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Introducing the New CAHPS Clinician & Group Survey 3.0

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Speakers

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Dale Shaller

Shaller (opening), Slide 1

Greetings, everyone. Good afternoon, good morning, depending on where you're situated in our country today. Welcome to our Webcast on Introducing the New CAHPS Clinician & Group Survey version 3.0. My name is Dale Shaller and I'll be the moderator for today's Webcast.

Shaller (opening), Slide 2

Today's Webcast is one in a series of Webcasts on CAHPS, which stands for Consumer Assessment of Healthcare Providers and Systems, and is produced by the CAHPS User Network. I know that many of you are familiar with the CAHPS surveys, but I'm going to give just a few words of background on the CAHPS program.

CAHPS is funded by the Agency for Healthcare Research and Quality, or AHRQ, and we develop standardized surveys for assessing patients' experiences with their care. And we produce a number of products and services that support their use, such as the National CAHPS Database.

CAHPS surveys have been developed for use in multiple healthcare settings, including ambulatory practices and facilities such as hospitals and nursing homes.

Shaller (opening), Slide 3

The CAHPS family of surveys has expanded rapidly over the past two decades. As shown here, facility surveys include HCAHPS for hospitals and CAHPS for dialysis centers as well as nursing homes.

The suite of ambulatory care surveys has expanded to include not just where it all began, with the CAHPS Health Plan Survey back in 1995, but now CAHPS surveys for surgical care, behavioral health, home health, and most relevant to our Webcast today, for medical groups, practice sites and individual clinicians, namely the CAHPS Clinician & Group Survey, or we refer to it as CG-CAHPS.

Shaller (opening), Slide 4
So our focus today is to describe a new version of the CG-CAHPS Survey, version 3.0, and to explain why a new version was created, how the CAHPS Team went about developing it, what specific survey items it includes, and how the instrument is structured.

We also want to talk about how the new 3.0 version differs from the previous 2.0 version and some of the testing that has been done to compare how a 6-month recall period, which will be used in the new 3.0 version performs relative to the 12-month recall period that was part of 2.0.

We also will describe some additional testing that's currently underway and planned for the 3.0 version. But more importantly, we want to hear questions that you may have, and we'll do our best to answer them.

Shaller (opening), Slide 5
To help address these topics, we're pleased to feature an outstanding lineup of speakers from the CAHPS Team, starting with Julie Brown, Director of the Survey Research Group at RAND. And Julie is a longstanding member of the RAND CAHPS Team and has co-chaired the CAHPS Instrument Team for the past two decades.

Lee Hargraves is Managing Researcher with the American Institutes for Research, or AIR. And Lee is a member of the Yale CAHPS Team and co-chairs along with Julie the CAHPS Instrument Team.

And we have Ron Hays who is Adjunct Researcher at RAND and Professor of Medicine at UCLA, who has served as a Principal Investigator for the RAND CAHPS Team since the beginning of the CAHPS program in 1995.

And again, my name is Dale Shaller, and I've been a member of the CAHPS Team for nearly 20 years, serving on the CAHPS Reports and Quality Improvement Teams, and also as Managing Director of the National CAHPS Database.

Shaller (opening), Slide 6
Before we get started, I'm going to cover just a few of the standard housekeeping details. If you need any help at any time during the Webcast, you can use the Q&A icon in the lower part of your screen. You can also join us by phone, by dialing this number that you see, 855-442-5743, and the conference ID number is 161-30-873.

Sometimes, it seems like your computer freezes during the presentations and you can hit your F5 button to refresh your screen, although what you might be experiencing is just a lag in the advancement of the slides due to your internet connection speed. So you can also try logging out and logging back in if that might help as well.

Shaller (opening), Slide 7
Given the large number of participants on today's Webcast, we're going to be taking questions submitted online only. And to ask a question, you click the Q&A icon to get the Q&A box to appear and just type your question in the text box and select Submit. And then we will review the questions as they come in and do our best to respond during the Q&A portion of the Webcast. We know that the Q&A part of this is often the most valuable to participants so we really do want to encourage you to send in your questions.

Shaller (opening), Slide 8
Today's slides are available for download by clicking on the icon at the bottom of your screen that says "Download Slides." And there you'll get a PDF version of the presentation that you can download and save as you want to.

Shaller (opening), Slide 9
And finally, we have a number of resources that are available which you can access under the Resources icon. And here you'll find links to the actual CAHPS Clinician & Group Adult Survey 3.0, an overview document explaining the 3.0 survey, and then further links that you can go to that allow you to read about the CG-CAHPS 3.0 survey in more depth and get survey implementation instructions. And there's some information as well about submitting your data to the CAHPS Database.

Shaller (opening), Slide 10
So our plan for the 90 minutes that we reserved for the Webcast today is to start with an overview of CG-CAHPS 3.0 from Julie. And then we'll take a few minutes to answer questions that come with respect to her segment. And then Lee will present findings from a study that compares survey results that were obtained in four community health centers, comparing the 12-month and 6-month version of CG-CAHPS since 3.0 is based on a 6-month recall period. And then we'll pause again for questions from you to either Julie or Lee. And then we'll conclude with a brief presentation by Ron about further testing that's underway or planned to inform the ongoing improvements that we will always be pursuing for the CG-CAHPS Survey.

