

The CAHPS Clinician & Group Survey: Strategies for Community-Wide Implementation

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Participants

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Donna Marshall, Executive Director, Colorado Business Group on Health
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Presentation

Operator

Greetings and welcome to the CAHPS Clinician & Group Survey: Strategies for Community-Wide Implementation Webcast. At this time, all participants are on a listen-only mode. A brief web-based question and answer session will follow the formal presentation. If anyone should require operator assistance during the conference, please press *0 on your telephone keypad. As a reminder, this conference is being recorded.

It is now my pleasure to introduce your host, Mr. Dale Shaller. Mr. Shaller, you may begin.

Dale Shaller – National CAHPS Database – Managing Director

Thank you and good afternoon and welcome to our webcast on the CAHPS Clinician & Group Survey: Strategies for Community-Wide Implementation. My name is Dale Shaller and I'll be the moderator for today's webcast.

Today's webcast is one in a series of webcasts on CAHPS, which stands for Consumer Assessment of Healthcare Providers and Systems, produced by the CAHPS User Network. The CAHPS User Network is administered by Westat under contract to the Agency for Healthcare Research and Quality or AHRQ, which is the federal agency that funds the entire CAHPS consortium. The consortium includes the RAND and Yale grantee research teams as well as many other government and private stakeholders, all with the common interest in measuring and improving the patient care experience.

The CAHPS family of surveys for assessing the patient care experience continues to expand for both ambulatory and facility based care. The CAHPS Clinician & Group Survey, or C&G Survey for short, is highlighted in this list since it's the focus of our webcast today on strategies for implementation. The C&G Survey is designed to assess patient experiences of care with medical groups and practices as well as with individual clinicians and practitioners.

We're really pleased today to welcome two outstanding speakers on our program. Joining us from Denver, Colorado is Donna Marshall, Executive Director of the Colorado Business Group on Health. And joining us from La Crosse, Wisconsin is Tom Schlesinger, Executive Consultant of the Gundersen Lutheran Health System headquartered in La Crosse. And again, I'm Dale Shaller, serving as the moderator for today's webcast and I'm a member of the Yale CAHPS team and also the Managing Director of the National CAHPS Database which is administered by Westat as part of the CAHPS User Network.

I'm going to begin the webcast with a brief overview of the CAHPS C&G Survey and the two major strategies that we'll be discussing for getting to community-wide implementation. Donna will then speak to what we refer to as the centralized model of implementation and Tom will address the decentralized or leveraged model of implementation.

As always, we plan to allow time for your questions and we'll do our best to answer as many as we can. To ask a question, you simply select "Ask a Question" from the navigation bar at the bottom of your screen as shown circled here. And all you need to do is type your question in the text box and select "Submit." Please feel free to send in your questions during the presentations and we'll address them during the Q&A session and we know from previous webcasts that participants really do value the Q&A session so we really like to hear from you so please send us along your questions.

At any time during the webcast, you can access the slides for downloading as well as an issue brief that's related to today's topic by selecting the event materials tab as shown here on your screen.

And finally, if you need help any time during the webcast, just select "Help" on the upper right portion of your screen and if you're dialed in to the telephone line to hear the audio, you can also dial *0.

One common problem is not being able to hear the webcast through your computer speakers. You can join us by phone at any time by dialing 1-877-407-4035 and entering the pass code number 358844#.

Another common problem is having your computer freeze during the presentations. You can try to solve that by hitting your F5 button on your keyboard to refresh your screen and remember that you may just be experiencing a lag in the advancing of the slides due to your own internet connection speed and you can also try logging out and logging back into the webcast and that might help.

Finally, if you have any other questions, you can call for technical help directly by dialing 1-866-490-5412.

Now, on with the program.

The motivation for the webcast today on community-wide implementation of the CAHPS C&G Survey stems from the growing demand for comparable CAHPS Survey results across all medical practices in a given market. The demand for comparable C&G data is driven by several forces including the need for standardized patient experience data for public reporting, pay-for-performance, quality improvement, and recognition of the patients under medical home.

While having such comparable data to go many can agree on, getting from here to there is not easy. For example, practices may use other surveys for assessing patient experience and may be reluctant to change. There are always issues related to cost of implementation and who will pay. And even if all practices in the community begin to collect C&G data, how can we assure comparability of results?

Well, before diving into potential strategies for addressing these implementation challenges, let me first quickly summarize the various versions of the C&G Survey available.

First, there's a 12-month version that asks respondents to report on their experiences with various topics included in the survey such as doctor-patient communication, access to information and care,

and the responsiveness of office staff. This 12-month version is available for adult and child primary care and adult specialty care.

