great questions, so we're looking forward to a great dialogue with our panel. Remember, if you have a question to submit, select "Questions" from the upper right portion of your screen.

After the webcast, we will have an audio recording as well as a written transcript of the webcast on the website. The presenter slides are already available on the website currently.

Before we get started in the question and answer session, I wanted to let you know of a couple of upcoming events. We have two webcasts scheduled for this fall, one is going to be on the topic of how physician practices are using their CAHPS Clinician & Group Survey data results to improve their performance, to focus on quality improvement. And then another webcast that's going to look at alternative scoring approaches for the CAHPS Clinician & Group Survey, as well as kind of how that data are reported.

Finally, our next User Group Meeting, which will be our 12th National CAHPS User Group Meeting, will be held from April 19-21 next year, and that will be held in Baltimore, Maryland.

So please save the date. There's always a lot of great information about all of our surveys and research at those conferences.

If you are interested in joining our Listserv to receive information, you can do so by going to the AHRQ website and get there by [www.cahps.ahrq.gov](http://www.cahps.ahrq.gov) and in the upper right corner you will see e-mail updates. Click on that and you'll be able to sign up for specific CAHPS e-mails, whether focusing on the database or if you want product updates, you can sign up to get those specific updates.

I want to just let everybody know that we also have Janice Ricketts, the CAHPS Database Manager for Westat who works with Mike, and is available to answer questions as well. So we may be hearing from Janice as well as Mike and Julie and Heather.

So the first question I have, I'm going to ask Heather to comment from the perspective of what was done in Minnesota and then ask Julie to respond in terms of generally the direction that CAHPS is going.

The question is with regard to the visit-specific survey, was the survey sent based on a specific visit that was identified for the respondent, or was the respondent sent a survey and asked to respond thinking of their most recent visit?

>> Heather Britt: We actually had them sort of target a specific visit. So we had sort of alluded to that, you had a recent visit on this date with this particular provider. So the -- but I'll let Julie comment on what the new version looks like.

>> Julie Brown: Sure. Just want to reinforce what Heather said, which was that the version that was field tested referenced a specific doctor, and then it also referenced a specific visit. Going forward, the version that we're going to continue to test, still references the specific doctor—that is, it asks you about the care you received from Dr. Jones, because it includes items that ask about your experience with Dr. Jones in the last 12 months, as well as your experience with Dr. Jones on your most recent visit. We don't reference a specific visit date. We realize that can be confusing, but the reason or rationale is because we're asking the patient to report on two different periods of time, and don't want to introduce a third more complex cognitive issue to that interaction.

>> Moderator: Heather, as you mentioned, collaboration, things are better when we collaborate, so thank you both for chiming in on that answer.

And I may ask you both to come in on this one but we'll start again with Heather. Can you comment a little bit more about the access questions and what -- how you evaluate, what you learned and how you decided that the 12-month was better for the access questions?

>> Heather: I think sort of a couple things. You know, that suite of questions asks about a number of different kind of types of visits that are -- or access needs that a patient might have.

And I think we, frankly from a practical standpoint, found when we were asking patients about access, really as it related to a specific visit, they didn't have a big enough window of time to have had all of the different kinds of experiences we would be looking for. So they didn't have a need for acute urgent care, as well as lab results, as well as additional sorts of things during that sort of short time period.

And when we compared its reliability and performance up against that 12-month instrument, clearly the 12-month instrument in that particular space performed better. It also just offers patients in general a broader landscape to look back across. Yes, I've had experiences calling my providers' office about certain things or have had questions or urgent needs or chronic care needs, those sorts of things. Much more likely they've had that variety across a year than having had it just within a small window of time.

So those are at least the two big things we were thinking about and looking at as we started to try to unpack this and think about, you know, we like visit-specific particularly from a QI standpoint internally. But there's a space where it really kind of falls apart and really isn't performing as optimally as we would like to see it.