So with that, I'm pleased to turn it over to Julie.

Julie Brown
Dale, thanks so much.

Brown, Slide 11
Hello, everybody, and thank you so much for joining us today. I want to start off talking a little bit about why did we update CG-CAHPS. Why create a 3.0 version?

While the stability of the survey content is important to support comparison of CAHPS scores over time, it is equally important to ensure that the survey keeps pace with the changes in the healthcare environment, so we continue the measure the aspects of care important to patients using language appropriate to the context in which care is delivered.

Care coordination has also been an area of ongoing focus. And the development we had been doing had finally reached the point where we had a good composite measure of coordination. And we wanted to make it available for users.

Additionally, CG-CAHPS is used for many programs and initiatives, some of which are associated with the Affordable Care Act as well as other national, state and local quality initiatives. Having an updated common core across these initiatives and programs better meets the needs of users and is essential to promoting alignment across all of these important efforts.

Brown, Slide 12
With any work that we do in CAHPS and survey development in particular, we're guided by principles. In this update of the survey, our aims were to achieve a common core across all CG-CAHPS versions to promote standardization and comparison; to balance survey length with a desire for robust content, again, capturing aspects of care important to patients in defining their experience; to improve the efficiency of existing domains, update item wording to match current practice -- that is, how care is delivered; and to maximize the reliability and the validity of the measures in order to promote continued use of CG-CAHPS.

Brown, Slide 13
So let's talk a little bit about how we went about making these revisions.

We began with an analysis of existing data to identify and model changes to composite measures. And that data came from a variety of sources and reflected a broad base of populations, not just commercial but also publicly insured.

We put our proposed changes out for public comment. And I want to thank those of you who took time to review and provide us your input. It was valuable to us as part of the process.

We also engaged in a dialogue with key stakeholders. And there are many stakeholders within the CAHPS community. But in this interaction we also talked closely and carefully with CMS and NCQA.

So let's turn now to some of the revisions and look at the effects of these 3.0 changes, starting with an updated list of composite measures.

Brown, Slide 14
As you can see on the left-hand side of the slide, you'll see the 2.0 measures. The "Access" measure, Getting Timely Care Appointments and Information, the "Communication" measure, How Well Providers Communicate With Patients, Helpful, Courteous, and Respectful Office Staff, and the Patients' Rating of the Provider.

As you look to the right of the slide, you'll see the 3.0 measures. Notice that the "Access" and "Communication" measures are still there, but in between those measures we've now added Providers' Use of Information to Coordinate Patient Care. That's the new "Care Coordination" measure. So where 2.0 had four key measures, three composites and an overall rating, CG-CAHPS 3.0 now has five key measures, four composite measures and the overall rating of provider.

So let's now drill down on each of those measures and see how they've changed. Let's start first with access.

Brown, Slide 15
Sorry about that, let me back up one point and speak to some additional changes in addition to the composites.

In addition to the new measure, "Care Coordination," we also changed the reference period from 12 to 6 months, and Lee Hargraves will speak more about that in this Webinar. We shortened the "Access" measure, that is the "Getting Timely Care, Appointments, and Information" measure, by reducing it from five to three items. And we also changed questions that refer to phone interaction to contact.

We shortened the "Communication" measure by reducing it from six to four items. And then net effect of these revisions is that we've reduced the core from 34 to 31 items.

All right. So now let's drill down on these changes, looking first at Access.

Brown, Slide 16
Again, on the left-hand side, you can see the 2.0 content for "Access." On the right-hand side you see the 3.0 content. So looking at the first change, again, you see they reflected the revision, from 12 to 6 months. You see in question 6 we've change to the word "contact this provider's office" from "telephone." You can see that other than that the item the remains unchanged.

You can see in the following question that asked about check-up or routine care, getting appointment as soon as you needed. You see we still got the question about contacting the provider's office during regular office hours. But we've removed two questions from this measure.

The question about after regular office hours contact has been removed because of low response to that item. It wasn't contributing much to the composite and was in effect hurting the validity of the measure or the reliability of the measure because few patients had that experience to report. In addition, we've removed the item on having the visit start within 15 minutes of your appointment time.

Brown, Slide 17
Now let's move on and look at how we measure "Communication." Again, on the left-hand side of the chart, you've got the 2.0 content on "Communication." On the right-hand side of the slide, you've got the 3.0 content on "Communication."

So again, we've retained the item on "easy to understand explanation." "How often provider listened carefully to you" remains. We've dropped the question about "easy to understand information about health questions or concerns". We've kept the item on the "provider showing respect for what you had to say" and the item on "how often this provider spends enough time with you." Again, this results in a shorter, tighter measure with approved validity and reliability.

Brown, Slide 18
So let's now talk about measuring Care Coordination. This has been an area where we've had substantial effort on CAHPS over the past several years, trying to determine the best way to measure such an important aspect of care delivery. And so now we have a new composite measure that finally meets the standard of performance for sharing with all of you.

