

# ***Evolution of the CAHPS and Clinician & Group Survey: An Update from the AHRQ's CAHPS Consortium***

**September 25, 2008**

## **Presentation**

>> Greetings and welcome to the Evolution of the CAHPS Clinician & Group Survey: An Update from the AHRQ's CAHPS Consortium. At this time all participants are in a listen-only mode. A brief question-and-answer session will follow the formal presentation. If anyone should require operator assistance during the conference, please press star zero on your telephone keypad. As a reminder, this conference is being recorded. It is now my pleasure to introduce your host, Ms. Carla Zema. Thank you, you may begin.

>> Good afternoon. And again welcome to the Evolution of the CAHPS Clinician and Group Survey webcast sponsored by the Agency for Health Research and Quality. This webcast will provide you with an update on the Clinician & Group Survey. We also call it the C&G Survey.

My name is Carla Zema, and I will be the moderator for this webcast. I'm with Saint Vincent College, and I serve as a consultant to support the CAHPS Consortium and the CAHPS User Network. One of my privileges is to work with the CAHPS survey development team.

I wanted to remind you can listen to this webcast either through streaming audio through your computer speakers or by telephone. So if you have any problems and you're listening with us through streaming audio and you want to join us by telephone, feel free to do so by dialing 1-877-705-6008. You may also experience a slight lag in the advance of the slides. This is dependent on your computer speed and the type of Internet connection that you have.

As most of you already know, CAHPS represents a family of surveys that asks consumers and patients about their experiences with health care. The first CAHPS survey was the Health Plan Survey. We will be focusing today on the Clinician & Group Surveys. The surveys were designed to evaluate patient experience with care with medical groups and clinicians at the ambulatory level. It includes not only medical groups and practices but also other ambulatory settings such as hospital outpatient clinics and public health clinics, for example. We have heard from a lot of users in those types of settings as well.

We have a great lineup of speakers today, including representatives from the Rand and Yale grantee teams in the CAHPS Consortium. They're directly responsible for the development of the surveys. As well as we're joined by two guests that work closely with the CAHPS Consortium.

Julie Brown will give you an update of the changes to the current C&G surveys that will be unveiled soon in the updated Survey and Reporting Kits.

Trish Gallagher and Ed Schor will discuss the exciting new updates to the Child Primary Care Questionnaire.

And finally, Dale Shaller and Michelle Ferrari will update you on a current development effort focusing on the visit-specific version of the Adult Primary Care Questionnaire.

In addition, Dale Shaller, who wears many hats with the CAHPS Consortium, is also the director of the National CAHPS Benchmarking Database and we found overwhelming response of wanting information about that. So he will also be able to give you some information about the CAHPS Database.

We've learned from our previous webcast that you really learn from our question-and-answer session at the end of the presentations and we really do enjoy hearing from you. So we encourage you to submit your questions throughout the presentations.

All you need to do is simply select the questions from the navigation bar in the upper right portion of your screen. You will get a popup box and you just type your question in the text box and select "send." You also have the option to send your question anonymously, too, if you prefer. We love to hear from you, so please send in lots of questions and comments throughout the presentations.

If you're unable to see the slides fully on your screen, in other words, if you need to scroll to see the entire screen, you can adjust your screen resolution to 1024 by 768, which will fix this problem for you. Each operating system is different, but generally you can do this by right clicking on your desktop and selecting display modes or display settings.

Finally, as the operator said, if you need any help during this webcast, you can dial "star, zero" if you're on the telephone line and you can also do it on your screen by selecting help, which is again in the upper right portion of your screen.

Now, let's hear from our speakers. Our first speaker is Julie Brown and she's going to talk to you about the updates to the Clinician & Group Survey and Reporting Kits. Julie has been with CAHPS and is part of the survey development team since the beginning of CAHPS, and she's a regular face that we all see both on webcasts and at our User Group Meetings.

So at this time I'd like to turn it over to Julie Brown.

>> Thanks so much Carla. Good morning to those who are in my Pacific time zone and good afternoon to those of you in the East Coast. When you registered for today's webcast, many of you indicated that you're new to CAHPS. I'd like to take a moment right now to give you an overview to help set the context for the topics we plan to cover in today's session. I'd like to start by taking a moment to explain what is CAHPS.

CAHPS is a kit of survey and reporting tools to assess ambulatory and facility-based care. Our initial emphasis was to promote informed consumer decision-making, but over time we've added tools for quality improvement. Several CAHPS sponsors use a CAHPS survey as a component of a pay-for-performance initiative and the Health Plan Survey is a component of the National Committee for Quality Assurance health plan accreditation program.

In addition, CAHPS surveys have been endorsed as measures of consumer experience with care by the National Quality Forum.

All CAHPS tools are in the public domain and available free of charge. The Survey User Network provides ongoing technical support of CAHPS through web-based resources and live user support. And I encourage you to contact them.

I should also say a few words about what CAHPS isn't, to clarify any questions you may have. We don't accredit or certify survey vendors and we don't recommend or endorse specific survey vendors.

So let me start or continue on that overview by reviewing the contents of the soon to be released Clinician & Group Kit. I should stress this is an update to the kit as the kit has been available for some time now. The kit contains survey and reporting tools as I mentioned, and the survey tools include four off the shelf survey templates for your use. We provide off the shelf survey templates to make it easier for users to pick up and run with the surveys we make available. We have an adult primary care survey, version 1.0. An adult specialty care survey, version 1.0. A child primary care survey, version 1.0. Those three surveys are all available as I said in version 1.0. We also have a template for a beta version of an updated child primary care survey. This is the child survey 2.0 that Edward Schor and Trish Gallagher are going to speak about.

We have two versions of the Clinician & Group Survey Kit. One version uses the standard CAHPS scale of never, sometimes, usually, always. We call this the four-point response scale.

The second version of the kit uses an expanded six- point version of the scale: Never, Almost Never, Sometimes, Usually, Almost Always, and Always.

So you must be wondering why we need two kits and two versions of the frequency response scale. Let me share our rationale with you. Our primary goal is to meet the needs of the organizations that use the CAHPS surveys. The six-point response scale is used in the Clinician & Group Survey instruments endorsed by NQF and it's also the scale used by many of the early adopters of that survey.

The four-point scale is the standard or traditional scale used in many CAHPS instruments. To date, our research has found that the two scales, four-points and six-points, provide similar precision when used to measure experience with individual clinicians.

We allow users to decide which response scale best meets their needs. When deciding which response scale to use, you should think first about your survey goals. Do you need to use NQF endorsed survey measures, for example? Think about the mode or modes of administration in which you will field your survey. The four-point scale may be more appropriate if you plan to collect data by telephone interview or interactive voice recognition, also known as IVR.

Think about your current use of CAHPS surveys. Do you need to compare data across different CAHPS surveys? If so, the four-point scale may be more useful for that effort.

