



Measuring Patients' Experiences with Medical Homes Using the CAHPS Patient-Centered Medical Home (PCMH) Item Set

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Speakers

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David Meyers, Director, Center for Primary Care, Prevention, and Clinical Partnerships, AHRQ
Patricia Gallagher, Senior Research Fellow, Center for Survey Research, University of Massachusetts Boston; Yale CAHPS Team
Sarah Scholle, Vice President for Research and Analysis, National Committee for Quality Assurance (NCQA)

Moderator

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Presentation Available

http://www.cahps.ahrq.gov/News-and-Events/Events/Past-Events/Webcast_110311_PCMH.aspx

Operator

Greetings and welcome to the Measuring Patients' Experience with Medical Homes Using the CAHPS Patient-Centered Medical Home Item Set webcast. At this time all participants are in 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 program please press star zero on your telephone key pad. As a reminder this conference is being recorded. It's my pleasure to introduce your host, Ms. Stephanie Fry. Ms. Fry, you may now begin.

Stephanie Fry

Fry (opening), Slide 1

Great, thank you so much and thank you all for attending AHRQ's CAHPS webcast to introduce you to the patient centered medical home or PCMH Item Set. Thank you all for coming. We really look forward to the next hour and a half to provide you with a bit of information and answer some of the questions that you may have.

Fry (opening), Slide 2

So to give you a quick overview of our agenda, next slide, please, thank you. It's a pretty full agenda. Some quick welcome and introductions. We'll tell you a little bit about AHRQ and their work in and around patient centered medical homes. We'll tell you -- we'll move on then and tell you about the development of the CAHPS PCMH Item Set and at the end of our formal presentation we'll have a representative from NCQA tell you a little bit about the distinction in patient experience reporting. Next slide, please.



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Fry (opening), Slide 3

We have a great lineup of speakers who are incredibly knowledgeable with us here today. Chris Crofton, David Meyers, Patricia Gallagher and Sarah Scholle who will each walk through various segments of our presentation today. A couple of quick notes for participants, as we go through -- next slide, please.

Fry (opening), Slide 4

We can -- you can ask questions as we go through. We're going to hold questions until the end and then do a question and answer session. That way -- but as we go through as questions occur to you please pop them in, they will populate in our question and answer section, and then we can follow up at the end of our formal presentation and go through as many of the questions as we have time for. So down at the bottom of your screen you'll see there's a place for you to type in questions so use that as you see fit. Next slide, please.

Fry (opening), Slide 5

The materials for this webcast are here on the Vcall site and you can access them through the little button you see there on your screen. The materials will also be posted to the CAHPS Web site in the coming couple of days. So you can look for them here for a little while and then, on the CAHPS site to follow. Next slide, please.

Fry (opening), Slide 6

If you need help along the way, star zero to get to an operator for Vcall is probably a really simple way to get through any troubleshooting you may have. There's also some other tips for you if you use the Q&A you can also -- if you're having problems you can ask a question, "how come I can't hear things?", "how come I can't see slides?" And our fine friends at Vcall will help get you squared away. So if you have any questions as we go through you can try these troubleshooting techniques or star zero or type in a question.

Crofton, Slide 1

So with that, we will begin our sort of more formal presentation and I will turn over to Chris Crofton who is the CAHPS Project Officer at the Agency for Healthcare Research and Quality or AHRQ and Chris, I'll turn it over to you to do our welcome and introductions.

Chris Crofton*Crofton, Slide 2*

Thank you, Stephanie. We can go to the next slide, please. I'd like to start by mentioning the AHRQ mission statement and that is to improve the quality, safety, efficiency, and effectiveness of health care for all Americans. Next slide, please.

Crofton, Slide 3

The CAHPS program supports that mission. We develop surveys to measure patient experience with care at the ambulatory and facility level. Next slide, please.

Crofton, Slide 4

Health care organizations, public and private purchasers, consumers and researchers use results from CAHPS surveys to assess the patient centeredness of care, to compare and report on performance and to improve the quality of care. Next slide, please.

Crofton, Slide 5

All of the CAHPS products are developed by a consortium that includes staff from AHRQ, two grantees, the current grantees are Rand and Yale School of Public Health. The CAHPS User Network and that is currently operated by Westat, and other government and private stakeholders. Next slide please.

Crofton, Slide 6

The CAHPS family of surveys is comprehensive and evolving and includes surveys for ambulatory care settings like health plans as well as facility settings like hospitals, nursing homes, and dialysis facilities. All of the CAHPS products are available free of charge on the CAHPS Web site. Next slide, please.

Crofton, Slide 7

Today we are going to introduce you to a new set of items developed by the CAHPS consortium, the patient centered medical home or PCMH Item Set. As you will hear over the course of the next 90 minutes the PCMH Item Set was developed to be used in conjunction with the Clinician & Group or C&G CAHPS survey. Together, the C&G survey plus the PCMH items, assess patient experience with the domains of primary care that define the patient centered medical home. While the PCMH items have just recently been released, there are already many practices and organizations that are looking to adopt them for a variety of purposes. Among these are URAC who will be recognizing the CAHPS survey for PCMH for quality performance reporting and improvement under their patient centered healthcare home practice achievement. Another user is NCQA who will be recognizing the CAHPS survey for PCMH for their distinction in patient experience reporting. And there are many others, again, because all CAHPS surveys are in the public domain and we don't have ways to track people who pull them down from the Web site, we don't have a specific number of users, but we have had a lot of interest in the PCMH Item Set.

Crofton, Slide 8

Thank you for joining us today. We're looking forward to introducing you to the new set of CAHPS items for PCMH. And with that brief intro, I will turn the floor back to Stephanie.

Stephanie Fry*Meyers, Slide 1*

Great, thank you so much, Chris. I'm going to very quickly turn it back over to David Meyers, who is the Director for the Center of Primary Care Prevention and Clinical Partnerships, again from AHRQ. So with that, David, I will let you take it away.

David Meyers

Thank you, Stephanie, and welcome everybody. It's extremely exciting for us at AHRQ to have all of you joining with us as we introduce this new and important tool. And my job today is to take you a little bit back to give you a framework in which AHRQ is approaching the patient centered medical home and our work in developing this module for CAHPS. Next slide please.

Meyers, Slide 2

I have the privilege of directing the Center for Primary Care Prevention and Clinical Partnerships here at AHRQ where we believe that revitalizing our nation's primary health care system is foundational to achieving our nation's triple aims in health care of delivering care that is high quality, accessible, efficient for all Americans. Next slide, please.