>> Julie: Carla, I'd like to add to that, if I may.

>> Moderator: Absolutely.

>> Julie: I think from the CAHPS perspective, our primary goal in developing the Clinician & Group Survey was to give the user community tools that they could use to promote assessment or discrimination between specific units -- in this case, an individual clinician or site of care. One of the challenges in developing and testing a visit-based survey was that the existing access questions we had didn't promote that level of discrimination at a level of reliability that made us comfortable. That's not to say you can't measure access issues around a specific visit, it means to say that our core access measures just aren't appropriate to be assessed at the visit-specific level.

And I hope I said that in a way that makes it clearer and not more confusing.

>> Moderator: Great. If anyone still has questions in that area, because we received multiple questions in that area, please feel free to send them in and ask for clarification.

I have a question for Mike or Janice. We have a participant that's working to implement the medical home model and they're looking at implementing the CAHPS survey for their providers. Do you know how many physicians or practices are currently using the C&G Survey?

>> Mike: What we've received is hundreds if not thousands. We've been in contact with a lot of different organizations. I don't have any particular numbers in front of me, but if you want to e-mail me we could give you an idea of roughly how many organizations are using this.

>> Moderator: Great. Julie, we have a question from the same respondent asking if they can use some of the questions from the CAHPS surveys and still be compared with other practices.

>> Julie: Okay. I think I saw a couple of questions. First off, I want to make something very clear. The reason we have a core set of measures is to promote benchmarking, standardization and trending. In order to be considered a CAHPS survey you have to field the core measures. Now, we have the supplemental items and those allow you to customize your survey or drill down or assess experience with an aspect of care you feel is important within your organization. My understanding of the benchmarking database and I'm happy to have Mike or Janice

correct me, is that they don't benchmark the supplemental items because there's just not a sufficient use or pool of users who field it in a group or Clinician & Group Survey.

>> Mike: This is Mike, and that is correct. At the moment we're not sure what supplemental items will be used widely. Once we start collecting the Clinician & Group instruments and we have an idea of what items are more widely used we could possibly implement supplemental items into the database.

>> Julie: And I think one caveat I'd like to add to what I said or one clarification, is that I realize there may be some confusion because I've mentioned so many different versions, 12-month adult primary care specialist, most recent adult primary care. The common unit that promotes standardization across those tools is the core measures. The core remains consistent across any CAHPS Clinician & Group Survey.

>> Moderator: Great. Heather, can you talk a little bit more about how the survey was deployed? For example, was it a mailed survey, web survey, did you hand it out and what response rates you got within Allina and any best practices that you learned in terms of how to improve those return rates?

>> Heather: Let's see, we did a mailed survey. It was two-wave mailing which is our standard process. What we didn't include was a sort of postcard as kind of an additional reminder. We just did the standard two-wave mailing, so for folks who had returned that survey after the first invitation, they weren't asked again to send that survey back in.

Response rates, I believe we were at about a 35% response rate. And I think that varied anywhere from 25, 27 up to even high 30s, low 40s depending upon the group that you're looking at across the state.

Best practices...you know, I think for us, a few of the learnings, quality control would be on that list as much as possible from the electronic health record. Most folks in Minnesota now have VHRs and using that data stream to source this. So making sure it's as valid as possible and depose through sort of the standard checking for valid addresses and those sorts of things. This two-wave mailing is something that we've used pretty regularly as a broad community. I think patients are accustomed to that sort of interaction and expectation.

You know, I think beyond that, and beyond again the sort of community being well trained, as it were, to anticipate that they're going to get these sorts of surveys and there will be this kind of mantra, I think those are the big pieces. We got feedback with the cover letter which was a standard cover letter all medical groups used that we'll probably do modification of next year. And I think our biggest learning this time around, we didn't de-duplicate across patients who might have been getting surveys from our existing processes, none of our medical groups did that. And we certainly

heard back from folks that in the future we need to straighten that out and clean that up. As a community we're trying to honor this idea that we need to step back from over-surveying as much as possible, and really need to do some concrete things to sort of appreciate the burden we're putting on patients and families.