Think, too, about your reporting needs. If your goal is to use or report data for quality improvement, you may want to use the six-point response scale. If your goal is consumer reporting, then you may want to use the four-point response scale.

Given what I've said so far, we'd like to poll you about your use of these two response scales. Which response scale are you most likely to use in the future? Please take a moment to give that question some thought and then mark your answer and we'll display the results. We'll also address your questions about the response scales later in the webcast. But before we do that I'd like to give you one last update

about changes to the survey. Before we jump into the changes, let's see if we can post the poll results. Hopefully you've all had enough time to vote.

Okay. Excellent. Thank you so much for sharing your feedback. I see that 44 percent of you are interested in using the four-point response scale or most likely to use the four-point response scale and 29 percent of you are most likely to use the six-point response scale, and 28 percent of you are not sure. That's very helpful feedback.

I'd like to move on now to talk about the new look for the CAHPS surveys. That's something we're very excited about. We have updated the format of the self-administered or mail surveys in the CAHPS kit. This applies not just to the Clinician & Group Survey, but applies to all the ambulatory surveys and facility-based surveys CAHPS supports. These format revisions include the use of serif font such as Times for all survey items and response options. We made this change because literacy experts have identified serif fonts as being easier to read. Again I need to stress that I'm talking about the mail or paper versions of the survey. That is the version that patients complete for themselves. The updated kit will use a sans serif font for the headings so that they stand out and act as visual markers for the person completing the survey. We also streamlined the skip instructions. The end product is a survey that should be easier for participants to read and navigate but that still provides important CAHPS design features or includes important CAHPS design features, I should say.

We continue to use a large, easy to read font size and the two column format remains as does the use of white space. White or blank space in the surveys is really an important feature as it reduces the error people may make as they navigate from one survey item to the next. And I'll look forward to any questions you may have about this and I want to turn the floor back over to Carla. Thank you all.

>> Thanks, Julie. Again, you can send in your questions at any time and we'll respond to them at the end during our question-and-answer session.

At this time we're going to turn the presentation over to Trish Gallagher and Ed Schor. Trish is with the Survey Center for Research and, like Julie, has been with CAHPS on the survey development team since the first round of CAHPS over 10 years ago. We also have the privilege of having Ed Schor with us. Ed Schor is vice president at the Commonwealth Fund and leads the fund's child development and preventive care program.

Ed is a pediatrician. He has had a number of positions in pediatric practice, academic pediatrics, health services research and public health. We were delighted that Commonwealth had an interest in funding the development of this survey. And we're also equally as excited to have his input as a national expert in pediatrics.

And so at this time I'll turn it over to Trish and Ed.

>> Thank you. Most of you know the Commonwealth Fund is a private foundation that aims to promote a high performing healthcare system that achieves better access and improved quality and greater efficiency, particularly for society's most vulnerable population, which includes children.

We approached the CAHPS Consortium to develop a revised version of the child primary care version of the Clinician & Group CAHPS. We felt the previous version had been very much built on the model of the adult instrument, which preceded it.

And from the perspective of the foundation, it did not sufficiently assess those aspects of child health care that distinguish it from healthcare for adults.

Thus, the rationale for the Commonwealth Fund to support the revision was to have an instrument that would reflect the differences between child and adult healthcare needs and the differences between the healthcare processes and systems that serve the two populations.

So let me quickly highlight what I see as some of the key differences. Six dot points here. First, children are actively developing physically, emotionally, cognitively and socially, and good quality care should assess that development and promote children's developmental progress.

Second, child healthcare is built on a base of scheduled and structured preventive care visits. Those are really the heart of the pediatric practice. Some aspects of that preventive care, in fact, like immunizations, are mandated by state law.

Third, healthcare outcomes for children are heavily dependent on the ability of the healthcare provider to engage and educate parents and have those parents adhere to agreed upon childrearing and healthcare management strategies. So there's always another party involved in child healthcare.

Fourth, while adult healthcare is driven by management of chronic health problems only a small portion of children have chronic problems, yet that group accounts for a large portion of healthcare use among children.

Although treatment of infectious diseases used to dominate pediatric practice, the importance of what are now called new morbidities, such as emotional and behavioral problems, learning disorders, developmental delays, and substance abuse are of increasing importance and a measure needs to tap into those as well.

And finally, children are the one group in the population most likely to live in poverty so are disproportionately affected by social and environmental determinants of health. Related, children's poverty makes them most dependent on publicly financed healthcare like Medicaid and SCHIP. So a measure has to somehow be able to take into account the social and environmental determinants in children's lives that the healthcare system may be able to address. The new CAHPS instrument was intended to respond to these differences in unique aspects of child healthcare. Now let me turn the presentation over to Trish Gallagher who will describe the development and ultimate contents of the revised instrument.

>> Thanks very much, Ed. The Yale team followed the CAHPS precedent for the instrument development process. This included input from stakeholders. For example, a representative from the American Board of Pediatrics was a member of the committee that oversaw each step of the development process.

We conducted focus groups with parents and guardians, including bilingual Latino parents. The next step was one-on-one cognitive interviews with members of the target population, in order to test the candidate questions.

The instrument that emerged from the cognitive testing then underwent a telephone pretest where behavior coding was used to code the interviewer respondent interaction. The goal was to identify item

wording that's difficult for interviewers to administer in a standardized way and to identify questions that are difficult for respondents to answer without asking for clarification.

Once the questionnaire was modified to reflect what we learned in that testing, the instrument was translated into Spanish, using the state of the art committee approach to translation.

Previous pediatric versions of CAHPS instruments have been designed for children under 18 years of age and have been widely used for children up to 12 years of age. Thus a survey gathering data about the provision of developmental and preventive care would need to include questions salient for this whole age range.

Since the different types of care are most salient for different age groups, previous efforts to gather information about the provision of preventive and developmental care have employed multiple skip patterns to allow different questions to be asked about children in different age groups.

To minimize the number of skip instructions that respondents would be required to navigate and to keep the instrument as brief as possible, we developed the parsimonious set of items relevant to children in all age groups.

Following the CAHPS precedent, we developed versions of the survey in both English and Spanish. We conducted a field test with patients and physicians who were part of the Massachusetts general physicians organization, a physicians group associated with Massachusetts General Hospital here in Boston.

A total of 1,000 pediatric patients were randomly selected from the sampling frame provided by Mass General. Samples of patients were selected from eight doctors. The subjects were randomized to one of two mode conditions, mail first or phone first.

For some, the first contact with the children's parents or guardians was the mailed questionnaire packet. A random half of this mail-first sample was provided information in the cover letters about how to respond using a web-based instrument.

Subjects in the phone-first sample were initially contacted by telephone and offered the opportunity to complete a telephone interview.