Meyers, Slide 3

In approaching our revitalization of primary care, several years ago we turned with interest to a growing national movement called the patient centered medical home and through our work with the community have come to believe that this thing, the primary care medical home, often referred to as the patient centered medical home advanced primary care health care home, many different ways to refer to this same concept, but really that it's a model for transforming the organization and the delivery of primary care. Next slide, please.

Meyers, Slide 4

We looked around and came up with our own definition of the medical home. Moving the fields we think a little bit forward by bringing together the fundamental definitions of primary care, the Chronic Care Model, and what the community was recognizing as the importance of putting the patients at the center of care. We at AHRQ define the medical home not really as a place, but again, as a model of primary care that delivers on five central domains: Care that is patient-centered, comprehensive, well-coordinated, accessible, and continuously improved through a systems based approach to quality and safety. Next slide, please.

Meyers, Slide 5

We recognized, however, that this ideal is still not what most of our folks in the country are able to receive in primary care and there are several reasons for that and to move forward on this journey towards this model of care, several foundational pillars will be needed to be put in place. Those include a robust and functional health IT system that makes many of these features possible. A prepared and well trained workforce distributed across the country able to work in this type of model, and most importantly payment reform to make this model possible. Next slide, please.

Meyers, Slide 6

So with this belief in this model, we turned to AHRQ's core business areas to say how can we support moving this forward and we look to what we do here at AHRQ which includes generating new knowledge, synthesizing knowledge into evidence that people can use, and then supporting people and using that evidence as they implement improvements in the health care system. So I'm going to quickly walk you through our work in the medical home in each of these three areas. Next slide, please.

Meyers, Slide 7

In terms of research, we've been quite busy. We recently released two major retrospective analysis of well developed systems in this country that are really models of how a medical home can be implemented in primary care practices, one with Health Partners in Minnesota and a second series of papers related to an integrated system in Texas serving mostly Hispanic elders called WellMed. Additionally, last year we released 14 two year grant awards for approximately 6 million dollars looking at how primary -- smaller primary independent primary care practices had gone through a journey of transformation. What were the barriers they were experiencing, how those were overcome, and what results they were showing and we look forward to seeing those results being published within the next one to two years. We also held a conference co-funded along with our colleagues at the Commonwealth Fund and the American Board of Internal Medicine Foundation that brought together researchers in family medicine, internal medicine and pediatrics to establish a research agenda around the patient centered medical home. If you're interested in that direction please look for that in the June 2010 issue of the Journal of Internal Medicine. Next slide, please.

Meyers, Slide 8

Most of our work, however, has been focused on providing a foundation for moving the discussion about the medical home forward and to do that we've published a series of white papers and decision maker briefs on important topics within the framework of the medical home. Three of them are listed now on your screen, though, they're now about seven and soon to be 10 of these available on our Web site. All of these were developed in collaboration with our colleagues at Mathematica Policy and Research as well as the National Committee for Quality Assurance. Next Slide.

Meyers, Slide 9

However, I should point out that these are not directed primarily at the people implementing primary care systems implementing the medical home, though there's much value in these papers for them. These were directing -- foundational white papers and decision maker briefs -- were focused on the researchers who surround the medical home and the policy implementation issues around the medical home. Two areas that AHRQ both has a strong interest in, but also thought a unique voice while many other organizations were supporting implementation for primary care itself. Next slide.

Meyers, Slide 10

Additionally, as researchers, we pulled together a database and made it searchable and tagged so that researchers and anyone interested in the medical home can learn what is known about the medical home. A year ago had 500 citations, a recent update now has over 1,000 citations searchable by any of the domains we talked about earlier about the medical home patient-centeredness; comprehensive coordinated, accessibility, quality, health, IT, workforce and payment as well as policy and outcomes and I'll show you in a minute where that's available. Next slide, please.

Meyers, Slide 11

Going forward, we thought about how do we take this information and make it -- help people use it to one product that is getting a lot of buzz recently is thinking about how one takes the Chronic Care Model and helps safety net practices, primary care safety net practices implement it. That tool kit is available on our Web site and currently going through -- it was already beta tested, but is now getting a full-fledged implementation test in the state of California. Additionally, this fall we'll release a guide for organizations who support primary care practice, teaching them how to establish or sustain a practice facilitation program, again as part of our work to help people move from the current model of primary care into a full-fledged medical home. Next slide.

Meyers, Slide 12

In addition to those three areas we just covered quickly, knowledge generation, evidence synthesis and implementation; AHRQ has a special role to play in the development of quality measures which we believe underline all of these important functions. Next slide, please.

Meyers, Slide 13

Within the patient centered medical home we're doing several things. One is developing measures around care coordination and primary care and if you'd like to visit our Web site you can find it by searching for the care coordination measures atlas. The next generation of that was just released and some new tools related to care coordination will be released this fall. Next slide.

Meyers, Slide 14

We're also this year beginning new projects related to developing measures of teamness; because we believe team-based care is really the way in which the workforce will implement the medical home going forward. That takes us full circle to today's talk. Next slide, please.

Meyers, Slide 15

Because the thing we're probably most proud of in our work is partnering with our colleagues at AHRQ who developed CAHPS and our colleagues in the Harvard Yale collaborative as well as colleagues at NCQA and at Westat to develop a new model of being able to assess how medical homeness -- the degree of medical homeness of existing primary care practices, and a strong focus of this work has been keeping patient-centeredness, patients' experience of care at the center of the PCMH movement. Next slide, please.

Meyers, Slide 16

Before I turn this over to the rest of our speakers to talk about this exciting journey we're on and the release of the tool itself, I'll let you know that to learn more about any of the topics I've spoken to you about, you can visit our new Web site p-c-m-h.ahrq.gov to learn more about the research, the foundational white papers -- next slide, please.

Meyers, Slide 17

The searchable database, and in addition to that, some summaries of what not just AHRQ, but what all of our federal colleagues are doing in this area, and soon you'll also be able to see a direct link between the work we'll be talking about today. Last slide, please.

Meyers, Slide 18

And with that, I want to thank you all for listening, for journeying with us on the patient centered medical home and making it a reality and I'll turn it back to our speakers.

Stephanie Fry*Gallagher, Slide 1*

Great, thank you so much, David. So with that piece of background and introduction from AHRQ, we're going to move forward and I'll turn it over to our resident expert in all things survey instruments, Patricia Gallagher, Senior Research Fellow at the Center for Survey Research at the University of Massachusetts, Boston and a member of the Yale CAHPS team. So Trish, over to you.