There's also a visit-based version which includes questions that ask respondents to report on their experiences with doctor-patient communication and office staff based on their most recent visit and then to report on access issues in the last 12 months.

And we now have a CAHPS version of a new survey to address an expanded set of topics that are relevant for assessing patient experiences with the patient-centered medical home. Those include coordination of care, shared decision making, self-management of chronic conditions, and comprehensiveness of care. This PCMH survey is currently in field testing and will not be formally released until mid 2011.

So these multiple versions of C&G CAHPS are currently being used in a number of regional collaboratives such as those involved with the Aligning Forces Program sponsored by the Robert Wood Johnson Foundation, which by the way funded the white paper on implementation strategies that forms the basis of today's webcast. The Aligning Forces Program also includes the Wisconsin Alliance that Tom is connected to.

The Charter Value Exchanges are another program supported by the AHRQ. That includes the Denver Coalition that Donna leads.

There are various health plans and medical groups that are beginning to adopt the survey for quality improvement and pay-for-performance. The Department of Defense is now collecting thousands of these surveys every year on military families. The American Board of Medical Specialists has decided to include a subset of the communication questions and its new maintenance recertification requirements and is growing into this and using the C&G Survey, an expanded survey that we now have in test form to assess patient centeredness (ph) in the patient-centered medical home.

The two basic strategies that we'll be discussing today for implementing the C&G Survey on a community-wide basis are the centralized approach which basically consists of hiring and funding a single survey vendor in order to create a single sample frame and then collect the data and examples of these approach include Consumer's CHECKBOOK model which Donna will be speaking to and similar efforts underway in Massachusetts through the Massachusetts Health Quality Partners initiative or MHQP and in California through the Pacific Business Group on Health or PBGH.

The second major model is referred to as the decentralized or leveraged approach and this basically involves integrating the core C&G Survey items into existing surveys that are used by medical practices in the market or that could be used by medical practices. It also involves standardizing protocols across these practices for sampling and collecting the data and then finding ways to aggregate the multiple data sets that gets collected through those various decentralized medical practices through a neutral vehicle such as the CAHPS Database so that those results can be publicly reported in a standardized way.

So that's a brief overview and then to begin the discussion for a more detailed look of the centralized approach, let me turn now to Donna Marshall, again, Executive Director of the Colorado Business Group on Health and Donna has been at the forefront of performance measurement and value based purchasing strategies to the Coalition Movement for almost three decades. And we're really happy to have you, Donna, and I'm turning it over to you now.

Donna Marshall – Colorado Business Group on Health – Executive Director

Good afternoon, everyone. It's really a pleasure to join this conference call. I'm going to be running you through a number of slides here on the centralized approach for survey administration. If I can have the next slide.

First, I'd like to start with a little bit about the Colorado Business Group on Health. We're a member organization not for profit and established in 1996. We've listed the mission and vision there and I would like to point out that we're proud members of the National Business Coalition on Health. There're about 60 of us around the country.

Next slide.

Then I would be remiss if I didn't thank the members of the board and the purchaser members on the left. We are also joined by a number of large associations and a number of affiliates including hospital physician groups, mental health centers, and other groups involved with the provision of healthcare in Colorado. We are very grateful for their support.

Next slide.

We're going to go in my portion of the presentation today over briefly over the importance of this project in our market. We'll touch upon some of the, I think, more important facets of the implementation effort and spend the most time of this discussion on the business models and some comparing contrast I think might be available especially after you get to hear Tom's presentation.

Next slide please.

This is so congruent with efforts that we've made in our marketplace. Our joke is that we were kind of in the business of transparency before the word transparency got to be commonly used in the healthcare world. So when we were approached with the concept here to do a project like this, it was a pretty easy sell in terms of whether or not we should proceed and devote some internal resources. So we have consistently promoted the value of transparency and our annual publication is called the Health Matters Health Plan and Quality Report, which we've actually started in 1996. So we've been publishing HEDIS metrics and health plan CAHPS results since 1996, featuring Leapfrog data since 2002, and we added Bridges to Excellence data featuring the physicians who qualify for that program since 2006. So in our 2009 version of our publication which is on the website, we actually have an article on our Clinician CAHPS project so if any of you are interested that's www.coloradohealthonline.org.

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Our partner and originator of this concept is the Center for the Study of Services and I think Dale mentioned them earlier in his presenting and opening remarks and we'll get to them in a second. I'd like to also mention that our major partners that we worked with before the administration of the survey were critically important to the success of this project. We solicited health plan participation and we're very grateful that both Aetna and United wanted to be our partners in this endeavor. As I mentioned, the members of the Business Group on Health, it was a pretty easy sell, but we spent a significant time with members of the leadership group and individual members of the Colorado Medical Society, the Colorado Association of Family Physicians, and key physician groups. We thought that was very, very important. We wanted to share the notion that we were working with the physician community. This is not a project we were doing to them but with them. And I think that

was a very successful strategy especially in a launch of a project like this which can be seen as threatening in an environment.