We followed the data collection protocols recommended in the CAHPS kit to conduct the field test. If after three contacts by mail respondents hadn't returned completed questionnaires, a trained interviewer called to offer the opportunity to complete a telephone interview.

Using these protocols, we achieved an overall response rate of 68%. We calculated that response rate using the conservative APOR response rate 1 number 1 formula. It's worth noting that only nine of the 200 parents offered the opportunity to complete the questionnaire on the web elected to respond using the web.

And then once we collected all the data, it was submitted to quite a bit of analysis. The case mix analysis indicated that the child age, health status and race, as well as the respondent age and education were important case mix adjustment variables. This was consistent with previous analyses of pediatric CAHPS data, except that child age was not a significant case mix adjuster in previous analyses.

Psychometric analyses of the new items to assess developmental and preventive care were conducted. Both composites had respondent level reliabilities of greater than 0.7. Although the reliability of each composite could have been increased by deleting a question, we decided to retain all of the tested items in each composite because of the substantive importance of the items that had a negative impact on the internal consistency.

In the developmental care composite it was a question that asked the doctor how the child gets along with others. In the preventive care composite, the retained item was whether the doctor talked about household problems that could affect the child.

The physician level reliability of each composite was above 0.8. Self-reported characteristics of respondents were examined by the mode of data collection. For two of the responding characteristics, age and education, mail, phone and web respondents demonstrated statistically significant differences.

Including the telephone data collection protocol, however, increased the overall percentage of mail respondents, younger respondents, and respondents who had not completed high school. Respondents who were younger or better educated were more likely to use the web option. However, as we already heard, the offer of this option did not significantly increase participation.

When comparing cases that respondents using the mode of administration to which they were assigned, only one difference by mode appeared. After case mix adjustment, the mode effect for all items and scales was not significant except for the preventive care composite, where those who responded by mail had a small but statistically significant higher preventive care composite score than those who had responded by phone.

In addition to the new developmental care and composite items, a question was added to identify parents who were not in the exam room during the child's visit. There comes a time in an adolescent's life when parents are no longer welcome to be present during the physical examination. This screening question allows appropriate respondents to skip the question that ask how often the doctor explained things in a way that was easy for the child to understand and the question that asked how often the doctor listened carefully to the child.

Before I talk about the new developmental and preventive care composites, I'd like to pose a question to the group by using a poll. Vote now by clicking next to your answer about which version of the primary care child instrument you are likely to use. And once you click your answer, please click submit.

Now, back to the new composite. The developmental care composite items ask whether the parent and the doctor talked about the child's learning ability, the kinds of behaviors that are normal for your child at this age, how the child's body is growing, the child's moods and emotions, and how the child gets along with others.

For the preventive care composite, the parent is asked if the parent and physician talked about things the parent can do to keep a child from getting injured, whether the doctor gave the parent any printed handouts or booklets with information about how to keep the child from getting injured, whether there was a discussion about how much or what kind of food the child eats, and another about whether the parent and doctor talked about how much or what kind of exercise the child gets. And lastly, whether there are any problems in the household that might affect the child.

Now let's see the results of the poll.



There it is. Thank you for responding. What have we got? We've got pretty well evenly matched. About 43% are both not sure which version to use and don't use a child primary care survey at all. So about 12% are going to use the new beta version and 1% are going to stick with the 1.0 -- about 1%.

All the questions in the developmental care and preventive care composites are new to CAHPS. None appeared in the 1.0 version of the CAHPS Clinician & Group Child Primary Care instrument. We expect the CAHPS Child Primary Care 2.0 beta questionnaire to become a national measure of pediatric care. The instrument will be available in the CAHPS 2008 survey and reporting kit with the same instructions as were provided for the 1.0 version of the instrument.

The 2008 kit will be available to be downloaded very soon. The link to download the CAHPS Child Primary Care 2.0 beta questionnaire I've been discussing was sent in an e-mail message to all webcast participants. But it will only be available for a limited time.

After the webcast, please contact CAHPS1@ahrq.gov to request a copy of the questionnaire.

>> Great. Thanks Trish and Ed. At this time I want to turn the presentation over to Dale Shaller and Michelle Ferrari. Dale Shaller is a member of the Yale team within the CAHPS Consortium, and he works on the survey development team, the reports team as well as the team looking at the use of CAHPS for quality improvement.

Dale also works in the CAHPS Consortium and he serves as the director of the CAHPS Database. And, again, he will present a little bit about the CAHPS Database at the end of the presentation.

Michelle Ferrari is the project manager at Minnesota Community Measurement, which is a nonprofit organization with a mission to accelerate the improvement of health by publicly reporting healthcare information. She administers Minnesota's Aligning Forces for Quality Initiative, which is a three-year, \$1 million grant from the Robert Wood Johnson Foundation on behalf of a broad group of stakeholders that make up the AF4Q leadership team. All right. Dale and Michelle.

>> Thanks, Carla. This segment of the webcast will describe the development and testing of a new version of the CAHPS Clinician & Group Survey designed to obtain patient reports on their experience with a specific visit with a doctor in an office-based practice.

I'll do a very brief introduction and then turn the presentation over to Michelle who will hand it back to me for the remainder of the segment.

Since the release of the C&G survey last year, which, as you've heard, frames the questions in terms of the last 12 months, a growing number of medical practices around the country have expressed interest in a visit-specific version of the instrument.

And based on this interest, the CAHPS Consortium decided to develop a visit-specific version in addition to the existing version based on the 12-month reference period. As you'll hear from Michelle, a project now underway with medical groups in Minnesota is providing us and them with a great opportunity to pilot test this new instrument.

And once the results of the test are available, users of the C&G Survey will be able to decide for themselves which instrument best fits their needs. Michelle.



>> Thanks, Dale. Just to start a little bit about our organization. Minnesota Community Measurement, as you heard, is a nonprofit organization and we collaborate across stakeholders in the state to report quality healthcare information. We currently report on the quality of 12 ambulatory care measures. But are committed to eventually addressing all six of the IOM aims for improvement which includes patient centeredness, which we're addressing through our new patient experience measurement process.

Minnesota Community Measurement and nine medical groups are currently partnering to pilot a process to collect and report patient experience data at the clinic site level in Minnesota. The survey just went into the field on September 15th and we'll close that in late November and our plan is to then publicly report the results for 123 clinic sites in early 2009. It's been a journey to get to this point, but very early on we selected the CAHPS Clinician & Group Survey tool as a standard instrument we would use for our measure. We modeled our approach on Minnesota Community Measurements' new direct data submission process where medical groups themselves are submitting quality data to our organization for public reporting -- although the patient experience measures varies somewhat due to the vendor component.

The specifications for this pilot though really developed through the one-on-one discussions we had at the beginning with medical groups we approached to participate. And these groups have continued to work with us very closely in the development of this measurement activity.