I need to note that this measure is for the Adult Survey and we'll continue to explore how best to measure care coordination in pediatric care. But the Care Coordination composite measure is three items – "how often this provider knew important information about your medical history;" "how often someone from the provider's office followed up to give you test results from a blood test, X-ray, or other test;" and "how often you or someone from this provider's office talked about all the prescription medicines you were taking."

Brown, Slide 19
In addition to these measures, we had some additional changes to update the CG-CAHPS Survey. And it's important to note that while we made all of these changes, there are a couple of things that remained unchanged. And a key measure that remained unchanged is the 0 to 10 rating, which is the hallmark of any CAHPS survey, and it stays just the same in CG-CAHPS 3.0. Also, the "About You" section remains unchanged in this update.

Brown, Slide 20
So in addition to those updates to the core survey and the stability of the 0 to 10 rating and the stability of the "About You" section, we've updated the supplemental items used to assess patient experience with a patient-centered medical home or PCMH. That's a supplemental set of items that you can append to the CG-CAHPS core survey to measure experience with a medical home.

We've moved PCMH item into the core survey. That's that question about all the prescription medicines you were taking, and that contributes to the Care Coordination measure. And we've reduced the PCMH items from 18 supplemental questions to six. And let's take a look at what remains for PCMH.

Brown, Slide 21
So here are the six supplemental questions that comprise AHRQ's PCMH Supplemental Item Set: "Did the provider's office give you information about what to do if you needed care during evenings, weekends, or holidays?"

And then some experience questions framed in the last six months: "Did you see a specialist for a particular health problem?" How often the provider, the focal provider named at the beginning of the survey, was informed and up-to-date about the care you got from specialists; whether you talked with anyone from the provider's office about specific goals for your health; if anyone from the provider's office asked you if there are things that make it hard for you to take care of your health; and if you talked with anyone in the provider's office about things in your life that worried you and cause you stress.

Brown, Slide 22
AHRQ provides surveys and guidance at cahps.ahrq.gov. The Adult 3.0 CG-CAHPS Survey was released in July and the Child Survey was released in September. Please note again that we anticipate future updates to the Child Survey as we further explore Care Coordination measures for pediatric care. We are updating the PCMH materials and translations, and we'll post updated supplemental items later this year.

Brown, Slide 23
So as you review and digest the information in today's Webinar, please keep in mind that we created CG-CAHPS 3.0 to better meet user needs in a changing environment of healthcare delivery. The updated survey improves the efficiency of the composite measures while maintaining measure validity and reliability. And last but not least, we have a common core to support alignment across multiple initiatives.

Thanks for your time today, and I look forward to your questions.

Dale Shaller

Brown, Slide 24
Okay. Great, Julie. And there are a number of questions that have come in. Let me start with at least three people have asked about the rationale for dropping the seeing provider within 15 minutes of appointment question. So could you address that?

Julie Brown
Sure. And I see that in particular someone asked if this was a result of feedback from specialists. And I can say that as we looked across the content, you all may all recall that earlier I spoke to the fact that we looked at existing data and analyzed it. And one of the things we did is we looked at the contribution of different questions to the composite, how much they contributed new and unique information, how well the composite performed with or without them, how well they did in measuring a specific, the desired aspect, in other words. Was each question a valid and reliable measure of access versus communication versus something else?

And in the environment of making trade-offs and having to determine sort of what's the leanest, meanest, most efficient way to measure access without sacrificing the reliability or validity of the measure, the 15 minutes of appointment question was just one question that was identified as not contributing as much to the composite as some of the other items. And so in the interest of being leaner and meaner but still having good validity and reliability, if not improved validity and reliability, we made the decision to drop this item. So it wasn't based on feedback from any one stakeholder audience or any specific type of care that was delivered.

Dale Shaller
Great. Thank you very much for that thorough answer.

Another question related to content has to do with the "recommend provider" question. The questioner asks, for consistency with HCAHPS, will that "recommend provider" question be included as a core or possibly as a supplemental item?

Julie Brown
Well, correct me if I'm wrong. My understanding is that question is always available to folks to use to supplement their CG-CAHPS Survey. At this time, it's not a question that we're considering for the core but that's not to say that it won't change in the future. But I think the important message is that it's there for stakeholders who want to include it in their CAHPS survey.

Dale Shaller
Great. So it exists as a supplemental item.

Julie Brown
Correct.

Dale Shaller
Here's a question related to a PCMH Survey. And I believe you covered that in your discussion of the new winnowed down list of PCMH items that are included in 3.0. So unless that answer wasn't completely provided. I think we'll move on.

Here's a question related to another version of CG-CAHPS known as the visit version. Will that go away by adopting all the core 3.0 questions?

Julie Brown
Well -- and Dale, I may want to turn this back to you to get clarification on what will be submitted to the CAHPS Database. But my understanding is that the 3.0 Survey is there for users who want it, but the Consortium's recommendation to the user community is really to embrace the 6-month version of the survey because we think that best meets users' information needs. And you can field that survey on an annual basis, quarterly basis, monthly or other frequent basis to meet your information needs.