And the last point on this slide is that we convened a community and consumer discussion around the data and around the release of the data before the data went live. That included consumer groups; members of Patient Safety Coalition, the largest physician malpractice insurance company in Colorado; and we also had a representative from the local region 8 Centers for Medicare and Medicaid. So it was quite a great discussion.

Next slide please.

As promised, a little bit more about our partner in the project which was the Centers for the Study of Services and this is a group that was founded in 1974 and they have been on the forefront of providing information to consumers on a number of different service industries but, of course, we've interfaced with them on the medical aspect of transparency in survey administration since we started publishing our Health Matters Quality Report. In fact, they do some work on some statistical and analytic for us looking at the health claim CAHPS Survey. They came to us. This was basically their concepts about how to put this project together and they've just been excellent partners.

Next slide.

So here are a few brief points on the overview of our survey administration. As we've said, we had a number of informational meetings. We worked with the health plans, who were the source of the sample data. They provided the names and addresses for patients who were associated with the primary care physicians. This data was sent to the Center for the Study of Services who compiled this Health Plan Data and created a sample frame. We sent informational letters to the physicians in advance of survey administration. These were signed, co-signed by the Business Group on Health, Center for the Study of Services, and also the Colorado Medical Society and the Colorado Association of Family Practice. And as you can see, the administration... so the survey responses were compiled by the Center for the Study of Services.

Next slide please.

The survey that we used was the Clinician CAHPS and it was the protocol... the NQF endorsed protocol for the 12-month version. And I've shared with you a few statistics here on some outcomes. The survey itself was administered almost concurrently in Kansas City and Memphis as it was in Denver. So a little bit of granular detail about the response.

Next slide please.

Now, while we were fielding the survey, we were busy thinking about the reporting... the reporting roll out for this kind of community project is really a critical step. We tried to think this through very carefully and this again details some of the meetings that we were able to convene. The formatting of the data and how you release the data is a very, very important consideration to the physician community as well as it should be, the ability to preview the results, and to delve into the technical and statistical aspects of this project really mattered. The physicians were very concerned that we had a transparent process. So we tried to live up to that. As you can see that the data was released 60 days in advance of reporting and we had about 38% of the physicians who were profiled actually went online and did review the data in advance.

In the next three slides, we have some detail about how the data are actually displayed. So it's kind of small on my screen but I hope you can see this a little bit better.

Can you back up one second, to slide 11? This particular display allows people to put in a name or put in a zip code. You can do all manner of sorts on this and importantly, you can select three of the physicians who you'd like to profile on a side-by-side basis.

Now, next slide, thanks.

Here is an example of a drill down comparing the three different physicians to each other as well as to an average score.

And the next slide please.

And this lists the components on a question-by-question basis of the roll out.

Next slide please.

We just wanted to share with you some of the results in Colorado from our survey. You can see that one of the most important questions, which is "the doctor always listens carefully to you," had a 78% rating of "always."

Next slide please.

As I mentioned, the initial pilot projects were in Kansas City, Denver, and Memphis. And I thought it was important to kind of share the business model that CSS is using. The results are free on their website on an individual and public use basis. Also coalitions such as mine and the two other sites in Kansas City and Memphis also have access to the data and the information is then being licensed for a fee to the health plans and that helps support the administration of the project.

Next slide please.

So I'd like to conclude the presentation by talking in some depth about variations on the business models and some of the advantages on the approach that we've taken to this. First of all, I just like to ask a question, where's the impetus to create a community based model? And so is that a business coalition? Is that in an Aligning Forces for Quality group? Is it some sort of other community-based organization that sort of has the desire and strength to do the heavy lifting for this kind of a project? So I think that's really a key. So in your community, where would be a source of a project like this?

Then I teed up a few key questions. Obviously, what tool are you going to use? Where does the sample frame come from? Is that going to be from the health plans, from the physician groups, from the health systems? Absolutely important that we have, you know, enough in the sample to make this really a robust sort of effort. Next, who administers the survey? Critically, who pays? And you know that's always the sort of key question when it comes to community coalition, how do we get funding to mount this kind of project? And not last and not least, how are those results going to be used? And we really need to get those questions framed up in advance.

Next slide please.