Patricia Gallagher

Thanks, Stephanie. Hello, everybody, thank you so much for taking time from your busy lives to listen and hear about our new PCMH instrument. We're very excited about this. I'm going to want to say that I sit on the CAHPS instrument team along with Julie Brown at Rand who is -- Rand and Yale are the members of the consortium now. First, I want to tell you -- give you a little overview of what I'm going to be talking about.

Gallagher, Slide 2

First, I'm going to talk about the CAHPS design principles and then give an overview of the CAHPS Clinician & Group Patient Centered Medical Home surveys. Then, go on to go a little bit into depth about how these instruments were developed. I'll give a couple of examples of challenges we had developing items around two of the domains of interest. And talk a little bit about reporting results of the surveys and then give you some links to CAHPS resources that are available to all the users of CAHPS products. So the CAHPS design principles were developed early on in CAHPS, that's 15 years ago now, and since then the first CAHPS instruments were to report about health plan experiences. And these principles have proven very robust, that we still use them and they're across all -- all the -- across all the instruments we've developed since the health plan instruments. So the emphasis, as you can see is first and foremost on patients. And we really -- we always conduct focus groups to find -- with patients in the target populations -- to find out what's important to them about getting care in the setting of interest. We also never take up the valuable real estate on a survey instrument with questions that we could find the answers to somewhere else. If you can get -- look in administrative data and find an answer, that isn't worthy, that question is not worthy of a patient survey instrument in the CAHPS world. So we want to ask patients only about aspects of care for which they are the best or only source of information. And we do extensive testing with patients and the parents or guardians of pediatric patients.

In the CAHPS surveys, it always involves reporting about experiences of care. And there are also some summary ratings and we'll talk a little bit more about that later. Standardization is the absolute key to what makes CAHPS surveys worthwhile because if we standardize, we can be confident in generalizing to the population of interest and we can also be confident about comparing CAHPS surveys that are conducted by different entities. So that you can actually compare results. And to do that, to make that really workable, we have standardized questionnaires, all the questionnaires have the same wording. The data collection protocols need to be followed so that you can compare results with confidence. The analysis is standardized as well as the reporting. We've developed many versions for diverse populations. As already mentioned, there's versions for adult patients and pediatric -- parents of pediatric patients, English and Spanish versions. We develop CAHPS questionnaires in parallel in English and Spanish because the findings, the qualitative findings from the Spanish versions often inform the wording for the English and visa versa. So these -- its right from the start we do the two versions in parallel. And then there are other diverse populations might include Medicaid and Medicare, et cetera. And as Chris mentioned, all the CAHPS surveys and products are in the public domain and freely available to anybody who wants to use them. Next slide, please.

Gallagher, Slide 3

This is an overview of the CAHPS Clinician & Group Patient Centered Medical Home instrument. So there are two component parts. The CAHPS Clinician & Group core questionnaire and that questionnaire is endorsed by the National Quality Forum. These core questions are asked in the CAHPS Clinician & Group survey, and there are 34 core questions in the adult version and 55 coreC&G, as we call it, questions in the child version. And then, to those core items we add the set of items that we developed over the past year or so, the CAHPS PCMH Item Set and for the adults there are 18 PCMH items and in the child there are 11 PCMH items. And this gives a total instrument length of 52 questions for the adult and 66 questions for the child. Next slide, please.

Gallagher, Slide 4

The CAHPS C&G PCMH surveys are absolutely available -- are appropriate for anybody receiving primary care in the United States. Because the domains of interest in the patient centered medical home really represent good ambulatory care and so it doesn't matter if a patient is getting care in a patient centered medical home practice or not. If they're getting primary care, these are the questions they should be answering and to report on how well it's serving them. As mentioned, there's adult and child versions. It's appropriate for a general population of patients -- all patients in ambulatory practices, it's appropriate to survey all patients using these instruments. There is a 12 month look back period. So what that means is, for example, many of the questions start this way: "In the last 12 months how often did X happen"? And we chose the 12 month referent period because a majority of the stakeholders thought that it was essential to capture care in patient centered medical home practices that extends beyond a single visit. A lot of the added value of PCMH practice occurs between visits. And, for example, shared decision-making is an important aspect of care in a PCMH practice. And it might not happen on every visit that there's a decision to be made or discussed, but over a year, many patients do have this experience and we can gather data using that year long look back. This is -- we're excited and this instrument to have the referent be provider or provider's office and given the important role of different types of medical professionals and patient centered medical homes this -- the PCMH survey asks about this provider. And we did a lot of work on this. This is, and what -- what makes this work, and we tested it extensively with real people, is that the very first question in the surveys are "our records show that you got care from the provider named below in the last 12 months. Is that right?" And there's a space for a sticker and a provider's name is put on that sticker or printed, as the case may be, and its right in the questionnaire or the

telephone interviewer will have that name right in front of them. So then we say, "is that right, did you get care from this person, Mary Black?" And if the respondent says "yes", affirms that, they go and answer. If they say "no, I did not get care from that person" they are then skipped to the demographic section and complete that and mail their questionnaire back so that we have some record of how well the sampling worked and how well people recognize a particular provider's name. So once they affirm that they have seen the named provider, there are instructions that say "the questions in this survey will refer to the provider named in question one as this provider, please think of that person as you answer the survey." And that has worked extremely well. It's a simple approach to what turned out to be a very complex problem. We tried defining providers and that confused people and some people are not able to very well read the word "practitioner," as in nurse practitioner. So that by sidestepping that through our qualitative testing we found this approach works well and patients are comfortable using this. Next slide, please.

Gallagher, Slide 5

The CAHPS team collaborated with the National Committee for Quality Assurance to develop the patient centered medical home instruments. The NCQA found that with the increasing attention to patient-centered care that it really drove their decision to update their PCMH recognition program and then NCQA invited public comment to identify what's important to people, before a PCMH survey and then worked with the CAHPS team to develop and test the items. Next slide, please.