Dale Shaller
Right. And I will add to that. The Visit Survey 2.0 version will continue to be supported by the CAHPS Database. But the 2.0 version of the Visit Survey is not being updated to reflect the new 3.0 content for precisely the reasons you mentioned. The Consortium is quite interested in moving users of CG-CAHPS to this new 3.0 version platform with the new core items that you just reviewed.

Related to that is a question about alignment. And the question is -- how aligned are the CG-CAHPS composites to other CAHPS surveys? And if they're not, is there a discussion underway to consider aligning them?

Julie Brown
Well, I think that for those of you who are familiar with CMS' PQRS and ACO initiatives, you'll know that for the 2015 reporting period, CMS is using CAHPS 2.0. CMS is giving very careful review of these 3.0 revisions that were just released in July and September for incorporation into future survey cycles for PQRS and ACO. We know that other key stakeholders are looking very closely at these revisions and determining how best to integrate them into their ongoing survey efforts.

Dale Shaller
Very good. Here's another question that's sort of related to one that was just answered by us -- will you consider changing "phone" to "contact" for the visit-specific CG-CAHPS Survey? And the answer is we aren't doing any changes to the item wording or content of the visit version of CG-CAHPS.

Julie Brown
Correct. I think we really view that as a legacy instrument. And again, we encourage all users to transition to the 6-month version of the survey.

Dale Shaller
Julie, we have a question related to the new Care Coordination composite. And the question is, "Is it clear how a patient should answer this when much interaction is occurring through patient portals? What would the effect of that be?"

Julie Brown
I think that's a really great question. And I really appreciate how thoughtfully one has framed that. And I'm assuming that in particular the questioner is referring to the items about followup to get test results. And while I think that portals are incredibly helpful and useful tools, for the larger patient community they still look to their provider's office to follow up, to give them test results, or to even ping them to remind them that something is there on the portal. And one of the things we found in our cognitive testing is that patients really do look to the provider's office to alert them that those information results are available, and are able to distinguish an answer separately from their experience with interactions with the provider's office versus interactions with the portal.

Dale Shaller
Very good. Now here's another question. I know that the team that sort of reviewed the data and came up with the recommendations for 3.0 did consider some additional wording changes to some of the questions. This particular person asks if we'd consider something more -- in her words -- modern or up to date with respect to administrative staff or front desk staff to replace the current terminology of "clerks and receptionists" in the office staff questions.

Julie Brown
Sure. And that is something we can continue to test. And I don't mean to sound old school or out of date, but one of the things we are finding is that there isn't anyone who doesn't understand what we mean by "clerks and receptionists." And we haven't identified anyone who gives an inappropriate response to that question. But when you think across the broad range of CAHPS audiences, and in particular the large volume of surveys that go out to older populations, as we go forward and test alternatives, we're being sure to explore how those

options are interpreted and how they perform with a broad range of patient communities to make sure that if we change those terms we're adopting terms that have consistent and common understanding across the broad array of patients.

Dale Shaller
Okay. Here's a question -- in fact there's a couple of times in what's been submitted so far regarding how applicable the new 3.0 content is to specialties beyond internal medicine or family medicine or primary care. The questioner goes on to say someone in optometry or ophthalmology might not score well on, for example, the review on medication you are taking question. So how broadly applicable is the 3.0 content to other specialties beyond primary care?

Julie Brown
I think that is a great question. And let me answer it in two ways. First off, for those of you who aren't aware, there is a CG-CAHPS Survey developed and made available by AHRQ that gets at procedural specialists. It's CG-CAHPS for procedural specialists. And so while that question -- while that survey has the common core, it also has items that are appropriate to providers who deliver procedural care.

When it comes to special groups like mental health or ophthalmology groups or hospitalists, CG-CAHPS may not be the best tool for those populations. And if the questioner is concerned about CMS' use of CG-CAHPS for PQRS or ACO, they can submit that query to the PQRS or ACO helpline and we can give them a more detailed response in the context of those programs or initiatives.

Dale Shaller
Great. We have just a couple of minutes left before we move on to Lee. And just reminding everyone that we will have another longer couple of sets of Q&A sessions before the Webcast ends. But this one is related to the child version of 3.0, and the question asks whether the PCMH Item Set also applies to the Child PCMH Item Set.

Julie Brown
The examples I gave for PCMH was the Adult Item Set. We're still working to finalize the Child Item Set for PCMH, and apologize for not making that clear. If you're familiar with the Child PCMH Survey, you'll know that it has a section of items on health promotion and health education that are very specific and unique to pediatric care, and we're in the final stages of locking down that content to make sure that we really make it as lean as possible but make it appropriate to the standard of care that's appropriate for the delivery of pediatric care.

Dale Shaller
Very good. There are a couple of questions that are related to the recall period, specifically about the 12-month and how that relates to a shorter recall period. I'm going to bypass those and Lee is going to address those issues I think directly. We can come back to those if the questions haven't been fully answered.

And I think, before we move on, Julie, just there are several questions that have come in with respect to penalties and release of data, and I think we need to clarify kind of broadly here the role of AHRQ versus the role of CMS and/or NCQA and any kind of actual requirements for implementation and reporting of CG-CAHPS. Would you like to take a stab at that?