Okay. Source of the sample frame. This actually in this slide, I tried to sort of tee up that there's really various ways that we can look at to conduct a project like that. We, of course, used multiple health plans to pool their data. But other opportunities might be if you have one dominant health plan that has sufficient number of patients per physician. Certainly, multiple health plans and multiple medical groups could come together and put their patient list together. You could have a health plan in multiple groups... multiple groups themselves or if you have a really dominant health system, perhaps they have the wherewithal to do that in your community. Similarly, we teed up a few questions on who administers the survey and, again, there're a number of options that I think we can present.

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Okay. I'd like to just talk about the advantages of the coordinated model and it occurs to me the first bullet as I reread it over, it was so clear to me, but maybe not necessarily clear to the audience. So let me explain a moment. We actually know by prior survey results and studies that consumers are really quite able to differentiate a question that says how well do you think that your physician communicates with you or listens to you or that sort of question, can differentiate really well that compared to how do you... how well does your health plan serves you. So the fact that you have data from multiple health plans... I think originally there was some concern that maybe people would be confused about these kinds of questions and if the source of the data was from Health Plan X or Health Plan Y, but studies have shown that people really do know how to differentiate the health plan from the physician. It seems obvious to those of us on the call but it has been a question. So that we you pool the data from a number of health plans, you really just do get the advantages of a larger sample size without mudding the water.

On the next point, sharing the cost and the start up overhead cost. That's absolutely also an advantage to a project like this. We heard from also a number of physician groups in the Colorado community that were trying to do the heavy lifting by themselves that it was really helpful that we'd come in with this consolidated project.

Clearly on the next point, the sample sizes are adequate as you could see from our previous slides of about 150 per physician responded burden is diminished when you have a singular approach, maybe on an annual basis. That's very helpful to the patient. Similarly, when we go out with singular results on physicians, we don't have a lot of noise in the community with different results from different doctors or different surveys conducted at different times. It enhances the likelihood of the impact on doctors in our case because for our situation in Colorado, we have a number of very small practices and we have a number of health plans. So where there's a lot of fragmentation in the marketplace, it's really important to work together to make sure that the physicians understand this is a community-based group and there are a lot of eyes on these particular results.

Visibility and impact on consumers is also impacted and the last and final point on this slide, inflation from possible physician push back. We did not have that issue but I know in other markets, there was a lot more concern on that particular topic.

Next slide.

To finish these points, the sharing and collaboration with other users is important across the board and we're hopeful that we get some consistency on a national basis of how these results can be used to enhance physicians' certification processes for internal medicine and the other specialty boards. Hopefully, this kind of a project mix is more cost effective because of the non-profit nature of the

coalition and our survey administrator and it's a once a year burden as opposed to an ongoing burden.

Next slide.

For us, it was particularly attractive where we had few resources and our survey administration partner could really help us kludge together the health plan in terms of participation. We helped a lot, too, in our market, but because there was a vision of a plan that could pull together the financing and the administration, that was extremely helpful.

And my final slide.

We've had over 50,000 unique website visits since we launched this. I don't know if that's a large number or a small number. I think when you've got a new project like this and consumers say they want it, it's important to continue to promote it. And if I would say there's one area of interest that I would say that we've had fewer resources than I had wished, it is the opportunity to continuing to promote the project. You can see a bit about what's going on currently in New York City and just to note that we're interested in repeating the project here in Colorado, perhaps next year if possible.

So that concludes my side of the presentation.

Dale Shaller – National CAHPS Database – Managing Director

Donna, it's terrific. Thanks so much. I want to thank those of you who have submitted questions thus far and I also just want to apologize for some of the background interference which I believe is at Donna's end and so you'll be able to mute that now, Donna.

Donna Marshall – Colorado Business Group on Health – Executive Director

Yeah, I'm very sorry. I'm in a little cubicle, sorry. Sorry for the background noise.

Dale Shaller – National CAHPS Database – Managing Director

Let me... before we move onto Tom, I do want to... there's a couple of questions that might help if we address them right now. One comes from Susie Dade at Puget Sound Health Alliance in Seattle asking how did you get the medical society and the family physicians to sponsor the work and to finance and even put the signature on the introductory letter to the survey.

Donna Marshall – Colorado Business Group on Health – Executive Director

We asked nicely.

Dale Shaller – National CAHPS Database – Managing Director

Okay.

Donna Marshall – Colorado Business Group on Health – Executive Director

Actually, the physicians recognized that when each health plan in the community perhaps is conducting their own surveys or the medical groups are conducting their own surveys at their own internal cost that that's quite a burden on everybody in the community and because we were using a national standardized survey and because we've been good partners in the past, I think building that reputation over time has been really important.

Dale Shaller – National CAHPS Database – Managing Director

Great. There's one more question, and then I want to get on to Tom, specific to your project, a question from Cliff Rowley at HealthPlus of Michigan, did your sample at the physician level include Medicaid patients or was it just commercial?