>> Moderator: Great. And then similarly, can you talk about how the data are going to be reported. For example, is it focusing at the clinic level, the provider level, and what report format are you planning? And if you could comment both from the perspective of what you're doing within Allina, and then what the larger Minnesota Community Measurement initiative is, in terms of reporting the data—if you're doing something different.

>> Heather: Yeah, I think I'll sort of speak about Allina a little differently, just so folks get a sense of how we currently report on the internal survey process here. The clinic staff actually receive a monthly report about how their clinic is doing that actually trends key questions back over time. And then providers actually see reports about themselves on a quarterly basis. But we've, you know, the sort of internal survey team here has a focus on really trying to make sure it has geared the volume and counts and that certainly process them in a certain way that is valuable at both a provider level and clinic level.

As I alluded to, I think there's lots of conversation here about that perhaps being too much data, and thinking about how to step back from that space.

We made data available at the clinic level to the leadership within the Allina Medical Clinic, as it relates to performance on our particular pilot test with Minnesota Community Measurement; folks were able to see clinic by clinic how do folks perform on every question as well as the composites.

The external reporting, so what's literally available on the Minnesota Community Measurement website for anybody to go take a look at, focuses on a subset of things. So there are three main composites as well as the zero to 10 questions. There are four different essential items or displays that show up, so providers and individuals are able to go in and sort literally by clinic for each one of those individual sort of composites or that 0-10 question.

We report only at the clinic level externally. The survey in fact was not geared towards, and our pilot experience is not oriented towards, doing a provider level analysis. I think in 2010, and as we evolve going forward, that will be a big question for us as a community—is how quickly do we want to get to that place, because I think we will ultimately get there but I think it will be a question of how fast and how resource intensive is that going to be.

But it's interesting, Minnesota Community Measurement did some consumer engagement testing with what their one display looked like to get a sense of what's too much information, what's too little. And so literally when you go to that website

you'll see places where clinics performed above kind of the average, and then you'll see the average and folks below average in one broad bucket so you'll only see two different colors that differentiate performance.

So I think we learned a lot just in that sort of consumer testing period alone about what might be the most appropriate way to show this across four different sorts of measures, without overwhelming folks who are trying to get some pretty basic information about patients' experiences in all these different clinics.

>> Moderator: Great, thank you. I'm going to move back to survey mode because we've had several questions and I'm going to ask Julie to comment initially and Heather if you'd like to add anything in terms of initial discussions that you might have had in Minnesota as well, but there's always questions on this. I know CAHPS has traditionally recommended a mail survey or telephone or combination. But everyone's really talking about online or web-based survey modes, as well as can you hand it out in the office.

Both from the perspective of concerns about young adults who may not complete paper or phone surveys anymore, lots of cell phones, as well as a way to address the cost of administration.

>> Julie: Okay, do you want me to go first?

>> Moderator: Sure.

>> Julie: This is a topic that's very near and dear to my heart, so thank you for asking about online surveys. Let me begin by saying the formal mode of administration that have been tested and that we have that are covering in the Survey and Reporting Kit are mail, mail with phone follow-up, and telephone.

Like many of you, we, you know, track and are aware of the growing number of web-based surveys. And it is a mode that we would very much like to implement if and when it's appropriate for us in the CAHPS setting. And we'll be exploring web and field testing for the Health Information Technology Item Set and there've been other field testing that's occurred and we've been tracking those results.

I think there are a couple of barriers to implementation of CAHPS in a web-based mode.

One is penetration of Internet use. We certainly understand that the number of households with land lines is falling but unfortunately the number of households with Internet access is still is not as prevalent as we need it to be.