Julie Brown
Sure. And so I know it gets very confusing, but something to remember is that AHRQ develops the CAHPS instruments, the broader, suite and family of CAHPS instruments and makes them publicly available. And many stakeholders, including CMS, take those instruments and adopt them for their own initiatives and programs.

So if you're participating in a program or initiative like the Shared Savings Program, ACO effort, the Pioneer ACO Model or the Physician Quality Reporting System, the conversation we're having today is about AHRQ's update to the instruments and the testing we've done and how we make those available.

If you have questions specific to how CMS is using those instruments, what penalties may be, what data you're accountable for, when things will appear on Physician Compare, I encourage you to go to CMS's Web site for either program and contact the help desk there. And they'll be able to answer your questions specific to each program.

Dale Shaller

Okay, great. Thanks for the clarification. And at this point, we still have some unanswered questions but I think some of the answers may actually reveal themselves in the next segment. And I'm going to turn it over to Lee now to describe the testing that's been done comparing the 12-month recall period to the 6-month recall period. And, Lee, take it away.

Lee Hargraves

Hargraves, Slide 25

Thanks, Dale. And thank you for this opportunity to talk about what happens if one switches to making this survey a 6-month recall survey. So I'll start by just providing a little bit of overview of the -- one of the reasons why this is important is because there are users of this survey who are fielding the 6-Month Survey and others are doing a 12-Month Survey in both the recall period and also thinking about the sampling frame. In other words, when one does the search for respondents, for patients, you can use the 6-month window and find all those folks who had a visit in the last six months or you could go on the 12 months.

Hargraves, Slide 26

So as part of an effort to harmonize or align these approaches, we would switch to the six-month period and a good thing to do is to test what are the effects of that. The general idea is the sort of a tradeoff. If you have a longer recall period, that gives people more events to talk about. On the other hand, if you have a shorter period, those events are more recent and perhaps more salient.

So that leads to the two hypotheses. One is that switching to a 6-Month Survey may shrink your sample as having a shorter sampling period will decrease the number of people who had a visit. And again, the shorter recall period may actually influence how people respond to the questions about those events. Something that happened three months ago may be different than thinking about something that happened nine months ago.

Hargraves, Slide 27

So in order to test this effect, I mean the simplest thing to do is to randomly sample some people to having a 6-Month Survey and some people to having a 12. Working with the Center for Survey Research at UMass Boston, there was an ongoing project to assess coordination of care among patients in health centers in New England.

So as part of that study, there was a real focus on folks who had a chronic condition or something that would lead to more intense use of care. So there was an algorithm created to search through all of the patients at the health centers, finding those who had a previous emergency department visit, hospital stay, or a chronic health condition, such as uncontrolled diabetes or asthma. And that was the main part of the study.

And then in order to do this study of 6 versus 12, it makes a lot of sense to make sure that we should have a representative sample. So we looked at all the other patients, the patients who didn't fit that algorithm to come up with a control sample. And then in each health center, we randomly selected some patients to get a 6-Month Survey -- actually, we focused on the 12-Month. Everyone got the 6-Month and then we randomly selected a pool of patients at each health center to receive the 12-Month Survey.

We also, in the process of doing that, the sampling frame was patients who had a visit in the last 12 months. So again, each of these samples, we had random selection.

Hargraves, Slide 28
I'm only going to present a few data tables because I know how much that can be fun to look at. But there are over 12,000 patients in the sample. There were 4,212 who were in that chronic care sample and then we had the control group which was 8,087.

And in general, the overall finding, looking all the way to the right, this is all representative of all the patients seen in the last 12 months. If you restricted it to only those who had a visit in the last six months, the sample would shrink by around 5%, 4.7%. So there is going to be a smaller sample. Of course that makes perfect sense if you only look for people with a visit in the last six months. Some people would drop out.

Hargraves, Slide 29
In doing the survey, I can talk about several different things. One is there's really no difference in response rate. The patients who received the 6-Month version, about 46% responded and this is responding to a sort of standard protocol; two mailings, reminder in the middle and then telephone follow-up, calling up to six times. The survey was also done in English and Spanish.

The point is that the response rate was about the same. And I wouldn't think that there was a hypothesis that that would be affected too greatly.

We looked at a lot of the characteristics of patients and the standard about you questions that are included in the survey. There's really no statistically significant difference between those who were responding to the 6-Month and those responding to the 12-Month Survey. That's in terms of age, gender, education, race, ethnicity and also their rating of overall health. That's the excellent, very good, good, fair, poor question.

We did find some difference in the mental or emotional health question. And I'll show you that data and I'll show it in two ways.

Hargraves, Slide 30
But basically, the distribution is different, the 6-Month and the 12-Month. And as Dale mentioned, you can download this and look at this later but what I'll do is I'll go to the next slide, which sort of breaks it up.

Hargraves, Slide 31
This is the sort of two categories, the percentage of respondents who said that their general emotional -- mental or emotional health was good to excellent was 71% in the 12-Month and 65% in the 6-Month Survey, a small difference but it is there.