Gallagher, Slide 6

This is a rather long and involved, but necessary steps in the development of a CAHPS instrument and what we followed for the PCMH instrument development. We leveraged on NCQA's public comment efforts and building on that, used those -- the comments that NCQA received to help inform our development. Both CAHPS and NCQA convened technical expert panels. There were in depth, one-on-one interviews conducted with the CAHPS TEP members. TEP, for technical expert panels. A literature review was conducted. And we had -- members of the CAHPS team had the good fortune and to be able to talk with patients all over the country in a focused group settings to find out what was important to them. We spoke with parents in Boston and Seattle, with adult patients in rural Minnesota and Philadelphia and they were -- in all of these groups, were in both PCMH and regular primary care practices. We then went on to my favorite part of instrument development, the cognitive testing. In cognitive testing, these are intensive one-on-one interviews, they last about two hours. And we take the candidate survey items that were developed following the first steps after -- that we've talked about. So after the focus group feedback, we then develop items based on everything we know so far and we conducted cognitive testing, so we talk to patients not only in the places that we conducted focus groups, but also in Miami, Florida and Rockville, Maryland. It was the cognitive testing was conducted in both English and Spanish, and based on the cognitive testing we revised the instrument and then created a draft or field test versions of the adult and child instruments for field testing. NCQA conducted the field test in English. We hadn't -- there was not time, we were on a break neck pace to be honest to get this developed in time for today. And so -- but a field test in Spanish and English and another field test is in the design stages so we will be conducting a Spanish language field test. But the NCQA field test was conducted in 43 practices: 10 adult practices, and 33 pediatric. And about 800 patients were sampled from each of those practices. The -- once the survey data was in, it was underwent psychometric analysis and instrument refinement. We were able to do some item reduction so to make this as parsimonious an instrument as possible we understand how important it is not only to us, but to all users that we don't have too much respondent burden and that it is a survey that is practical to administer. After -- after the field test, NCQA opened up another public comment period and based

on those public comments as well as another round of -- excuse me, cognitive interviews we did another, more instrument refinement and brought us to where we are today. You can go to the AHRQ Web site and actually see our instrument; you may have it right in front of you. Next slide, please.

Gallagher, Slide 7

The domains of interest, just looking at the left of the slide, so the Clinician & Group, the core domains are access to care, provider communication, and office staff. Interactions with the office staff. The -- we've added in the patient-centered medical home domains about of comprehensiveness, self- management support, shared decision-making, coordination of care and information about care and appointments. Next slide, please.

Gallagher, Slide 8

I want to talk to you about a couple of examples of the exciting work it was to get this instrument in place. Shared decision-making is an important aspect of care provided in a medical home setting. And key elements of good medical decision-making include that the patient knows there's a decision to be made, the patient learns about the risks and benefits associated with that decision, and the patient's goals and concerns are part of the decision process. And our four Item Sets that we created for the instrument does address all of those domains of interest. And we worked with leading experts in the field from the Foundation for Informed Medical Decision Making and the Shared Decision Making Collaborative in Minnesota. They helped us develop these items. And let me read you the items so it makes a little more sense. The first question that is asked is, "In the last 12 months, did you and this provider talk about starting or stopping a prescription medicine"? That's what we refer to as a screening question. So if a patient answers "no" to that question, they get skipped out and they aren't asked any other questions about medication, about discussions about medication. But, and so that, having that screening question allows us to identify the correct denominator for the substantive items that follow so that it's not everybody answering even though they may not have had that experience, so the screening questions are extremely valuable.

So then we go on, if they screen in, they affirm, yes, we talked about stopping or starting a prescription medicine, then they're asked, "When you talked about starting or stopping a prescription medicine, how much did this provider talk about the reasons you might want to take a medicine?" Not at all, a little, some, a lot. And they answer that. And then they're asked, "When you talked about starting or stopping a prescription medicine, how much did this provider talk about the reasons you might not want to take a medicine?" With the same response categories. The final question in the series is, "When you talked about starting or stopping a prescription medicine, did this provider ask you what you thought was best for you?" And these items, we tested them in the field test. Actually, we tested two sets of items, two sets of these four items. One about prescription medicines that you just heard, and also another set of four about having surgery or a procedure in the previous 12 months, talking about having one. And it turned out from the field test data, let us know that there just isn't luckily, there isn't taking prescription medicines just doesn't happen as often in the pediatric population. So it was not possible to get an analyzable sample and it wasn't worth the space on the questionnaire to include those four items for the child instrument. They did work well, however, on the adult instrument and the pediatric shared decision-making, or SDM items, are available for use as a pediatric supplemental set for anybody who thinks that would be appropriate for their patient population. The -- I guess also, luckily, the surgery items also did not lend us enough power in the general population to warrant including them. We're working now to develop -- further develop those items and are keeping them in our back pockets for perhaps another survey situation. So stay tuned. We'll see them again, I think. Next slide, please.

Gallagher, Slide 9

The second issue around -- that was interesting for the item development was patient self-management support items. And here's what made the cut. These are the items that made the cut. "In the last 12 months did anyone in this provider's office talk with you about specific goals for your health?" And the second question is, and the answer categories are just yes/no. And then next question is, "In the last 12 months did anyone in this provider's office ask you if there are things that make it hard for you to take care of your health?" What you can hear there is that the referent change from this provider to anyone in this provider's office. And we again, this was another -- we spent a lot of time on this because this is obviously about the care team approach, the team, which is certainly one of the hallmarks of the patient centered medical home. And we -- in cognitive testing we found and in the focus groups, because we were asking them, too, who counts -- do you think you have a care team, and if so, who's on that care team? And what was disappointing to us, because we really did want to use care team, was that, the patients, they love their providers. And they think most by and large, you know, they -- so they consider anybody who is taking care of them as part of their team and that will include people outside of the practice of interest. So in order to be fair to the practice that is being surveyed, it's not fair to have them reporting about experiences that happened outside the practice. So that when we confine it to, did anyone in this provider's office talk with you about, that was well understood and people confined their responses to the practice they're supposed to be talking about. And it worked well.

These items, as you can see, these self-management support items, are what do I want to say? I want to tell you that they're a part of a larger set of items that we tested because we had developed a number of items to get at self-management support for people with chronic conditions and we developed those items only with people with chronic conditions in mind. Because they have, obviously, different needs than people without. And we did, however, include them in the field test just to see if by chance we could include them and ask everybody. And it didn't turn out that we could. So we brought that self-management support down to these two items that are appropriate to any patient. And then we are developing -- further developing those -- the larger set for populations with chronic conditions. Next slide, please.

Gallagher, Slide 10

Now it's reporting, so once all that data is collected, it gets reported out both internally for quality improvement or deciding which -- I'll just leave that quality improvement is one of the main reasons to use it internally. Externally, when you report externally, it might help prospective patients choose among different practices. Or providers because this can also be analyzed at the provider level. So the composite measures that are supported, once again, it's the core Clinician & Group composites of getting care quickly, provider communication and having a helpful and courteous office staff. And in the child survey only, there are another two reporting measures: the provider's attention to the child's growth and development, and provider's advice about keeping the child safe and healthy. And in both the adult and child instruments, there are 0 to 10 provider rating, where patients rate the named provider on a scale of 0 to 10 where 0 is the worst provider possible and 10 is the best provider possible.