A second barrier is having a sample frame that is a source of contact information that includes e-mail address. Because inviting participants to take part in a web-

based survey via e-mail invitation usually involves a much better response rate than sending them such an invitation through mail.

Third is really identifying the population for which it's the most or right appropriate mode of the survey. And I still think that while we have some lessons to learn from the upcoming Health Information Technology Item Set, I do think we'll have to give careful and thoughtful consideration to how to implement this mode if it's a mode that we're able to implement going forward.

>> Heather: This is Heather. I think in Minnesota we've begun to have conversations about this, but I think we'd love to get there. And I think we have some medical groups that are doing a better job than others and really accumulating, for their patient population, a great, healthy set of e-mail addresses that are valid going forward.

Wouldn't say we're in that territory yet. We certainly have some saturation and uptick of folks engaging with electronic health record, access our EHR, but it's not nearly the level that we would expect. And I think we'd want a better connection to our patients electronically before we as a broad provider group were comfortable with that transition. With that said, I know that after we field again in 2010, it will be like an active question for the Minnesota community to think about when it's ready to ultimately make that transition.

>> Moderator: Great, thank you. Mike, what kinds of selected benchmarks are going to be available through the CAHPS database for individuals to access that don't have the...that haven't submitted data, so they can't get into the password-protected side. What's going to be available publicly?

>> Mike: At the moment we're planning national benchmarks, regional benchmarks, and some sort of specialty benchmarks. It all depends upon how much data we get and where it's spread across that we can report that type of data.

>> Moderator: Okay, and on the specialty side, are you planning on reporting the data by specialty?

>> Mike: That's our hope. We would like to report by specialty data. Again, it depends upon how much data we receive for each specialty reported to us.

>> Moderator: Great. Heather, do you have a large percentage of no-shows in your clinics and how do you deal with open-access scheduling?

>> Heather: This is going to be a much better question for our medical director for quality, who I hope will be able to participate in the fall CAHPS call.

I think, I'm not an expert so I'm only going to say a couple of things about open access—I think the system has been really purposeful in making sure that where it

could, it got patients in to see the clinicians that were their regular provider. So you were matched with your PCP, who you should be matched with.

So that's really one of those sort of platforms and pillars and that means doing a couple of things, hold aside a portion of appointments, for folks at any given moment so having some booked and some that are really open for immediate access for those patients.

With regard to no-shows, I don't know what the percentage or the volume is like for our system. So it's certainly an issue as it relates to the survey work we look for appointments that were sort of closed or that were completed in order to make sure we're not just grabbing anybody who happened to be on the schedule. But from an open access standpoint, I don't know what that volume looks like. I apologize, I'm certainly happy to take that question by e-mail back to our VP for quality and dig in and find out.

>> Moderator: Great, thank you.

I'm going to put this question to Julie first, and then ask Mike to comment with respect to the CAHPS Database.

There seems to be a little bit of confusion, there's a lot of different C&G versions now, survey versions, and are we working towards one standard version, like there's a hospital survey? And if not, how does the comparison work when you're looking across multiple survey versions?

>> Julie: Thanks, Carla. I think, as I hope I made clear, the common element to any version of the Clinician & Group Survey is the core. The core is the set of measures that really make a Clinician & Group Survey and they're the same in any Clinician & Group Survey—the meat of the survey that's going to allow for benchmarking, whether you're fielding the adult specialist care version, versus the child primary care version, versus the adult primary care version. The core measures that will allow comparisons of physicians within a system or of clinics across systems, or at the national level.

In a perfect world, there might be, you know, one flavor of a CAHPS Clinician & Group Survey. And I can't say over the next several years that one version may emerge as the dominant version. But right now, the needs of the user community are so broad that we have multiple versions to address all of those needs which may be unique to a specific clinic or may be unique to a system of care, or may be unique to the information needs of a specific payer.

And I think we're hesitant at this point to withdraw a version and kind of, you know, remove a tool that is still of use to a specific sponsor or user.