From the start, our number one aim was really to build a standardized approach so that we were successful at achieving comparable results and yet we wanted at the same time to respond as best possible to medical groups' concerns.

And the top concerns that we heard when we had these discussions was that, one, for those groups that had current surveys under relationships in place that they be able to continue those relationships for this pilot, and, two, we heard a very strong appeal from the group for the survey tool to address the patient more specific and recent visit.

What we heard from the medical groups we spoke to is that the 12 month reference period seemed to be too far back of a look back to provide a specific and timely feedback they were interested in having. In addition, medical groups told us that framing the questions about a specific visit would be more in line with their existing survey practices, would have more face validity and credibility with their practitioners over the last 12 months' version, and would have more direct application to internal quality improvement activities.

So with the help of Dale who has been working very closely with us on the development of this Minnesota pilot, the Minnesota group brought this feedback back to the CAHPS Consortium, who, after hearing similar comments in other markets, decided to create a visit specific version. So at this point I'd like to turn it back to Dale to tell you more about the development of this visit-specific version.

>> Thanks, Michelle. So to take on the development work for the new version the Ambulatory CAHPS, or A-CAHPS, team established a subgroup chaired by Julie Brown of Rand and Trish Gallagher of the Yale team, who you've heard from on today's webcast, who came up with a existing set of questions from the 12 month core. Given budget and time constraints, the subgroup decided to forego additional cognitive testing on the items since most of them had been developed and tested as part of the supplemental item set released with the 12 month version. The full A-CAHPS team reviewed the draft questions and a draft was submitted to the groups in Minnesota for their review. This was really a collaborative process over a

period of several months between the A-CAHPS team and the Minnesota workgroup, with very significant work from Minnesota on the content and design of questions. We went through several drafts until a final version emerged that fit the needs of the pilot project and was consistent with CAHPS design principles.

So what we came up with is a 32-item questionnaire consisting of basically the same content as the 12-month core, the adult primary care version of the 12-month core, but adapted to fit the visit-specific frame of reference. Now, there's a copy of this questionnaire posted on the CAHPS webcast page. So I'm hoping that many of you had an opportunity to download that instrument and you can sort of refer to it as I describe the content.

The test version has four access questions instead of the five that appear on the 12-month version, since the phone questions, two of the phone questions, don't really work on a visit-specific basis. So we dropped those, and we added a question on follow-up for test results after the visits.

The survey has the same content for doctor communication, which are six questions, "Office Staff", two questions, and the doctor rating question on a 0 to 10 scale.

At the request of the Minnesota groups we added a "would you recommend this doctor's office to your family and friends?" question and an open ended question on how this doctor's office could have improved the care you received during your visits.

Also, at the request of the Minnesota groups, we shortened the survey by deleting the three questions in the demographic section of the 12 month version which get at whether the respondent has a chronic condition or not. All of the other demographic questions remain as well as the two "did you get help completing this survey" questions.

In addition to the question content, we needed to think really hard about the questions at the very beginning of the survey that verify that the respondent in fact had a visit with a specific doctor on a specific date. In the case of the Minnesota pilot instrument, a label is inserted with the name of the doctor and the date of the visit. The respondent is asked to confirm that visit with that doctor and is instructed to think about that specific doctor and visit as they answer the questions. The questions themselves then are framed in terms of your visit throughout the survey.

We also added a question at the very front to ask if this visit was their most recent visit, so we can test if there are any differences in answers between the most recent visit and visits that are not the most recent visit.

Finally, and maybe one of the most important areas that we worked on, was to create a response scale to the questions asking about your visit that would make sense. Since we couldn't use the frequency-based scale of the 12 month version, the Never to Always scale, we came up with a simply yes/no scale for access questions. That is, did this happen or not. And then a graduated yes/no scale for the "Doctor Communication" and "Office Staff" questions, and that's structured as a "Yes Definitely", "Yes Somewhat", and "No."

We've been talking about all these survey response scales. At this point, we'd like to pause for another short poll and ask you all to respond to the following question: Which reference period do you prefer? You can select "Visit-Specific", "The last 12 months" or "Not Sure", and then once you've selected, press the vote button.

And we'll give you a few seconds to respond to this. And while we're waiting, let me encourage you again to submit questions if you've had them. We have received a number of questions thus far in the course of the webcast and we are reserving plenty of time at the end to make sure we have a chance to answer them. So I'm going to see if we have any results to post.

OK. Quite a few of you, over half of the respondents to this poll have voted in favor of "Visit-Specific." That's very interesting. A third of you aren't sure. And about a fifth of you want to continue to use the last 12 months. It's a very significant finding because this is exactly why we're doing the development work in Minnesota that will lead to our ability to make available a visit-specific version of the Clinician & Group Survey.

Given the pilot underway in Minnesota, there's a lot of instrument design issues that we're very interesting in evaluating, to see how the new survey compares to the 12 month version. Among the issues we want to test are what sample sizes are needed to obtain sufficient reliability at the clinic site level, which, as you heard from Michelle, is the unit of comparison in the Minnesota project.

And this is an extremely important issue, since we don't really have any prior empirical data on this for a CAHPS instrument based on a specific visit. Where there is a much more limited response scale in terms of yes/no versus a more graduated scale or six-point response scales in the 12 month version.

We'll also evaluate differences in response rates and the actual scores to the questions. And how individual sites rank using the visit-specific survey versus the 12 month survey version.

And, of course, we'll conduct all the usual psychometric tests used to assess a survey instrument such as the percent of responses that are at the top end or ceiling scale, or the bottom end or floor of the scale, the percent of missing responses to items, and the correlations between question items and their composites.

And we're really fortunate that the largest participating medical group in the Minnesota pilot, ALINA Medical Clinics, has agreed to work with us to conduct a test by fielding both the visit-specific and the 12 month survey in separate samples in two of its largest clinic sites. The sample sizes and mode of administration will be exactly the same for both versions. They're going to be mailed surveys sent to a sample of 1,028 patients where we hope to achieve at least 360 completed surveys per site for each version. That assumes a 35 percent response rate. Westat is funding the collection of the 12-month comparison sample and the Yale team will be conducting the analysis. And we expect that analysis to be completed in early 2009, about the same time as Minnesota Community Measurement and the participating medical groups are reviewing the visit-specific survey results across all of the clinic sites.

In summary, we hope to learn a great deal about the performance of this new visit-specific version of the C&G survey in the context of the Minnesota pilot and through comparison with the special test of ALINA to the 12 month version. But there are a number of other important issues that we'd like to learn more about which we won't be able to address in the Minnesota pilot which we'd like all users of the Clinician and Group Survey to be aware of, in case you have an interest in working with the CAHPS team in the future, as you field your surveys. For example, we'd really like to know how the four-point scale compares to the six-point scale in the 12 month version. We have some evidence on a few of these issues but we'd really like to have more current and complete data if we can get that.