Hargraves, Slide 32
In terms of people's use of healthcare, utilization, there were no differences between the 6- and 12-Month Surveys in time with provider. That is how long a patient has been seeing their particular provider. Whether or not they fall in the health center for routine -- to get an appointment for routine or urgent care, whether they had medical questions or specialists visits, there's no difference in the percentage of patients who were taking prescription medications.

However, there were some differences in the number of visits and also the question about whether or not they've had tests, X-rays or other tests. And I'll show you that data. It's a busy slide, why don't we just focus on one thing. I find the need sometimes to do that.

Hargraves, Slide 33
The percentage of respondents who had one visit, just one visit alone. Respondents to the 6-Month Survey were much more likely to have had only one visit compared to those in the 12-Month Survey, which I think that makes sense. A longer window allows for more visits. In fact, if you look at the bottom line, those patients who had 10 or more visits, it's much higher in the 12-Month Survey than in the 6-Month Survey. That seems to make sense to me when you increase the sampling frame.

Hargraves, Slide 34
And then the probability of someone reporting on a blood test, X-ray or another test. Respondents to the 6-Month Survey were twice as likely to not have had one of these tests. The 6-Month Survey, about 13% of respondents say that they had no test ordered for them. And the 12-Month Survey, about 6.6%. So there's almost a double in the rate of not having a test, to use double negatives. What that also means is if you have a longer time window, there's a greater opportunity for an event of having a blood test, X-ray or other tests occur on the 12-Month Survey.

Hargraves, Slide 35
And this is in the 2.0 version of the survey, these are the composites that were used. And what this slide shows, and I'm on slide 35, is the top box scores. And if you're not familiar with the notion of what a "top box" is in paper survey, people are checking boxes. The top box response is the most positive response. In other words, if they're asking a question "never," "sometimes," "usually," "always," then "always" is the most positive response.

And what this slide summarizes is the composites that were in the survey, plus the 0 to 10 rating. And from these composites, there was a slight difference. In fact, you'll notice that I'm using a questionable measure of statistically significant which is p-value of less than 0.10. But I think we want to know if there's even a little bit of a difference.

And these differences are observed after one adjusts for whether or not a person responded by mail or phone. They're adjusted for the age of the respondent, the gender, educational level and both measures of general health. These are the things that are typically used in a case-mix adjustment.

One trend that you can observe is that in every one of these measures, the top box score is a little bit lower in the 12-Month Survey. And I think that's one of the takeaway messages here is that it seems to be consistent. In fact, if you look at it at the item level, you'll see that same kind of consistency.

Hargraves, Slide 36
So the bottom line is, when one switches from a 12-month sampling frame and a 12-month recall period, there are certain effects that one might see. The sample will be a little bit smaller. Not dramatically but it will be smaller.

And then also, switching from 12- to 6-month recall periods will mostly affect some of the items that assess experiences with providers, the communication composite and the 0 to 10 rating of the provider. That's the worst, best, 0 to 10.

So I think that there may be a tendency if one is looking at trend data that there might be a slight uptick in performance measurement. Not a great shift but it may be there.

And I guess now would be the question-and-answer time.

Dale Shaller
Okay, great. Lee, thanks so much for the review of the study that you and other members of the CAHPS team worked on in the Connecticut context.

Hargraves, Slide 37
We have a series of questions that have continued to come in and they kind of run the gamut. I didn't see any particular question targeted to your study of 12 versus 6 but there is kind of a general question theme regarding the 12-month recall and the 6-month recall and a visit frame.

And I just wondered if, Lee, could you elaborate on either the 12- or the 6-month, actually compared to the visit frame and how is it that we know that a retrospective recall period can work as well as a visit -- sort of most recent visit frame if what you're interested in doing is feeding back information to practices and clinicians for improvement.

Lee Hargraves
That's a good question. I think that one's always concerned about recall. I mean, I think that going from 12 to 6 actually makes things a lot better for doing trends data. And actually, in the study that we were doing, it worked out perfectly because having a 6-month recall means that we're actually surveying them 6 months later to find out what has changed in the practice because they were doing an intervention there.

Having a 6-month window does give a fairly good representation of who's in the center, who's using it and it also allows for people to summarize visits, which is one aspect of the survey that's important. There's a lot of respondents when they're thinking about in the last six months, did this happen? They're summarizing their experiences. And I think that's important to kind of get general pictures because one notice is a lot of patients have many, many visits during that six months period and they can provide some information.

Dale Shaller
Right. And we know, just to add to that -- that's very helpful, thank you -- that a number of health systems have successfully used the 12-month recall period on a continuous sampling basis for internal improvement. So we recognize that there are multiple uses for the CG-CAHPS survey.

And just kind of a general point that I like to make is we set about with the 3.0 version development for a number of reasons, to improve the survey along the lines that Julie has reviewed for reliability and efficiency, but also to bring requirements that we know are being used by CMS, NCQA and other states, regional collaborative into alignment so that we all can eventually move to a common core.

And the judgment was 6 months is actually a very good timeframe recall period for doing just that.

So that's kind of a general point. And knowing that there's good experience and evidence that one can, in the health system, use a 6-Month or a 12-Month Survey for sampling on a regular basis either weekly, quarterly, monthly, whatever suits the needs of the particular health system and still do a very credible, helpful and clinically acceptable job of collecting and reporting that information back to clinicians for improvement.