>> Mike: This is Mike. We plan on supporting any version of Clinician & Group that becomes available and we'll report any data that we collect on any version for Clinician & Group.

>> Janice: Carla, this is Janice and I'd like to add to Mike's comment.

>> Moderator: That would be great.

>> Janice: As we do with reporting health plan data, we report that separately by population type with regards to Medicaid and commercial, and we do report those separately. For C&G, we are looking at analyzing and reporting the visit-specific survey data separately from the 12-month reference survey. And we'll report those separately as we would also for adult data versus child data.

>> Moderator: Great, thank you.

>> This question is for Julie. The participant was so pleased to hear that Allina was considering including pediatrics and specialty as a visit questionnaire as well, and the question is, how soon is the CAHPS consortium going to support visit surveys of those versions of the survey?

>>Julie: I think the question is about other versions of the most recent visit survey.

>> Moderator: Correct.

>> Julie: Pediatric and a specialist version. I repeat that only because I think my headset cut out for a moment.

We have talked about creating a child version of the visit, most recent visit survey. There are some challenges around pediatric care that don't make that a simple translation and it is on our big list of issues to explore within the team.

As well as the issue of specialty care. I wish I could give you a definitive answer and say those tools are coming and they'll be released by this day. But unfortunately, I can't. We have to limit to what we can do given the scope and funding of the CAHPS3 Consortium. So we're balancing other priorities and we'll certainly work as hard as we can to have those percolate to the top. But for right now, they're still in the hopper, you know, waiting to see how we can address them.

>> And I'd like to add from the User Network perspective, in the same way that we have worked through the technical assistance line with many users on the idea of the provider version of this survey before we were able to officially do that through the instrumentation development team, we will work with you to help you try to meet those needs in the best way that we can through the technical assistance portion of the User Network.

Moderator: And Julie, of course, was talking about an official version being released from the instrument development team.

>> Great. I'm going to throw this question out for Heather and then ask anyone else on the panel to comment.

We received several questions related to quality improvement and there always is kind of the two camps of thought in terms of one that says you really can do better quality improvement with the visit questionnaire, versus others that kind of say well, you know what, we need to look at things over time and so the 12-month version is really better and so can you talk about, Heather, how you look at it from a quality improvement standpoint and some of the issues that—or benefits of using the various versions for quality improvement?

>> Heather: Yeah, I mean I think I'll start with the caveat that we're just starting that work using this instrument internally, both at Allina as well as across the other medical groups in Minnesota than participated in the pilot. It was a key point of decision making when we first started this work two years ago. Almost two and a half years ago, Minnesota Community Measurement started conversations with the provider community about the idea that they wanted to add experience to their suite of measures that they were interested in examining. And in those one-on-one questions, both with medical groups and insurers, I think they heard the message repeatedly that anything that was going to be something that was sort of annually publicly reported also had to fit with this current milieu of internally doing quality improvement and aiming to do that in a relatively rapid cycle so we had to find the space in the middle of all of this.

So I think that literally, Minnesota Community Measurement thought, I think, that we would just do the 12-month and that would be it. And certainly our chief medical officer for the Allina medical clinic was one of the folks who really stood up and said you know what, it's got to fit internally with QI, and for that, that means the most recent visit orientation we as a system internally had been fielding. And our internal survey currently is a visit-specific version. So for us it would have been extremely difficult, I think, for folks to hear a message that wasn't as it relates to doing action around patient experience. So we were one of the folks who sort of pushed but I think the sense was broadly the community was engaged enough in quality improvement and culture shift work here that it wanted to sort of think about QI.

With that said, now that we're on the other side of this there were some medical groups and probably still are some medical groups who have clinicians and providers who feel the 12-month version would be more helpful. I think your VP for quality would say there are challenges when they sit down with the clinician, in a one-on-one conversation about here's how you did, or when they take them to a staff from a clinic about here's how you did. They want to be able to do that with a recent context for folks.