Another issue is the effects of different modes of administration, especially the use of interactive voice response and Internet modes.

We'd like to understand the impact of including or not including a postcard reminder in a mail mode after the first survey mailing.

And there's increasing interest that we've heard from a number of areas in the country on expanding the referent for the CAHPS surveys beyond "this doctor" to include other clinicians, such as nurse practitioners and other allied professionals. So we'd really like to know how well that works.

So we invite all users to consider partnering with the CAHPS team to help explore these and other testing issues so we can continue to improve the performance and the usefulness of these surveys.

We're going to make another transition here. I'll hand off to myself to talk a little bit about the National CAHPS Benchmarking Database. We heard a huge number of registrants were interested in this topic so we decided to add just a brief segment here to bring you up to date on where we are with the national comparative database for the various C&G Surveys.

For those of you who may be new to the CAHPS, the CAHPS Database is the national repository of data contributed on a voluntary basis by users of the various CAHPS surveys. The database is funded by AHRQ as part of the CAHPS User Network administered by Westat. We also have a national advisory group that provides oversight and direction to the program.

The database is designed to support benchmarking with national comparative data to help users assess their performance and to identify opportunities for improvement. And we also maintain research data files that are available for authorized users in their research on patient assessments of quality and ways of improving the actual design of the surveys.

The CAHPS Database has over 10 years of data and millions of records for the health plan survey, which we've been supporting since 1998. We have three years of data for the CAHPS Hospital Survey and we're just getting started on the national database for Clinician & Group Surveys as they're adopted and data become available to create a database.

Developing a national database is bit of a chicken and egg proposition since we need data to create benchmarks, but users are often, they often want to see benchmarks before they contribute data. So, at the beginning stages of database creation we're always somewhat kind of opportunistic about where we begin to gather data from early adopters and we're looking with Clinician & Group to the large regional collaboratives and states like Massachusetts and California, the individual health plans and medical groups that are using the survey now, and other large users such as the Department of Defense, which has been administering the C&G Survey in its TRICARE program.

We're also serving to be the aggregator of the visit-specific C&G data that will be collected by several vendors for the medical groups in the Minnesota pilot that Michelle described. We'll be building both a visit specific database as well as a database for the 12 month version that would includes the four and six-point response scales. There's a lot of versions we're trying to maintain track of and maintain and support a database of each one.

As has always been the case, we're interested in collaborating with survey vendors around the country. We've done it successfully in our previous work to make sure that our requirements for the national database are in alignment with those processes and to be able to provide them with the opportunity to add our national comparisons as a compliment to their own client databases.

As we talk to vendors, we're gathering feedback that is helping us to develop data submission specifications which we hope to release in early 2009 for the full range of information needed to construct a comparative C&G database. This information includes not only the respondent level survey data but also information about the characteristics of the medical groups and practices that are being surveyed. And that's really important, because what we compile are summary level benchmarks according to characteristics. We never report individual names of sponsors, or health plans, or providers.

In the case of Clinician and Group CAHPS, such characteristics might include the specialty of the physician, practice location, the type of the practice, ownership and the size of the practice.

So we're exploring the feasibility of collecting those kinds of data elements right now with the C&G sponsors we're working with.

I want to just quickly highlight that in order to present all of these data that we collect, these national comparisons, we're developing a new online reporting system for all of the CAHPS surveys that we support. That will enable users to go to our website and view custom comparisons on demand and summary level comparisons as opposed to the pre-constructed tables and charts that we've published for years as PDF or Word documents.

And as a special incentive to survey sponsors to contribute data to the database, we will have a password-protected area on this online system where sponsors can view their results, compared to selected benchmarks.

We plan to present a preview of this system at the national CAHPS User Group Meeting this December. December 4 and 5 in Scottsdale, Arizona. We hope you can join us there.

We also hope, and it depends on the development process for the remainder of this year, to have some preliminary data compiled from these early adopters so that we might be able to present at least some rough national data for some versions of the Clinician & Group Survey.

I just want to conclude by emphasizing that participation in the CAHPS database is entirely voluntary. All the data that we receive are protected from identification by name since we only publish the summary level data by the types of characteristics that I was just describing. And I want to emphasize we really want users of the C&G Surveys to participate in the database by contributing their data and in exchange receive access to all the components of our new online reporting system. So if you're interested in participating or you want to learn more about it, please contact us by e-mail at [ncbd1@AHRQ.gov](mailto:ncbd1@AHRQ.gov). Our toll free number, which is listed on the screen. We answer those calls within 24 hours and you can also visit the CAHPS Database pages on the CAHPS website.

So that concludes my remarks, and I'll turn things back to Carla now for questions and answers.

>> At this time, I wanted to remind you that if you would like to ask a question, you can simply select "Question" from the upper right portion of your screen. Dale mentioned the User Group Meeting. This is our 11th national CAHPS User Group Meeting. It is a free conference sponsored by AHRQ. It will be held December 3rd through 5th in Scottsdale, Arizona at the Doubletree Paradise Valley Resort. Here we highlight users' experiences with the survey; we also try to bring you up to date on all the work of the consortium, not only for the C&G Survey but all of our survey products.

And so a lot of you identified areas that you would have liked us to touch base on in this webcast, and we certainly, we just didn't have the right amount of time to touch base on all the topics you were interested in. But a lot of those topics will be addressed at the User Group Meeting such as an update from CMS, some of our other surveys, and there is one full track dedicated to the Clinician & Group Surveys.

So that's an event that you don't want to miss out on. You can register for this event by going to the CAHPS website which is [www.CAHPS.AHRQ.gov](http://www.CAHPS.AHRQ.gov).

After the webcast, we've had a lot of questions on will the slides be available, and the answer is yes. So after the webcast you can go to the CAHPS website. It will probably take a little bit of time for us to get the slides in order to post them because we have to make them 508 compliant. But we will post the slides. There will also be a webcast recording as well as a written transcript. And there will also be a link where you can listen to and see a replay, a captioned replay, of the webcast as well.

We've gotten a lot of great questions. So if we aren't able to get to your questions, please feel free to submit them through the CAHPS line, which is, again, [CAHPS1@ahrq.gov](mailto:CAHPS1@ahrq.gov) or the toll free number.

All right. We're going to start with some questions and answers. The first one is for Julie. We had a question as to, you mentioned that the six-point response scale was better for quality improvement. So the question was, is there specific research around using the six-point response scale versus the four-point response scale being better for quality improvement or would both scales allow for the use of the survey results for quality improvement?

>> Thanks Carla, and I'd like to thank the participant who submitted that question. We want to clarify that both the four-point and six-point scales are appropriate for quality improvement. In some instances, you may be measuring or trying to affect change in physicians who are already scoring pretty high within a composite or on a specific item or a specific set of measures or in their overall Clinician & Group score. In that instance, when you're trying to raise the bar from high performance to even higher performance, the six-point scale is probably more appropriate for helping you to discriminate at that higher end or even at that lower end and capture small incremental growth, smaller increments of change, which is why we suggested it may be appropriate for quality improvement.