Gallagher, Slide 11

And so added to these core reporting domains, next slide please, we also, of course, add the PCMH reporting domains of providers paying attention to your mental or emotional health, and that's only in the adult instrument. Providers support you in taking care of your own health. That we already talked about, the self-management support and the provider discusses shared decision-making around medication. Next slide, please.

Gallagher, Slide 12

The brand new, very exciting CAHPS Web site is up and running now and you can see the Web site address there cahps.a-h-r-q.g-o-v. And I invite you to take a look. We're very proud of it, it looks -- it's very -- its increased usability for all users and we hope you find it usable. Next slide.

Gallagher, Slide 13

Users of the CAHPS survey products have access to a lot of resources. Of course, the surveys themselves are available, the questionnaires, as well as detailed protocols on how to administer them, sampling, suggested wording for responding contact materials including cover letters for the questionnaires, reminder postcards, et cetera. And then there's the CAHPS database where if you like, entities can submit their de-identified data to the CAHPS database so that you can do benchmarking, you can compare your findings with other practices across the nation and see how well everything is going for you. There's access to current information about CAHPS products, educational conferences and webcasts like today, the one we're on today, as well as one-on-one technical assistance. Next slide please.

Gallagher, Slide 14

I want to give you a consumer report about the one-on-one technical assistance. I've had the occasion to call the CAHPS help line, and they're just terrific. Westat -- persons that, I guess is the right term and they are available through the Web site. Call the help line, they're just terrific, they're very nice people, they are very knowledgeable and they'll give you real answers to real questions. You can also e-mail them at CAHPS1@AHRQ.gov. And feel free. Please use these resources; we don't want you scratching your heads about anything. Please talk to us. Stay in touch. I want to thank you all for your kind attention.

*Gallagher, Slide 15 [Thank You Slide]***Stephanie Fry**

Thanks, Trish. That was very helpful. Trish, before I turn it over to Sarah for the next piece, we had a couple of questions about what's the difference between the PCMH survey and the Clinician & Group survey and can we use the PCMH survey in place of the Clinician & Group survey. Can you just say one just quickly explain how those two are connected?

Patricia Gallagher

Sure. And that goes back to the slide with the three purple boxes. The one on the left was the core Clinician & Group instrument. So that really is the core Clinician & Group survey.

Gallagher, Slide 4

And one thing that we only -- and then excuse me, let me finish that thought. So there's the core Clinician & Group and then the added PCMH items and that is the PCMH questionnaire. So can, the direct question is can the PCMH -- the expanded Clinician & Group questionnaire, including the PCMH questions, be used in place of a Clinician & Group survey? And I'm going -- and the answer's yes, because it encompasses the Clinician & Group survey. And one thing that we didn't -- I had mentioned in passing is that there are supplemental item sets. There are supplemental items that are of -- that are available for use for particular settings. If they're of interest to users, you can go in and look at the supplemental sets, for example, health literacy or cultural competency or -- oh, there's just a wonderful array of different item sets that you can look at and decide, oh, I do want to include these. So you aren't confined to these questions although in order to be a CAHPS Patient Centered Medical Home instrument you need to include all the core questions and all the PCMH supplemental

items that make up that 54, 66 item, depending whether it's an adult or child instrument. Does that answer the question, do you think, Stephanie?

Stephanie Fry

I think it -- I think it does. And I think people were just curious about what the link is between the two. So if you have been using the Clinician & Group survey or you're considering using the C&G survey and now you see PCMH coming out and wonder how do you do both it's the PCMH Item Set is simply inserted into the existing Clinician & Group core. So you should have all your bases covered that way.

Scholle, Slide 1

So with that little piece of wrap up, we'll move on and turn things over to Sarah Scholle, Vice President for Research at the National Committee for Quality Assurance or NCQA. They are one of the sort of early partners and adopters of the PCMH Item Set so Sarah, I'll turn it over to you.

Sarah Scholle

Great, thanks, Stephanie. Delighted to be able to talk with you on this exciting new program that we have and we've really enjoyed working with the CAHPS consortium to develop this new version of the CAHPS survey. And next slide, please.

Scholle, Slide 2

We actually began thinking about how to evaluate patient-centeredness in primary care practice about five years ago and we're grateful to the Commonwealth Fund for supporting our work to try to overcome methodological challenges to including patient perspectives into medical home qualification and through a grant we started to try to identify a core set of survey items and explore the feasibility of alternative sampling and other data collection strategies. We'd worked with a group of experts to try to figure out what was making it so hard to think about actually getting the data on patient experiences to use in our evaluation of practices who wanted to be recognized as patient centered medical homes and we felt like we had to really focus on this. So Trish has described a number of the activities that we did. We initially started off looking at a number of instruments and we decided to work with the CAHPS team to adapt the CAHPS Clinician & Group core survey for this purpose and we think we've gotten a really nice product here. Can we go to the next slide?

Scholle, Slide 3

So as David mentioned there are a number of aspects or domains of demonstrating the patient centered medical home model and I think it was 2011 standards address issues around access, around tracking patients, managing care, coordinating care, and implementing quality improvement. And one of the issues that came up is we were developing this new version of the standards was the need for more attention to patient experiences. And so we focused on trying to understand what would that look like in a way that is incorporated both in the standards and as well as an opportunity to give special recognition to practices that actually tried to collect data in a way that would allow apples to apples comparisons. So next slide.

Scholle, Slide 4

So in our standards, our 2011 standards, practices can get credit for providing reports of patient experiences results as documentation for meeting elements on collecting patient care. But we have also developed this voluntary distinction that allows practices to get kind of extra credit for collecting data in a standardized way that will allow them to be compared to other practices across the country. Next slide.

Scholle, Slide 5

So within the standards, this is element 6B called measuring patient and family experience. We're looking for practices to obtain feedback from patients and families about experiences with their care and a survey is one component of the ways to get feedback. Practices can get credit for using any survey. They'll get more credit for using the CAHPS PCMH survey, but they'll get full credit if they also use other approaches to get feedback from families like focus groups or interviews or having a patient advisory council. As well as getting feedback on experiences of vulnerable patient groups that might not be represented in a survey. Next slide, please.

Scholle, Slide 6

Distinction in patient experience reporting is separate from the medical home, the patient centered medical home recognition. This requires practices to use the patient centered medical home version of the CAHPS survey addressing these core domains. In addition practices have to use a standardized sampling approach, approved data collection methodologies, report the data to NCQA. Now in this initial rollout of this distinction program recognition is based on reporting data, but it is our intention to have the requirements for distinction increase over time. We couldn't start out the gate with scoring based on results because we didn't have any data for benchmarking results and so it is our intention to do that once we get some experience with this survey tool. Next slide, please.