And that they get a lot of pushback that context isn't recent. So for us it's been a platform, it's been something that folks will attend to, that are sort of satiated by and able to engage in the quality improvement work and hear the message and begin to do the work and really expect that particularly for the medical groups like us who do this work ongoing, it's a continuous fashion, both quality improvement work and the measurement, they'll be able to see more change frequently. I think we're all comfortable with the idea that public reporting is something that certainly on an annual basis is probably more than enough. But that internal piece is something that was really important to us. So I think it allows folks to hear the message in a way that I'm not so sure, at least we would be as our own medical group convinced that they could otherwise hear.

So I hope that helped.

>> Moderator: That's great. Anyone else want to add to that? Again, that's something that we hear a lot from users and we typically hear both sides, similarly to what you were challenged with, Heather. So it's an ongoing discussion.

I wanted to at least address -- I know we've had several questions and we always field questions through the technical assistance line about whether CMS or any other entity is going to require the use of the Clinician & Group Survey for pay-for-reporting initiatives. CMS has several initiatives linked to a CAHPS survey, for example at the hospital level.

We work closely with CMS, they are certainly part of the CAHPS Consortium, but we obviously don't make any of the policy decisions and so that really is a question for CMS, but since we got it so many times I wanted to really address that.

We provide the survey and the survey development and the research and survey development side of that work, but the policy decisions do come from CMS and so that's a question that would need to be answered by CMS.

Heather, how often, or will you plan on administering the survey?

>> Heather: I think that's still something that the broad community with Minnesota Community Measurement is trying to figure out. Internally, so the internal survey that the Allina Medical Clinic is doing--it essentially fields a continuous basis. So every week they're pulling data for the purpose of surveying.

But this broad, we deal with Minnesota Community Measurement for public reporting on the website, you know, I think we'll do it again in sort of essentially put it in the field of May of 2010 so we did this last fall, do it again then, so we're on about an every other year schedule, it looks like. I imagine ultimately that will be an annual event in part because I think medical groups here will sort of finally, you know, if not now, in relatively immediate future, make a decision about using this instrument as what they field internally and a portion of that data they'll sort of share out for public

reporting. So we'll likely have access to a rather ongoing continuous data stream. But I think we'll put out news—a position of sharing at least once annually, a quarter's worth of that data.

>> Moderator: Great. I see that many of you, I know, are not able to stay for the full webcast, so what you'll see on your screen is an evaluation of the webcast, and we do take this information very seriously, we use it for planning, especially when you tell us what topics you'd like to hear. If you have to leave early, thank you for joining us, but please fill out the evaluation before you leave. We're going to continue with the questions and answers.

Julie, can you comment on the 4- versus 6-point version response scales and how that relates to the various survey versions you mentioned?

>> Julie: Sure. Those of you who may have been early adopters of the Clinician & Group Survey may be aware that the initial version of the survey that we released for use included a 6-point version of the “never to always” scale. That is never, almost never, sometimes, usually, almost always, always.

And that's the version that was submitted to NQF, and they endorsed as a measure of patient experience with care.

Being mindful that we wanted to make sure that people knew that we had a version that used the 4-point scale. Also in some testing there appears to be a very slight mode effect using the 6-point scale in interactively and some telephone administration is we may not have seen that consistently thus we wanted to make the 4-point scale available.

We leave it up to the user community to decide which version of the response scale is most appropriate for them. So that if you're looking for something that's been endorsed by NQF, then we have the 6-point scale available. If you're looking to use the tool for quality improvement measures, the 6-point scale may be more appropriate but the 4-point scale is appropriate to discrimination at the level of individual clinicians.

>> Moderator: Great, thank you.

Mike, can you comment on getting better access to the password-protected portal? You may not be the survey sponsor, so perhaps a health plan is sponsoring the survey as part of a multi-payer collaborative but would the practice themselves be able to access the data?