The one thing I'd like to stress there is the "may" and a lot of it really does have to do with the specific quality improvement initiative that you're undertaking. This may be a chance for me to plug Talking Quality and some of the other components of the kit that provide insight, real world examples and other advice for people who are using all of the CAHPS tools for quality improvement.

>> Great. Thanks. This question is for Michelle or Dale. There were several questions around the sampling of the survey, in terms of when the patient actually completes the survey. Can you kind of talk about and confirm whether or not this is an in-office-based administration, as well as the optimal time between the patient's visit and the time that the patient completes the survey?

>> Thanks, I'll take a stab at that and Dale can add in.

We did actually change the sample frame time period based on the new visit-specific tool. With the 12 month version, the sample frame typically looks at the last 12 months of visits. We are looking at the most recent three months of visits. So for our survey that was fielded in mid-September, we took visits that took place between May and July of 2008. And so that allowed us to both get enough sample that we would have adequate sample size for the clinics but also give us more recent visits. And this is a



mailed survey. We are following the same CAHPS protocol for a mailed survey. So this is a two-wave mailed survey that's completed in the patient's home.

>> Great response.

>> Great. In terms of there was a question regarding what response rates we've seen and just wanted to clarify we haven't gone into the field for testing so we don't have any information as of today around response rates. But hopefully we will have some experience from the field tests that we can share that with you soon.

This question I'm going to pose it to Dale, Julie or Trish, since all were involved in the development of this survey. But the question is could you clarify what you mean by the chronic conditions items being dropped from the visit-specific survey that they might be helpful to clarify the differences between the visit-specific survey which was available on the webcast, which is the version and the slight difference in what Minnesota would have administered in their field tests.

>> I can answer the chronic conditions that were dropped appear in the 12 month version in the About You section. They basically ask whether or not the respondent has a condition or problem that has lasted for at least three months, whether they take medication prescribed by a doctor and whether that medication is to treat a condition that has lasted for at least three months.

Those items are in the demographic section to help an analysis after data has been collected and possibly some case mix adjustment depending on the chronicity of the responding population. We find that people don't use those very often for analysis. And because of the interest in being as brief as possible, it was the preference of the group in Minnesota to drop those three questions out of the demographic section of the visit-specific survey.

>> This is Trish. Could I add a little to Dale's excellent answer? The chronic condition identifiers can also be used if you would like to do subgroup analysis, to look at the differences, if any, that in quality of care or reports of experiences of care that patients who have chronic conditions have, compared to those who don't. And anybody who fields this survey can always elect to include them and they're part of the supplemental items.

>> And they are actually included in the survey that we have posted on the website. They are not being fielded in Minnesota, but they are in the version of the survey that you downloaded on the CAHPS Consortium.

>> I see, maybe that was the source of the question.

>> I have a question for Julie in terms of the different survey formats. One of the participants would like to know if you can use a survey format other than the two column format as long as the recommended font is used.

>> I did see that question, and thanks for submitting it. And I guess I'd like to give it a tentative yes. And the reason why my yes is so tentative and hesitant is that not having a clear vision of what the alternative format might look like, I think as long as you're using the large font size and you're preserving white space, you're probably okay. But would really want to see the format. For example, one thing that I have seen and that we sometimes have some concerns about is when people take response options, that are usually presented vertically, with never at the top and always at the bottom and rank those and display



them horizontally. Where "Never" is at the left and "Always" is at the right. I think that's an approach that requires some testing and that we have some concerns about. But certainly think we're open to other formats, just recommend that one think carefully about how a range of populations would navigate your format.

>> Great. Thank you.

>> A question for Michelle. Is the Minnesota survey aimed at commercial Medicaid and/or Medicare patients, or is it all inclusive regardless of the line of business?

>> Our survey is all inclusive because we're approaching this from a medical group model. The medical groups are providing the sample frame that includes all of the patients that they see.

>> Great. Similarly, we had several questions on whether or not the surveys could be adapted for Medicaid populations.

>> I'm sorry, can you repeat the question.

>> Julie this might be a question you can answer. Whether or not our surveys can be adapted for the Medicaid population? Of course in the health plan versions of our survey, we have Medicaid -specific versions of the survey, but in our Clinician & Group family of surveys, there's not Medicaid-specific surveys.

>> Well, certainly defer to Trish Gallagher as well. One thing I'd like to share when we were developing the Clinician and Group Survey, we were careful to test it across commercial and publicly insured populations, Medicare as well as Medicaid. So the questions and content and topics that are covered are appropriate for the full range of populations that one might encounter.

>> That's exactly right, Julie. And the only thing I would add, if the so-called 12 month version is fielded, it would be a six-month time reference for the Medicaid population.

>> I would just add to the point that Michelle was addressing the survey that is being fielded in Minnesota is being fielded to a sample frame that is inclusive of all of those populations. So we're expecting that the questions will work for Medicare and Medicaid and privately insured patients as well as uninsured patients.

>> This is a question for the development team for the visit-specific survey, what is the rationale for not including an overall rating with the most recent visit?

>> Julie or Trish? Do you have an answer for that? We rate the doctor zero to 10 but not the overall visit. That's true.

>> Going out on a limb, I can tell you that our development approach was to look at the -- one of the things we wanted to do was preserve comparability of core content between the existing Clinician & Group Survey, that is, the 12 month survey and the visit-specific survey. We were looking at existing core measures and thinking what minimum modifications would be required for the question to be appropriate in a visit-specific format and realizing that a rating of the visit might be useful from a quality improvement or other perspective but it wasn't something that was on our radar at the time. We were really trying to keep the item set as small as possible and preserve comparability.

>> It's a good point. We might have wanted to put that out there, park that for a supplemental or maybe for consideration in the future.

>> Great. We also had two questions in terms of our ECHO survey, which is our survey of behavioral healthcare experiences and whether or not we will move towards a visit-specific version of that survey.

>> Trish, do you want to?

>> As you can hear by the silence, that's an excellent question. And I think the short answer is we would like to move toward that. It would depend on funds and time available.

>> Great. Another sampling question in terms of the visit-specific survey: Is there a target number of completed surveys, either per clinic or per physician that you're shooting for?

>> Go for it Michelle.

>> In Minnesota we're aiming at a 35 percent response rate. But we were actually hoping we would see upwards of 40 percent.

>> Mike, at the physician level, I think the target of 45 completes per physician still applies; is that correct?

>> That's what -- yes. Whereas in Minnesota the analysis is at the clinic site, not at the individual practitioner.

And we've actually -- I mean this is one of the things that we will hope to learn from doing the pilot is the actual number of completes that are needed to get a sufficient reliability at the clinic and site level.