Donna Marshall – Colorado Business Group on Health – Executive Director

It was just a commercial sample.

Dale Shaller – National CAHPS Database – Managing Director

Okay. All right. There are several other questions that I think we like to address when we get to the Q&A together at the end. But, Tom, let me turn it to you and quickly introduce Tom Schlesinger again with Gundersen Lutheran Health System in La Crosse, Wisconsin. Tom is in charge of strategic planning and that organization has been there for 10 years and it's heavily focused on service to patients and other dimensions of quality measurement. Tom?

Thomas Schlesinger, Ph.D. – Gundersen Lutheran Health System – Executive Consultant

Thank you very much, Dale. Hello, everybody. I just want to talk a little bit about this alternative approach that you've heard that there was centralized approach from Donna and what I'm going to be highlighting is a different kind of approach that we've done here in Wisconsin for purposes of this pilot.

Next slide please.

So Gundersen Lutheran is an integrated delivery system here in southern Wisconsin, Minnesota, and Iowa. About 6500 employees, 450 doctors, 2 hospitals, about 41 clinic locations, physician-led organization, and as an integrated healthcare system, you know it is really the continuum of care so it's clinic and hospital connected with the integrated healthcare system, and an administrative and medical leadership within the organization.

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One thing I did want to be highlighting is I'm speaking from the perspective of Gundersen Lutheran. We are members of the Wisconsin Collaborative for Healthcare Quality, WCHQ. And WCHQ is an alliance similar to what Donna's is in Colorado. We have one in Wisconsin. Donna's, as I believe, was really begun by a group of purchasers and who had been reached out through the provider communities to partner with them. The collaborative in Wisconsin was really a provider-started organization but then reached out to purchaser organizations. So I think our perspectives are a little bit different in how we're coming at that and that's part of what you'll see. What I really want to highlight today is how public reporting really drives the improvement at Gundersen Lutheran. So I think Donna's approach is sort of public reporting helps drive consumer choice and that drives improvement. Here at Gundersen, we use public reporting to help highlight areas that need work, involve senior leaderships in what that work is, and then that work drives all the way down to individual departments and individual providers.

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So how does this work? First, you have set a standard measure nationally where different provider organizations are measured on the same thing. In this case because the C&G CAHPS Survey is just developing, we will have a standard measure. We don't know quite which version of the C&G CAHPS that will be and it may be this hybrid one that we're working on. But first you need a standard

measure that you can collect from different provider organizations. That data is then publicly reported. In the case of how we use it then, our boards... our senior boards as well as our senior leadership will review the publicly reported data. Look at what areas that need change, and then hit advance, if you would, Oren (ph). And then that same set of data that is publicly reported is then used for quality improvement internally. So it's not just that the data is publicly reported and we hope that consumers use the data and we hope that providers look at the data, we use it to hold everyone responsible and accountable for improving the patient's experience based on that data.

Next slide.

So transparency is really a fundamental belief of what drives improvement here. We were one of the founding members of the Wisconsin collaborative. And we very firmly believe that the same data that's publicly reported should then be adapted by the provider organization to drive their internal improvement because it's one thing to put the data out there and show what performance looks like. The other kind of use for it is to measure change. So what we do is... maybe we don't look good in some things. We say where were you before we started an intervention, we changed something in the process, and then we look at the data to see if it's getting better. So we used that same set of data to try and improve the patient's experience. That data is viewed organizationally, it's broken out by individual department or hospital unit, and then it's broken out at the level of the individual physicians who receives their own results for their own set of patients. So the data that's publicly reported is collected in larger numbers and broken out by units and trended over time so we can then use that information for improvement purposes.

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So this is basically what I was saying in terms of we get organizational results but as well the individual departments receive their data every quarter, individual providers will receive their own performance data twice a year and, importantly, that data is trended over time so they can see are they making improvements in their practice that they're making things better or are they going the other way?

Next slide please.

So for the purposes of this pilot, we were particularly interested in the C&G CAHPS Survey. In particular, in this thing called the hybrid or the visit-specific version of it because we want to measure change over time. So as Dale had mentioned, there's a 12-month look back version of the survey that asked patients about their experience over the past 12 months. That's less helpful to provider organizations that are trying to use the data to see if we're making things better. So we like this specific version. When we heard about the opportunity to pilot, we really jumped at it. So for purposes of this pilot, we used a single vendor, Press Ganey, and three different medical organizations in Wisconsin chose to be part of the pilot and because Press Ganey was a common vendor among all three provider organizations, they were able to administer the survey. Because the C&G CAHPS movement towards public reporting is happening quite quickly, we were on a tight timeframe in terms of getting the data out there to be reported and to be compared using models that we're talking about today. And then we were particularly interested in migrating from a proprietary vendor-based school for our improvement purposes towards using the C&G CAHPS data as what drives internal improvement here.