Scholle, Slide 7

So the sampling guidelines for this distinction program asks the practice to select the random sample of patients who had at least one visit in the last 12 months and the target sample size is based on the number of clinicians who have a panel of assigned patients within the practice and the starting sample sizes are based on a response rate of 35%. I want to note here that NCQA will be providing additional information on how practices could use a rolling data collection process that will be up on our Web site in a short time. But we will be allowing some rolling sampling and data collection. That's a change from what has previously been reported. Next slide, please.

Scholle, Slide 8

Data collection for this distinction program has to be administered by NCQA trained and approved survey vendors. The reason for having standard methods, standard data collection processes and using a survey vendor is because the intention of this program is to allow comparisons to a national benchmark and so it's critical that we have organizations, practices using the same methods. That's what we need to have to allow fair comparisons. There's research showing that different kinds of data collection, particularly different data collection processes affect the results, that there can be bias when data collection occurs on site. And so we do not allow on site data collection and we require participants to use NCQA certified vendors. We do allow a variety of data collection modes. Mail, telephone, mixed methods, and in addition IVR and Internet processes and the Internet approach can be used with any of the others. We are allowing flexibility in this initial year -- initial period of reporting as we are looking to see what the impact is and to think about how we will adjust for those differences and or account for those differences in future benchmarking efforts and scoring efforts. Next slide, please.

Scholle, Slide 9

So practices must submit annually to retain this distinction or recognition. We will have two time periods during the year when practices or the vendors will be able to submit data on behalf of practices. Next slide, please.

Scholle, Slide 10

And just to be clear about what the distinction means, it means that practices have submitted the CAHPS PCMH data using the procedures I've described. And practices will receive credit within the PCMH 2011 standards, that element 6B, and they can also announce that they have the distinction in patient experience reporting. That distinction is only available to practices that have NCQA's PCMH 2011 recognition or in the process. We will -- we hope that other practices will also submit the data so that we will have a benchmark. Next slide, please.

Scholle, Slide 11

So this slide simply summarizes some of the information I've provided about eligibility and the reporting periods for 2012 will be April and September. And again, the length of the recognition is for one, or distinction will be for one year. Next slide.

Scholle, Slide 12

And just to wrap up, there's more information about our patient centered medical home programs and those elements that relate to patient experience on our Web site along with our distinction in patient experience reporting. Thanks very much and we again, very delighted to have this excellent collaboration with the CAHPS group and AHRQ. Thank you.

*Fry (closing), Slide 1***Stephanie Fry**

Great, thank you so much, Sarah. So that brings us to the end of our formal presentation. We have an additional half hour to get through as many questions as we can. There are some questions that have already been queued up and, as I said, we will do our best to answer as many of them. If you haven't submitted questions and wish to do so, again, down at the bottom of your screen you should see a field that you can use to ask a question. I would also alert you -- sorry, next slide, please.

Fry (closing), Slide 2

So submit your questions now or at your leisure over the next half hour. I would also encourage you, if you are not already signed up for the CAHPS e-mail updates, you can go to the CAHPS site and you can sign up to be alerted to updates on the CAHPS site. So events such as this or other new and exciting things that we may be posting on the CAHPS site, so it will come directly into your inbox and let you know that those things are there. Next slide, please.

Fry (closing), Slide 3

After the webcast, if you have questions or comments, I think you've seen this on a couple of different slides; we certainly encourage you to reach out to us either by e-mail or to phone us directly. Also, if we don't happen to get through your question and we didn't come anywhere close to answering the question that you're interested in you can follow up in this way. You can send us an e-mail and say, hey, I still had this question, could you respond to me or let me know about this particular issue and we will get back to you that way if we don't get to your question here live on this event.

On the CAHPS site, in the coming days, as I mentioned earlier we will also have the presenters' slides and a recording of the webcast, a transcript will follow when that is available shortly. Next slide, please.

Fry (closing), Slide 4

As a final note, following this webcast, you will be prompted to complete an evaluation, and we do very much encourage you to complete the evaluation so we can get your feedback and we can make improvements for our upcoming webcasts. Again, comments or questions can come straight to the CAHPS team through e-mail, phone, and please do go ahead and check out our new Web site that just launched and has all kinds of information including lots of information on the new PCMH Item Set.

So with that, we will jump into some questions and see how much of -- see how many of your questions we can answer over the next half hour. So Trish, I'm going to direct a couple of questions to you to get us started here. So there was a question -- there were a couple of questions around how do you add additional items to the PCMH Item Set, and do you need to put them all at the end? So can you add additional items, and if so, how would you use either the CAHPS supplemental items or other home grown items?

Patricia Gallagher

Sorry, I was on mute. Those are good questions. So adding items is encouraged, that's fine to do. The CAHPS supplemental items have instructions -- specific instructions on item placement so that they can go within the body of the questionnaire. We also appreciate that having fielding items that have already been fielded by a user that aren't CAHPS items could be very useful particularly for trending if you're switching from an instrument that you've been using before, you can see, have a bridge questionnaire where it trends, you can test the trending. We ask that any items that are not either core items or supplemental items are placed just prior to the about you or demographic section so that it doesn't change the context of the questions that are asked.

Stephanie Fry

Great. We also have a couple of questions in here about why isn't a patient satisfaction survey required for all PCMH's, regardless of who is providing the accreditation, and I think that's an excellent question. As the CAHPS consortium, we developed the instruments and we make them available and in terms of who picks them up and requires them for what purposes or ties funding to them for what purposes unfortunately is not within our purview so it's an excellent question, an excellent question to which I don't think we have an answer here on the phone, but wanted to acknowledge that there were a couple of people who did go ahead and ask that.

Trish, again, I'm going to come back to you because there were just a couple of other questions that kept coming up again and again, so I will send two your way that you can answer. One is about the length of the survey. Is -- how does the length impact response rate to the survey? And the other one is about reading level. There were a number of people who asked about the reading level for the survey so Trish, I'll send those to you.

Patricia Gallagher

Thanks, Stephanie. I'll start with the reading level. We aim for -- the Clinician & Group is at the seventh grade reading level and we, developing the PCMH additional items, we also aim for a seventh grade reading level, but some concepts in the medical home practice are too complex, are a little tricky to word at a seventh grade reading level so there is a few items that go at a little, little higher level. Another, the sentence construction that we use can help -- can simplify understanding. We use that -- a clause in the last 12 months how often, so that clause first can lead to a -- at a reading level analysis that results in a higher reading level but we think that sentence construction helps simplify things for respondents.