>> Mike: That's something we're going to discuss further. We've got to see what data we receive, the relationships and it's very possible we could have the practices have their own unique access and like at the group level, they have access to all the

practices beneath them and like a summary of their results. That's something that is yet to be decided.

>> Moderator: Okay, great. I'm going to ask Julie to once again comment on the application of CAHPS for medical home. We kind of talked about another participant that was implementing a medical home model and we hear a lot about that; it's a popular initiative right now within group practices. Can you talk about the use of CAHPS and the application to medical home?

>> Julie: Sure. And what I'm going to say is very limited. If anyone else can expand on it, don't hesitate to. The short answer is we think there are measures, especially within the CAHPS supplemental item set, that can be useful at assessing patient experience with a medical home. My understanding is that there's a large national initiative or medical home demonstration and some of the demonstration sites are using and testing the CAHPS tools in this way.

I don't have at the front of my brain the list of items that we thought were useful in assessing medical home. I believe it included the supplemental set on shared decision making and the supplemental set on coordination of care. But beyond that, I have to apologize, my brain is hitting a wall.

So we're in the early days of understanding the usefulness of the CAHPS tool in that setting but we certainly do think there's utility.

>> Moderator: And just from my perspective, I'll add on that, Julie. The CAHPS consortium does work with many of the different demos, there are several demonstrations going on right now in terms of the application of CAHPS medical home and working with the instrument team. We did develop kind of a draft list of all of the CAHPS items, supplemental and core items, that can be used to measure the various means of medical home and we're working with those various stakeholder groups now to try to refine that list, to really have a better answer, I guess, in a more definitive answer about how CAHPS can be used to measure medical home.

But if you'd like more detailed information, please feel free to come through the User Network as well and we can work with you individually and kind of bring you to up speed on at least where we are in that process.

All right. Let's have a question from, I'll start with Mike and maybe Julie and Heather can add on to that. From medical groups that are currently working with a survey vendor, for example CSS, what would be the benefit of moving to the CAHPS Clinician & Group Survey, away from their proprietary versions of their survey?

>> Mike: I'll defer this question to Janice.

>> Janice: The person that you would have to be able to compare your data to national benchmarks, aggregated data that's collected across a broader range by region and by specialty that you would be able to compare your data to.

>> Julie: I'd like to add one point to that if I may. This is Julie. Check with your vendor, because your vendor may already be fielding the Clinician & Group Survey for someone and may not have realized it might be a tool that you're interested in.

Many of the vendors that we hear routinely mentioned all have expertise in fielding the survey and are experienced with the CAHPS administration guidelines.

>> Heather: This is Heather. In Minnesota, every medical group is currently fielding from an internal standpoint, something that looks slightly different and is sort of their own version tailored over time. So for us, this survey offered an opportunity for us as a community to have a common platform for not just sort of benchmarking and performance, but also communication and understanding about how we as a group of medical groups wanted to think about the work we were doing with care with patients. So it's much easier for us to really teach each other from a collaborative having this common instrument. And you know, the benchmarks are also a tremendous appeal for us both from a standpoint of locally as well as from the standpoint of appreciating where we sit nationally.

>> Moderator: Great, thank you. And we've had a lot of great questions and we are now at the end of our time so I'm going to be respectful of everyone's time. Thank you all for participating in this webcast. If you submitted a question or you didn't think we quite answered your question, please feel free to resubmit your question through either the CAHPS technical assistance line which is [cahps1@ahrq.gov](mailto:cahps1@ahrq.gov) or for the CAHPS Database through [ncbd1@ahrq.gov](mailto:ncbd1@ahrq.gov), and we will get you answers to your questions.

So again, we do have some more webcasts about the CAHPS products and surveys and using the CAHPS data coming up in the fall. And thank you all for joining us and thank you to our great panel.

Thank you, this does conclude the conference. You may disconnect your lines at this time. Thank you for your participation.

(End of presentation).