Next slide please.

So just to recap our pilot, we used the same version of the survey. It's called the CAHPS Clinician & Group Survey visit-specific or the hybrid version. There were three provider organizations and it's us plus two other provider organizations that were present... oops, I think you went one too forward. And then we had... in each of the provider organizations, there were three primary care locations that were surveyed or part of the pilot. All visits made to a doctor or physician assistant or nurse practitioners were sampled and surveying occurred between June and August of 2010. Surveys were mailed out by the vendor. They were the sampling occurred by the vendor, the mailing occurred by the vendor. They input the data and they reported it. So they're doing it to ensure the integrity of this process because eventually the goal would be that the vendors collect these data and send it in to some central database and that's similar to how much of HCAHPS which is the hospital version of this standardized survey. That's similar to how HCAHPS is done. Much of it is collected by vendors and sent into a central database.

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So our business model is necessarily different from Donna's. We're a physician-led organization who is really focusing on delivering superior quality of care and service to the patient. So it's part of our doing business. It's like the other organizations may measure their customer satisfaction, we do it likewise, and then we use it to drive individual improvement initiatives within really throughout the organization. Every department has their own set of data and they decide what they need to work on all the time and then use the data to measure change. We have a service excellence department that manages the survey process as well as works with the frontline staff to educate and train them on how to improve the experience of the patient. So it's a little bit... definitely a different business model and it's driven by our role as a provider organization.

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So what happened after we did all these? As what we really wanted to do is we wanted to see how seamlessly we could integrate the C&G CAHPS Survey into our existing survey process, so it was appended, so to speak, onto our existing survey by the vendor. It was really seamless as far as we were involved. Press Ganey, our vendor did a fair amount of work on their side to integrate the survey and then report the results, but there was really minimal additional cost because we were already mailing out patient surveys. We mail out normal... on a normal basis about 100,000 surveys a year because we're a larger provider organization. It was pretty seamless in terms of how it's integrated into existing sampling and mailings and we didn't see much in terms of disruption on our end as a provider.

When you get the results, things are a little bit more problematic in how we did it because we had standard survey from Press Ganey that asks a whole set of questions about their experience in the clinic and then we have this C&G CAHPS Survey and it's results. And so we actually have two sets of data. One, vendor survey based and one C&G CAHPS survey based. If you're the department that receives that data, it's a little bit problematic in terms of which set of data do you look at, the publicly reported one or the one that you've been using for several years.

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As way of an example, I want to show you what our experience is with the HCAHPS or the hospital CAHPS survey. Because what we have there is we have something similar where we have the publicly reported question and then we have the survey proprietary vendor based questions and then go out to the same set of patients. Even though they are similar questions they don't necessarily capture the

same things because the questions are worded differently and the response scales are different. So for instance both the vendor survey and the HCAHPS survey contain a question about noise at night. This graph shows how the two different surveys, how that data trends differently over time. From our point of view, as a provider organization, we really are dedicated to improving the publicly reported scores because we feel those are the things that, you may say, the powers that we have decided are the most important things... are the most important things to the patient. And so we... given how these two sets of data differ, we would say we would like to focus on the publicly reported data and that's important to new provider organizations that are thinking about, now I have two surveys, what do I do? How do you use a publicly reported data and still drive improvement in your organization?

Next slide please.

So you can go out to the Wisconsin collaboratives website, wchq.org, and view our reports and you'll be able to pull up the results that are comparative results not too dissimilar to what Donna showed. One real distinction is that Donna goes down to the level of the individual provider and WCHQ goes down to the level of the practice sites and that's probably a fundamental philosophical difference about how the data is used. Because this is survey data and it's based on a sample, the number to move around from one sample to the next, it may be based on 100 responses and you ask different 100 people and get slightly different responses. And so while we report at the individual level, the individual provider level, we do that internally and we do it for professional development purposes that doctors get their own scores. We don't publicly report at the level of the physician rather at the level of the site.

Next slide please.

So what happens next? Well, we did find, for purposes of the pilot, that it is a pretty smooth, pretty seamless transition to trying to use the publicly reported CAHPS question sets and it is a somewhat limited question set, it's not overly large, and so you may want to work with a vendor to add some additional questions for other things that you want to measure, but our own strategy here would be that the core set of questions that we'll be working on are those things that are publicly reported. It is very useful to work with a vendor in this process because you don't just want one data point that is publicly reported. You want to have the data over time so you can have improvement efforts and use that same data to measure improvement.