Chris Crofton

This is Chris. If I can add on a little bit to what Trish just said. These -- asking a person to make a decision about a provider or a health plan or any other health experience, that is a cognitively complex situation. You're asking a person to take lots of different pieces of information about cost benefits, patient experience ratings and so on and use that to pick an outcome that's best for them. That is a cognitively complex task. And there is only so far you can go with making that a simple thing to understand. So it's important to do things like assess the grade level and it's important to test things cognitively as Trish spoke about to make sure that people are understanding an item in the way you intended, but at the end of the day, it's a difficult judgment situation for a person to be in and we try to make it as easy as we possibly can.

Patricia Gallagher

The second question was about the instrument length. We fielded -- the field test involved a very long instrument, it was 110 items, but many of those items were included just for field testing and they were they -- we would ask the same question in a couple of different ways. We asked a series of questions about what a checklist of certain chronic conditions that a patient could report that they have so they could see how items were working for that population. So ultimately, as I mentioned, the instruments are now 52 items long for the adult and 66 for the child. And we find that we have when the CAHPS data collection protocols are followed, there's no problem, this is not too long for patients, it seems that once a patient, once a respondent starts answering a questionnaire if they find it of interest to them they will complete it. They will go ahead. We did some empirical testing earlier in CAHPS where we found that items -- don't -- that instrument lengths actually did not have a significant difference on response rates. And these, the instruments tested were about 23 items, I think. 34, 54, and 78, 76 for the adult and the child instruments were a little bit longer, going up to 93 items at the top end. And none of those showed a significantly lower response rate when compared to shorter instruments. They all get about the same.

Stephanie Fry

Thanks, Trish, I think that's really helpful. We had a question about NCQA. Is one vendor who is accrediting PCMH. Who else is the -- who else is the CAHPS team working with or who else is AHRQ working with in that vein, so we may have a couple people to respond to this, but David did you want to start by warming us up here?

David Myers

I'm sorry, Stephanie, can you repeat the question?

Stephanie Fry

A question about who -- so in addition to working with NCQA, who has AHRQ and the CAHPS team worked with in terms of accrediting organizations or other commissions or organizations in our work thus far?

David Myers

Great, I apologize for making you have to repeat it. And what I'd like to start with is the answer is how AHRQ -- who else has AHRQ been working in the larger PCMH space. We value very much our partnership with NCQA which involves CAHPS as well as some of the foundational work we've been doing. We also have a strong relationship of URAC in the development of their PCMH training materials and certification process or recognition process, excuse me. And also with the Joint National Commission and their work in this area and now that the tool is available we look forward to the CAHPS tool is available, excuse me, we look forward to sharing that both with URAC and the JNC just to make them aware of that and as you said earlier we don't

require anybody to use these tools, but we're hopeful based on the work they've been doing in PCMH that both organizations will embrace it moving forward. And I'll turn it back to Chris and the rest of the CAHPS team to say in terms of the CAHPS development process who some of the other partners are.

Chris Crofton

Well we work frequently with CMS. We worked with them on development of the hospital CAHPS survey and we try to cast as broad a net as we can in pulling people in to advise us about different topics of survey development. So if we focus on an area like PCMH we will look for people who are working in that area or who are establishing an accreditation system or are on the -- or in an organization that enlightens them about the consumer point of view in relation to that issue. We just -- we try to reach as broadly as we can to pull people in who can increase our knowledge about the topic area or other things that we might need to know to make the best possible survey and reporting products. I think in terms of accreditation David covered the list there.

Stephanie Fry

Great. Thank you. There were also a number of questions, Sarah Scholle, I'm going to send this one out your way about many health plans are helping to fund PCMH practices, do you envision a role for the health plans in promoting the CAHPS C&GPCMH, sort of so what's the role there in terms of do you see anything coming down the pike in terms of help for practices?

Sarah Scholle

I think there are at least three ways that health plans could help practices. I think in support practices in using this survey. One, they could help to support the data collection and reporting. Certainly in -- there's several states where there are health plans that are working together with practices and to conduct annual or ongoing surveys of patient experiences at the medical group or practice level and that's one way that health plans could help particularly small practices, to manage the process of getting data. The second way they could help would be to work with practices on quality improvement and help to support collaboratives or provide opportunities for practices to learn about how to use these data and quality improvement and to learn how to -- what other things they can do as follow up to surveys when they find a problem and on a survey and try to direct their work. And the third thing that health plans could do would be to provide rewards to practices that step up to the plate to collect the data in a standardized way and to report it and to allow themselves to be compared to other practices.

Stephanie Fry

Great, thank you. And I'm going to do -- Sarah, keep you on the line as well and have Trish, you respond separately. There were some questions about how to administer the survey. Can we do it through patient portals, can we do in office administration and you know sort of what are the sampling guidelines? And I know we won't get details about each of these, but wanted to alert people that what the CAHPS consortium has put out as sort of a general framework for recommendations differs a little bit from NCQA. So maybe Sarah I'll get you to lead off and then Trish, if you want to bring in the CAHPS perspective, we can also have people go to NCQA and CAHPS' Web sites respectively for more information. But Sarah can you --

Sarah Scholle

Sure. So within the patient centered medical home's recognition program, within the PCMH 2011 standards, practices can get credit for administering a survey and any kind of survey in any kind of way as long as they're using that information there's also expectation that they use that information for quality improvement. They get more credit for using the CAHPS PCMH survey and there really are no requirements about the data

collection method. For the distinction program, so for this separate distinction and patient experiences reporting, practices do have to follow the standardized procedures and use a NCQA vendor, certified vendor, that follows these rules and the reason for that is, and those rules did not allow on site data collection and the reason for that is because we know that there's a potential for bias on data collection when it's happening on site. There have been research studies that have shown this and many of you know what it's like to be handed a survey at the restaurant and it's with a sense that we really want you to fill it out and there's a particular way to fill it out. And so we're really trying to make sure that the data collection allows for fair comparisons from one practice to another across the country and so those standardized processes are listed here and you can find more on the NCQA Web site.