Ron Hays
Dale, can I add one thing?

Dale Shaller
Please do.

Ron Hays
This is Ron Hays. The other thing about this is the specific questions. They're valuable because they're focused on a specific visit that we found in analyzing data that they're much less reliable than the more periodic assessments. So in order to get reliable data, it takes a lot more observations and it's not practical in a lot of cases to actually get that many observations.

Dale Shaller
Right. Thank you, Ron. And we also noticed, just to add on to that, with the visit version, and I know that users have experienced this because we've interacted with many of them, that the actual scores in the Visit Survey tend to even top out higher in terms of ceiling effects because of the smaller response scale, the yes definitely, yes and no, three-point response scale as opposed to the never to always, four-point response scale that was used for the 6-month and 12-month recall period.

Okay. A number of questions here. One, I'd get back to some of the content and ask, Ron, I'm glad you've joined and please feel free to chime on any of these. We're going to field a number of questions before we move into your specific segment on additional testing.

One question relates to sampling recommendations, CAHPS' published guidelines with respect to sample sizes that are recommended for different size sites or the individual provider level. Has any of that changed in moving from 2.0 to 3.0?

Julie Brown
Hey, Dale, this is Julie. At this time, the sample size recommendations for sampling at the site of care, group or individual clinician level or individual provider level remain unchanged as we transition from 2.0 to 3.0

Ron Hays
And just to remind people, so that's about 300 completes per group or site and 45 for individual physicians because when you're focused on an individual physician, you don't need as many observations because the variance is less than if you've got multiple physicians across sites.

Dale Shaller
Great. Thank you, both. A question related to the sampling timeframe. And I think Lee, kind of maybe have been prompted by your presentation. Are we able to choose the sampling timeframe or is this an automatic change? In other words, if moving to 3.0 with the 6-month recall, is the recommendation then to drive your sample frame for because it's within the last 6 months?

Lee Hargraves
Well, I think you want to do everything you can to maximize your response rates. So if you did, for example, a longer timeframe but then you ask people to focus on the last six months, then there'll be a lot of surveys that will be returned without meaningful information. So I think you want to make your sample frame match the survey recall period.

I mean it never is a perfect match because we're dealing different kinds of data for sampling. But that's why the questionnaire actually includes, did you have -- how many visits did you have and one thing that someone says, I didn't have any visits, then it really doesn't make sense to ask them to talk about -- to tell us about things that didn't happen. So I think you want to make those parallel.

Julie Brown
Can I add one addendum to that, Lee and Dale?

Lee Hargraves
Sure.

Julie Brown
I agree 100% with what Lee is saying. But I also want to remind some users that when you're dealing with a population that might have more frequent visits than the norm, think about an older population perhaps with Medicare or if you're really drilling down on people with -- who are getting ongoing care for chronic conditions. In those instances, it may be appropriate to think about drawing a pool of patients who had care in the prior 12 months with the understanding, as we said, that if they haven't had a visit in the last 6 months, they won't be able to answer the questions.

But in those populations, many users have found that they have visits so frequently that a 12-month draw includes a large number of people who've had visits multiple times across that 12 months.

Dale Shaller
Great.

Lee Hargraves
They may even had a visit between the time you drew your sample and the time you got the survey to their doorstep.

Julie Brown
That's for sure.

Dale Shaller
Okay, here's a question related to the content of the care coordination composite. The question is, understanding that there's less follow up on blood tests on the 6-Month Survey, so wouldn't that affect the new care coordination domain? Do you anticipate changes to the care coordination domain in the near future?

Julie Brown
That is a great question. Thank you for submitting it. In developing and testing a measure of "Care Coordination," we actually developed it and tested it with a 6-month reference period. And that worked fine in our quantitative and qualitative testing. So we don't anticipate changes to that composite based on the reference period.

But I do want to say that Care Coordination, because it's such an important aspect of care to measure, is something that the Consortium will continue to focus on going forward with our top priority to be firming up a measure for pediatric care. But we'll always be monitoring how best to measure this for adult care.

Dale Shaller
Thanks, Julie. Lee, directed to you, the question is about the fact that the 6-month lookback makes it more important that the surveys are fielded at the time each year for trendability. Is that true? Isn't the 6-month lookback period more prone so seasonality effects? Thoughts on that?

Lee Hargraves
Well, I think that's a -- I remember doing work on hospital surveys and having this same sort of discussion of what happens during cold-flu season if there is such a season. And I guess there is because they give shots for every year at the same time.

But there's always this notion that there might be a seasonal effect that haven't -- I haven't seen great evidence of that. I do think that what users might want to -- I mean you could think about surveying every six months to get a picture. But I still think that having it the same time probably makes sense organizationally and for many other reasons. But I don't see why one would want to sort of think about annual survey or something of that nature. Others on the Webinar may have more to add.

Ron Hays
Well, I agree with -- it's probably always a good idea to standardize the time you administer it just to be safe because there is some evidence of seasonality. But I doubt that it's a huge effect, but just to be careful, it doesn't hurt to standardize the 6-month assessment if you're trending.