And then for purposes of public reporting, I really think it is extremely helpful to indicate whether a difference between lots of practice sites is statistically significant. Now that we're really in the clinic environment, you're really working with large groups of physicians who are scientifically minded and if you really want them to buy into the process, it's important that you report statistical significance as we go forward.

And I think that's it for me.

Dale Shaller – National CAHPS Database – Managing Director

Tom, that's great. We really appreciate that. And I appreciate both Tom's and Donna's presentations and the various questions that have been submitted thus far. We have about 10 minutes and I would really like to use our time as efficiently as possible. We are going to address these questions that have come in. You can continue to ask questions again by going to the "Ask a Question" navigation bar and typing the question in the text box and selecting "Submit."

Let's start with one question right back to you, Tom. And there's a question from a medical group wondering if the different response scales in the integrated survey that you used caused any confusion among respondents, if you know the answer to that.

Thomas Schlesinger, Ph.D. – Gundersen Lutheran Health System – Executive Consultant

We haven't talked to individual patients in terms of that. I do agree sometimes that individual response scales can be a little bit more confusing like first kind of technical reasons that the different response scales work better on the two types of questions that are asked and so there was really a statistical need in order to really differentiate performance to use in different scales.

Dale Shaller – National CAHPS Database – Managing Director

And we have found through research within the CAHPS consortium that respondents are able to effectively handle different response scales within the same survey without any difficulty. I got it. Really interesting global question that I want to direct to both Tom and Donna, it comes from one of the alliances. What was the single biggest problem you encountered and how did you deal with it? You make this sound all so easy. Donna?

Thomas Schlesinger, Ph.D. – Gundersen Lutheran Health System – Executive Consultant

Donna, you first.

Donna Marshall – Colorado Business Group on Health – Executive Director

Thanks for that question and I do want to apologize for the background noise. I am in a public place, but I'm so sorry for that. Yes, I would say the single biggest obstacle was making sure that we had adequate and... more than adequate buy in really from the physician community. We do have very small practices that predominate in Colorado, on average are two to five. They're often more in an individual model even though they're practicing together not on large clinics. So we just really wanted to make sure that this project was really well received across the board, and I would say that the communications aspect before the survey got sort of put to bed was our biggest challenge, and I was... I would have to say I was happy with the way it all came about.

Dale Shaller – National CAHPS Database – Managing Director

Great. Tom?

Thomas Schlesinger, Ph.D. – Gundersen Lutheran Health System – Executive Consultant

I think our biggest challenge is probably yet to come. There's this old Chinese saying that weighing a cow doesn't fatten it. And so what that means is measuring the profits doesn't improve it. And so in terms of the measurement piece that has gone relatively smoothly really for us so far, the real work is improving it at this point and what we have to do is... what we want to do is begin to transition the organization and all the providers within the organization from the tools that they've been used to and using for probably 10 years now, introducing them to the whole concept of this data is now going to be publicly reported as well. And that it's the different questions that different metrics that will be using and getting 7000 some people to change.

Dale Shaller – National CAHPS Database – Managing Director

Very good. I have a question here, Tom, I'm going to direct to you. It's from a health system in Michigan. Excuse me, I'm sending this to Donna because the question has to do with the ability to basically piggyback or partner with health plans who are may be using their own surveys and try to minimize respondent burden by kind of integrating what this kind of survey into what health plans are already doing with their members.

Donna Marshall – Colorado Business Group on Health – Executive Director

If I could summarize the question because it was kind of a long question. It was sort of, and help me, Dale, if I don't get this right. It's sort of what can we do to maybe help integrate the new C&G CAHPS into what the plans are already doing in the marketplace.

Dale Shaller – National CAHPS Database – Managing Director

Right.

Donna Marshall – Colorado Business Group on Health – Executive Director

I would say that it's just so important consistently within a community that we look at promoting nationally standardized instruments because even though people really hate to let go of the history that they've built with their past instruments and I do think Tom's presentation of a transition strategy is a good one. I think it's really important that we get on the same page. Otherwise, we have dueling surveys and dueling events and dueling response categories and dueling ratings. And I think in the long run, that does not serve any of the consumers well in any particular marketplace and I don't think it really gets to the goal, which is how do we help providers improve their practice and how can we provide really meaningful feedback to them and so anything that we can do to help drive towards standardized measuring processes I think are good ones.

Thomas Schlesinger, Ph.D. – Gundersen Lutheran Health System – Executive Consultant

I totally agree with Donna.