We've developed a sampling scheme for the clinic sites based on the size of the clinic site. It's based on some empirical data from the Massachusetts statewide survey which kind of followed a similar approach, where they varied the number of target completes according to the size of the practice.

So we've adopted that idea but we've modified it to kind of overshoot for what we think might be necessary for that reliability when the response scale has changed from this four or six-point response scale to a much more constrained yes/no or the three point yes/no scale. So I think it's an open question, and we're hoping for enough sample for each of these clinic sites that we will actually be able to do solid comparisons.

>> Just to give you an idea for our variable sampling schema, we're looking at target completes that range from, 90 completes for a clinic size of two to three docs/physicians up to 360 targeted completes for much larger sized clinics.

>> So when I mentioned that the test that Alina is helping us with when we are actually going to do a head-to-head comparison of visit-specific versus 12 months. Those will be done in those two larger clinic sites, we'll be looking for target completion of that 360 that Michelle just mentioned.

Let me add one more thing, Julie mentioned the 45 completes for physician completion. For medical groups we've said in the NFQ-endorsed specs that the target is 300 completes per medical group. That's just kind of the standard that's out there right now.

>> Similarly for sampling, is there a certain number of visits that are required in order for a patient to be sampled to be entered into the sampling frame?

>> No, any patient that was seen during that three-month period was equally eligible to be part of the sample.

>> But they had to have a visit.

>> They had to have at least one visit during that three-month period.

>> And the question was really centered around patients that may have visited but that the clinic but that might not be there regular doctor or the doctor they see on a regular basis.

>> Right. And again we're trying to measure the experience that took place at that clinic. So regardless of their length of relationship or how frequently they go to that particular clinic, we'd still be interested in the experience they had.

>> We ask that question on if survey, so we will know for every respondent whether they're responding about their regular doctor or the doctor that they happened to see at that clinic for that visit.

>> Several questions about benchmarking and trending from all aspects: from the version 1.0 child survey to the 2.0 beta version, from the four-point scale to the six-point scale or vice versa as well as trending between the 12 month reference period and the visit-specific reference period.

So I don't know if all those can be addressed at once or --

>> I don't know how to address all that at once. Can you pull out a question from that?

>> I think I heard something about trendability of 1.0 and 2.0 versions of the child survey?

>> Yes.

>> Go for it, Julie.

>> I'm just parsing questions here. I think that's a really great issue and defer to Trish on this one. I think one of the things that's really key is that there's a common core. The value of the 2.0 child survey is that it introduces some new content area that we all believe is very, very important. So I would think that the two versions would be trendable, with the understanding there's new topic or content in the 2.0 version that isn't in the 1.0 version so that you couldn't trend on those composites.

>> But it should be no problem at all to trend on, it will not be a problem on the doctor communication composite, which remains the same as well as the other composites.

>> I know there are a lot of other questions built into what you just said, Carla.

>> Should we as a group tackle the four-point versus six-point scales?

>> Well, so what we're planning to do right now from a National Database point of view, we'll take all of those surveys in. There's a conversion that can be done fairly easily, if you've collected the six-point scale data that can be collapsed pretty reliably and easily into the four-point scale response categories. You can't go the other way.

So we're not going to lose any data in the database. We won't ever sort of erase anything. So we'll always have sort of the granular data that's submitted to us, and it may be that the four-point response scale for the 12-month version, we might have all of the data that were submitted using that instrument. We could add to that the collapsed data from the six-point version and call that the four-point expanded data set, but I don't think we ever want to lose the ability to take them apart in case we have users that want to just compare to the data that were collected, strictly using the four-point version. So a lot of this we'll be figuring out as we moved forward as we actually see the degree to which users move towards six-point or four-point, and my sense is that will help dictate a lot of the availability of benchmarks if we have more or less users in any one of those camps.

>> Dale, if you could comment also on trending between 12 month and the visit-specific version if someone wanted to move toward the visit-specific version but had been implementing the 12 month version previously?

>> I think that's going to be really hard to do. Like when we described the visit-specific instrument, the question content is the same. Virtually the same.

But the response scales are different. There are one or two questions that would be pretty much exactly the same, the 0-10 rating. Off the top of my head, I can't think of anything else because the response scales have changed for each of the question stems.

So I think it's going to be very hard to do any sort of comparison from 12 month to visit-specific. I don't know if Trish or Julie you want to comment on that?

>> No, I agree with everything you've said.

>> You've encapsulated the issue, Dale. It's a real one, but we think it's worth it to move forward with this new instrument.

>> Given the poll responses, it was clearly over half of the users in the webcast are inclined toward visit-specific. We also know that there are a number of national initiatives, the American Board of Medical Specialties probably the most prominent among them, that is looking at utilizing a portion of the CAHPS Clinician & Group Survey in a "your visit" or visit-specific format.

>> In terms of the analysis of the Clinician & Group Survey data, are there any adjustments for mode effects in terms of phone versus mail data collection methodologies?

>> Not for the 12 month version. In all of our field testing, we found that when collecting comparable data, mail and live operator phone, I think that's an issue that one of the issues Dale mentioned will be explored in the analysis of it the visit-specific version.

>> Well, we won't have any point of comparison in the Minnesota pilot on mode because it's all going to be done by mail. I guess when I mentioned it, it's actually a call for anyone out there who is using different modes, if they want to help us answer that question more precisely, we'd be really happy to work with them on that.

>> Great. Dale, could you please clarify. You mentioned that Minnesota is serving as an aggregator for visit-specific data across multiple vendors and medical groups. And can you clarify whether that's just for Minnesota and perhaps some statements that were made with regard to the CAHPS Database of what could potentially occur at the national level.

>> Well, we're playing a specific role in the Minnesota pilot that Michelle described where given Minnesota Community Measurement's interest in being responsive to other groups wanting to retain their current vendor. Instead of opting for one single vendor for this pilot, we, some entity needs to take the data collected by the various vendors working for these groups and put it all together. And so the CAHPS Database volunteered to play that role partly because it was a function that needed to be filled, but it will also give us some chance to get some direct experience in collecting and analyzing that data.

So that's the role we're playing in Minnesota. We've played that role in other markets for other projects. In California, we serve as an aggregator for hospitals collecting Hospital CAHPS data for the CHART project. And we certainly are interested in playing that function in other markets if they followed the same kind of a model here that's being followed in Minnesota.

Can't commit to doing it everywhere, but we'd certainly be interested in exploring that because it's an avenue for us to have a hand in the actual handling of the data that would end up being in the database anyway.

If I didn't answer the question I'll be happy to try again.

>> Thank you. Can users insert their own questions, their own CAHPS-like questions into these surveys?

>> I'll take a try at that one. The short answer is yes. We really think that it's wisest, most wise to insert those questions just prior to the demographic section, the About You section, in each of the questionnaires because we know that context effects happen. That the questions asked around questions affect how people answer a specific question.