Patricia Gallagher

This is Trish. I'd like -- we appreciate very much that cost is a concern for practices. We know that for some practices, conducting a survey, they have to make decisions about whether or not to buy new stethoscopes or not, I mean, it's very real and we appreciate that and we work -- we tested a number of different ways to administer and the patient portal is very promising. In fact, we have done extensive testing in developing the set of items for health information technology using e-mailed administration where patients are e-mailed a hot link to a survey and given a P.I.N., personal identification number, so to enter and use it, and we have very good results. We're not yet ready to have that protocol for the PCMH instrument, but speaking for myself I can see it coming relatively soon. That is very promising and it looks good for having limited mode bias -- limited amount of bias introduced by mode of administration.

However, as Sarah mentioned, the CAHPS team has done some research and I know there's been research outside of CAHPS work, but for the CAHPS work we really wanted to see so many users asked us what about in office, that's the way we've been doing this, can't we do it this way? Can't we just hand them the questionnaires, they're here, why not? And we did -- we randomized patients to different modes of administration in two different studies. The first one, excuse me a second, had to clear my throat. The first one was where we had the office staff hand out the questionnaires and we did this out across a number of practices in upstate New York. And one of the practices was especially interested in making this work and they were the perfect practice and we thought, okay, maybe this really will work because they were entirely ready to do it right and wanted to follow all of the rules.

Another one of the practices at the other end of the continuum was -- this is was an imposition for them. They were not pleased about doing it and it was clear from the start that this -- we hypothesized that would be the practice where we'd have the most problem. And, in fact, that is what turned out. But what surprised us the most was that the practice that was most motivated. There, the problem is they don't hand the questionnaire to every patient. And it's not their fault. We all know from going to doctors' offices that often there's congestion around the receptionist area or that people can leave through different doors and that actually handing a questionnaire to every patient, it becomes problematic. And if an office staff knows that this patient's husband just died and, oh, we don't really want to bother her with this, or they're obviously in a lot of pain or they just -- it's very hard to be even handed about handing it out. And that showed in the testing.

So then we said, okay, and as well as in the results, you get different results because we had randomized -- one week we would hand out questionnaires at a doctor's office and the next week we would mail questionnaires to the patients who had come to the office that week. And the differences, there was a great deal of bias introduced by mode of administration there. So, okay, let's take the office staff out of it so that we'll have

somebody who doesn't know the patients, whose only job it is to hand these questionnaires out. So we had trained survey administrators, is what we were calling them, and we would have them stationed there to hand the questionnaire to every patient and as they were leaving, and darn it, that didn't work either. And we really - because we were trying for this. But what happens is that the survey administrators are human too. And they were in some practices, safety net practices and other practices, there's extraordinary long wait times and that can happen in any practice where there's an emergency. So if you have patients sitting in a waiting room for an hour, an hour and a half waiting for their appointment and there's obviously there's somebody there handing out questionnaires to everybody who's come in and left before them they wander up and say, "why don't you give that to me, I can do that now," and they did. They would hand it even though they were trained not to, they would hand it out. They would also decide that another problem that showed up there that I've already alluded to is that there would be multiple exits, and covering those becomes highly problematic. That people slip through the net. That they get out without getting their questionnaire. And, again, it just did not -- it introduced bias and that's the last thing we want to introduce. I'm going to -- I'll leave the sampling guidelines to somebody else, please.

Sarah Scholle

This is Sarah. I did want to say that the Internet, using the patient portals, we're looking at the patient portals, that the Internet administration is clearly an option through our program.

Stephanie Fry

And I think we can direct people to both the NCQA site and to the CAHPS site. There's detailed information about recommended approaches for data collection including the new e-mail that we've recently added as part of the CAHPS recommended approach. There's a little description in there also about why in-office administration is not recommended and there's some guidance coming soon on sample sizes and recommended sample sizes so stay tuned for that.

Sarah, I'm going to continue to heckle you. There were a couple of questions about what does the distinction mean for the practice? So to get that distinction, what does that do for them, what does that mean for that practice?

Sarah Scholle

Well, the distinction is -- recognizes that they've stepped out in front and that they have -- are allowing themselves to be in this group that will be ready to be compared to others in this initial period it's based on reporting and eventually it will be benchmarking. So here's what we're hoping. We've heard several other questions earlier about, well, why isn't this required? Well, NCQA can't require that practices do this. We offer it as a voluntary option. And practices seek recognition because there are rewards available to them in their marketplace and it might be that they're eligible for enhanced fees or a case management fee. They may be eligible for financial incentives, pay for performance rewards. We heard interest from a number of stakeholders in being able to understand the performance of whether practices are truly patient-centered from the patient's perspective. And so this distinction program is the first step in providing data that are reliable and valid that can be used for those kinds of comparisons. We also hope that these data will be available to be used by consumers and so that consumers can know where to go. We make public practices that have achieved our recognition and we hope that in local areas, in marketplaces that this information about distinction and eventually distinction based on results will be used by stakeholders, both to financially reward practices and by consumers to select their doctors and nurses.

Stephanie Fry

We're approaching the end of our session and I just wanted to remind people about the evaluation survey. It pops up in a separate window so we very much appreciate the time that you would take to provide us some feedback on this webcast. I think we've got maybe time for two quick questions. Sarah, one more for you that I think should be pretty straightforward. There were a number of people asking if there's a list of NCQA approved survey vendors or where to find an approved vendor?

Sarah Scholle

That will be on our Web site. I understand, in December. We're doing training soon.

Stephanie Fry

The vendor training is happening imminently and you'll have a list in December? Perfect. And Trish, I think maybe the last question for you. There were some questions about what if the practice has both pediatric patients and adult patients, what -- which instrument should you use?

Patricia Gallagher

Well, I would say use both. Use both. Because -- but it really is of what's of interest to the practice. If you -- what are you interested in knowing about your practice? Do you have particular quality improvement efforts that are germane only to adult patients then you might clearly just want to field the adult survey. It really depends on your research and information needs which you would -- if you would like to know about the overall experiences of your patients in your practice; I would say both adult and child because clearly there are differences in those patients.

Stephanie Fry

And just to clarify, can you speak very quickly on who responds to the pediatric survey?

Patricia Gallagher

Pediatric survey, the respondent is the parent or guardian of the named child, of the sampled child.

Stephanie Fry

Great, thank you. By my clock we are right at 3:30 so we won't keep people longer than that. Thank you very much for your ears and your participation in today's webcast. There are a number of questions that we didn't get to. If we didn't do justice to the question you asked or we didn't answer it at all, please do follow up and send it through our technical assistance line. We're happy to field many of those questions or send them out to our various presenters to get you responses thereafter. We don't want to leave you befuddled or needing more information that you haven't gotten on today's session. So, again, please fill out our evaluation that pops up in a separate window and thank you very much for your time today.

Operator

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

(END OF TRANSCRIPTION)