Dale Shaller – National CAHPS Database – Managing Director

We have several questions that kind of get at the role of a potential mandate coming down from CMS at some point related to the use of this survey and I guess this question comes up at least once a day within the CAHPS consortium and we basically have to handle it by saying that we can't answer for CMS. There is ongoing sort of speculation that eventually there may be some requirement for an ambulatory-based survey at some level for use by Medicare and/or Medicaid, but that's something that has not been decided and is something that really CMS has to basically respond to.

Thomas Schlesinger, Ph.D. – Gundersen Lutheran Health System – Executive Consultant

Dale, there was something right in the Affordable Care Act talking about public reporting of the physician experience?

Dale Shaller – National CAHPS Database – Managing Director

Right. There is a provision in the Affordable Care Act that talks about the development of a physician compare website. The CMS is currently working on that. They've held some public meetings to get input. The timeline for building patient experience into that is still to be defined and I know that there is an aggressive timeline but it would be, I think, a couple of years out before that decision is actually made.

There is the inevitable question about what does this cost? And I don't know if either of you can frame this in a way that would be translatable to other markets but I'm going to ask either Donna or Tom or both of you, if you can give some indication of what was the cost burden of doing your projects in this respective strategies in your markets for getting the survey done. Donna?

Donna Marshall – Colorado Business Group on Health – Executive Director

Okay. I don't have a specific dollar figure to present to the listeners today on this webinar, but it is a significant burden in terms of overall cost. When you consider compiling the data and getting all the mail outs done in conformance with the protocol, when you consider running all the statistics and

then putting the information up on the website as well as all the collateral meetings and convening that needs to be done along the way, which is why there's so much benefit to a larger collaboration in terms of sharing this cost and making it an affordable... a much more affordable sort of endeavor.

Dale Shaller – National CAHPS Database – Managing Director

Tom, do you have any comments? I think because one of the, I think, big arguments for the leveraged approach that you described is building the cost of doing the survey into an ongoing process.

Thomas Schlesinger, Ph.D. – Gundersen Lutheran Health System – Executive Consultant

Yeah, because in our case, it's already part of an ongoing effort. You have the initial start up cost of switching the surveys and things like that, but very little... very little actually ongoing additional cost and ours is a continuous process because it's all about measurement for improvement as opposed to a one-time process or I mean a once-a-year process of public reporting. So in the case where providers are already in the process of doing patient satisfaction or now in this case, patient experience, it's really a minimal additional cost. I think it's really different in Donna's market, which is much more fragmented and there are may be many smaller practices that may not be doing... I mean have efforts around patient satisfaction that are ongoing.

Dale Shaller – National CAHPS Database – Managing Director

Very good. We are only a minute away from the hour and I want to just wrap up by mentioning a couple of things and to promise all of you who have questions that submitted them, we will do our best to get back to you individually even though we weren't able to address them live to you in today's webcast. I want to mention because this is a question that came up, Oren (ph) if you can advance the slide, a number of times in the registration questions regarding the CAHPS database. We have preliminary comparative data already compiled for the 12-month version of the CAHPS database and that will be widely disseminated soon. It will be available on the CAHPS website very shortly. We are also receiving new submissions of both the 12-month and the visit versions. Currently, we only have a week left for that submission period to be open. It closes on December 15th and we plan to do an online reporting of those comparative results in April of next year and then we will continue to collect and report national comparative data with the C&G CAHPS survey on an ongoing basis, hopefully two times a year. So if you have any questions or you want to contribute data to the CAHPS database, here's the contact the information by email or by toll free number.

Could you go onto the next one?

If you have any questions or comments that you weren't able to getting answered today, we're always around and available to answer your questions either by email at the address shown here at cahps1@ahrq.gov. We have a toll free number that you see here and there's a lot of information on the CAHPS website.

A number of questions came up during the webcast that were kind of technical about availability of the surveys in different languages or the difference between the four-point and the six-point 12-month percent scales, the availability of the information that we're presenting today, all of that information will be posted on the CAHPS site. If you don't find it easily, call us and we will direct you to the information that you need. The slides and the recording, and a written transcript of today's webcast will be available in a matter of... I'm not quite sure if it's days or at least within a week or so at the conclusion of the webcast.

Finally, I just really want to thank Donna and Tom again for some great information, very well presented, and to all of you today that have participated in our webcast. Please do take time to complete the evaluation survey on your way out. Your feedback is really important to us. And again, if you have any questions, you can reach us at this contact information and we look forward to future webcasts that involve you and to interacting with you on the implementation of the CAHPS C&G survey as we know this is a vital interest and it's spreading and we're happy to be a part of that movement and that you're part of it as well. So thanks again and everyone have a great day.

Operator

Ladies and gentlemen, this concludes today's conference. You may disconnect your lines at this time and thank you for your participation.