So in order to have comparable data across, even in your own groups or across groups, that it's best to put all of the non-CAHPS questions after all the demographic ones. Does that make sense?

>> Great, thank you. In the development of the visit-specific survey, did you look at other visit-specific surveys? For example, the Bureau of Primary Healthcare's visit-specific survey, they require a minimum of 30 or so completes per site. And sites that are interested in ongoing QI feedback, repeat it on a rolling basis.

>> I think as I mentioned earlier, our goal was really to preserve the core topics that were in the 12 month version of the Clinician & Group Survey in the visit-specific version of the 12 month survey. Our task really had a narrow focus in that we were trying to determine what is the minimal adjustment that one might make to translate the existing Clinician & Group Survey into a survey that would assess visit specific experience with care.

>> I understand. That's a great response on the content issue and for the development of the survey instrument. All these administration questions I think are really, we are really exploring what is the best way to proceed in the context of a project with multiple medical groups and multiple clinic sites using different vendors. And in not really knowing what sample sizes are necessary for sufficient reliability across these clinic sites.

When the ultimate aim, as Michelle can sort of describe, is to actually move to public reporting of these results at the clinic site level. So it's a little different than collecting data with an instrument for internal use for quality improvement, which many of these groups have been doing for years anyway. It's moving towards a standardized instrument across the groups that has got enough sort of power and validity to actually support public comparisons.

>> This is a two-pronged question. One is if one of the, if Julie, Trish or Dale could comment on the use of incentives to improve response rates, and Michelle, specifically, on whether you considered the use of incentives in the Minnesota pilot.

>> I can start answering that. Incentives can be used, and they have been proven to work. Test after test or experiment after experiment with incentives is that the most effective incentive is prepaid cash incentives, and they could be as small as, very small, a dollar. We've all gotten the nickel in the mail now. It seems to be enough, even a small cash incentive, to get people to read the material. And once they're reading, reading and see what they're being asked to do and what it's for, they're more likely to respond.

>> From the Minnesota perspective, we certainly did have this conversation, and I think probably just mostly in interest of cost decided not to pursue incentives, but I know some of the groups use this practice in their current surveying. Some of them, for instance, offer coupons for particular health related items. But again just to keep the cost within scope we decided not to pursue an incentive.

>> The Minnesota group sort of liked to group amongst themselves, "This is Minnesota, so people just responded to surveys." Response rates tend to be higher in this market compared to other parts of the country.

>> Can you also clarify or talk a little bit more about whether the Minnesota work is focused at the clinic level or at the individual physician level.

>> Well, the survey itself asks the patient to talk about their interactions with both the physician, but also clinic staff. We are planning to publicly report the results at the clinic site level. So for various medical groups that are participating each medical, each primary care clinic site was required to participate and would be reported at that level.

>> Another clarification on the methodology being used in Minnesota. If you could talk about the different waves that you're doing, whether it's mail only, are you doing telephone follow-up. Are you following up with another survey or a postcard reminder. If you could kind of clarify that as well.

>> Sure, we're doing a two-wave mailed survey, and both mailings will include a cover letter and the complete survey. So the survey will be sent twice to those that didn't respond to the original mailing. We elected not to use the postcard reminder. However, that is I believe the standard protocol for CAHPS, and I believe there's been some discussion about whether that, how much of an increase those response that brings. We, again, because of cost considerations, decided not to include that. So we're just doing a two-wave mailed survey but we're not doing any telephone follow-up.

>> I'd like to put in a plug for the postcard reminder. We find that it's a very cost-effective way of increasing your response rates. Across many experiments using postcard reminders. on average it's

about a three percent bump in response rates when the postcard reminder is used. and it's really an inexpensive way of getting that kind of response increase.

>> Great. Julie or Trish, if you could comment on any other work that the CAHPS team is doing looking at alternate modes, such as online administration, or other types of alternate modes.

>> I guess this is an opportunity to put in a plug for the upcoming User Group Meeting. There will be a special session there that actually I think Trish is participating in on kind of alternative methodologies for the Clinician & Group Survey. So I think that rather than give an answer here that may be too preliminary, I think I'd like to say watch the space and put in a plug for the User Group Meeting in December.

>> Thank you. I think I would have followed up on that as well. Are visit-specific surveys available in any other language besides English?

>> Not yet. I would think it will be because traditionally with the CAHPS surveys at least published a Spanish version. Julie can actually comment on that because RAND does a lot of that translation, but I think we'll probably wait until we get out of test mode about that version before we move into language translation.

>> I think that given, as Dale's reminded us, one of the reasons we're presenting this information is also to put out a call for others who might like to assist in testing the visit-specific version. I think we'd certainly welcome the opportunity if someone wanted to help us test it in Spanish. Ideally we like to test all of our CAHPS instruments in Spanish and English. I agree with Dale, historically the CAHPS Consortium has always provided materials in Spanish and English. While we recognize there are languages beyond that for which users have needs. For financial reasons, English and Spanish are the only languages we do support. We do provide recommendations and guidelines for translations for users who find they have a need that's not met by the English and Spanish materials.

>> Wonderful. We had a question about whether or not the visit-specific survey was being fielded in any other types of clinics, and I will take that question because we have shared this test version with a number other different types of sites, such as public health clinics, that are interested in using the survey as well. So we're coming to you with start-of-the-art updates, so we don't have a lot of information that we can share about user experiences, but look for that information shortly both at the User's Meeting and subsequent to that we will be very proactive about sharing the experiences that we are gaining from various users of this survey.

>> Can I also just put a plug in. Because these are always in the public domain, we never really know for sure who is using a CAHPS survey at any given time for a given application. I mean we have a pretty good idea about that, but really want to ask all of the users on the line and out there that we hear from you so we know that you are using the instrument and if you're clearly willing to participate in the Database or just share your experiences with us because that's how we're going to learn as the CAHPS community.

>> Absolutely. And, again, just to reiterate, we had a lot of questions about how to get the surveys. The Child 2.0 beta version will be part of the updated Clinician & Group Survey and Reporting Kits that will be posted shortly. If you need them in the interim and you were not able to download it from the website, please contact the survey User Network technical assistance line, and we can get you a copy of the survey in the interim. The visit-specific survey will not be posted on the website because it is a test version. But again you can get the version through the technical assistance line.

And with that I'd like to say thank you to everyone who submitted such valuable questions and if we did not get a chance to answer your question, please again feel free to submit it again through the technical assistance line, and we value your feedback and ask you to spend a few minutes completing the

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evaluation that appears on your screen, because we do listen to your feedback and use this to develop future events that we may have for you. Again, thank you to our presenters and to all of our participants.

>> Ladies and gentlemen, this concludes today's teleconference. Thank you for your participation.