Dale Shaller
But at the same time, a system could use the 6-Month Survey, not at just a particular point in time during the year but on an ongoing basis, as we were talking about just a little while ago. So you really want –

Julie Brown
Yes, I agree with you down there. Some users who are fielding the survey quarterly using the 6-month reference period and some are even doing a monthly sample draw in which they refer to the past 6 months of experience.

Dale Shaller
And this question has come in that the sort of -- I think this is an important clarification. If patients have multiple visits over a period of 6 months with different providers, is it hard to attribute the provider communications score to one provider? And Julie, I'm going to pass that to you to clarify that every single questionnaire asks this frame in terms of a specific focal provider. So go ahead.

Julie Brown
Yes, Dale, that's a very good point. And please understand, with these 3.0 revisions and the recommendations we're making about changing to the 6 months' timeframe and using the 6-Month Survey in place of the Visit Survey, we're not advocating for any change in how the provider is identified.

That is that every CG-CAHPS Survey should name a focal provider. And that focal provider can be a nurse practitioner, a physician assistant, a clinical nurse specialist, a primary care provider or a specialist provider. And that name is what anchors the patient quite often and in all candor to the site of care. So even if you're fielding the survey at the group level or at a larger system level, that provider identification is very important to anchor the patient to who it is you're asking about and what kinds of experiences to include.

And we found that in our qualitative testing and focus group work, patients do attend to that provider identification in an answer for their experience based on that provider and the individuals they interact with in that provider's setting.

Dale Shaller
Thanks, Julie. Here's a question that I think kind of continues the same thread of content that we were just reviewing but I'm going to just kind of nail this by asking, is it best to have the sampling period match the lookback period within a survey? So it kind of gets back to what you were addressing, Lee. And I think that the answer to that is yes.

Julie Brown
Well, I will give the caveat to that, Dale.

Dale Shaller
Okay.

Julie Brown
Again, there are individuals who are drawing monthly samples and not fielding the survey about the past month but fielding in about the past 6 months. I agree with Lee that if you're doing this once a year, that best recommendation would be to have the sample draw match the lookback. But again, with so much of this guidance, there are always unique aspects to any situation or setting that could cause one to want to deviate from that a little bit.

Lee Hargraves
And I'll just reiterate what Ron said. I mean, I think the important thing is when you're doing -- you don't change your method back and forth between, well, we're going to do monthly sampling and then we're going to do quarterly sampling. Because if you do think that some things were sensitive, then [you] want to have a uniform method.

Dale Shaller
Right. Okay. There's still a number of questions we haven't quite gotten to. I want to make sure we have time to include some of the work that we're doing on additional testing because that may promote some answers to existing questions or provoke a few new questions.

So, Ron, I'm going to turn it over to you now to talk about the testing plans underway with the CAHPS team.

Ron Hays

Hays, Slide 38
Okay, thank you, Dale. What I'm going to do is just summarize five areas where the CAHPS Consortium is conducting some preliminary research and then will be continuing this work in the future. So anything that I say just take with a grain of salt because it's not definitive, necessarily.

But the five areas are listed here. So there's actually some work on shortening the survey that goes beyond what you've heard so far. We're also looking into simplifying item wording, looking at the effect of incentives on response rates and looking at different ways of collecting data, as well as looking at whether different race, ethnic subgroups respond differently to CAHPS items.

So I'm going to quickly summarize these.

Hays, Slide 39

But we actually have an in press article in Medical Care that's listed at the bottom that is based on an analysis of a large number of surveys. So you already heard in the Webinar about changes to the 3.0 Survey including the fact that it's a reduction of three items in the core from the previous version of the survey.

But in addition to the analyses we did to make those decisions, we've analyzed four data sets to look at more radical shortening of the survey just to see what might happen. So we have data from an HMO that's implementing PCMH care from 152 ACOs, from 53 ambulatory care clinics, and from 28 safety net practices. So in total, it's about 137,000 observations.

And this article describes our look at, well, what if we reduced the core composite? So we could reduce the Office Staff, two-item composite to one item. And the Access and Communication composites to two items each. And it looks like there are some combinations of items that actually will produce reliability that's pretty much equivalent to full-length surveys.

So this is not definitive in anyway, but it does suggest that it's possible at least in an empirical sense to maybe come up with even shorter versions of the surveys in the future for certain applications.

Hays, Slide 40

This other effort, the second thing I want to talk about is something being led by Jose Calderon. So we know that the CAHPS Clinician-Group Surveys were targeted to be 7th grade reading level, whenever possible, and that's the way we try to go about things from the beginning. But at this point in time, we decided, well, maybe it's worth revisiting those items just to see how they're doing.

So Dr. Calderon who's a researcher at Charles Drew University in L.A. is leading this effort to reexamine the readability of the survey items. And he's experimenting now with alternative wording and layout.

So in this one example that I show here, this is question 5 in the CG-CAHPS 3.0 Survey, and it's a screener item. So at the top it shows you that screener item and what I show to the right is a summary of the readability. So if you do a readability estimate, this comes out about 12th grade level. So it's high school reading level.

So even though we target 7th grade, it turns out for some items, we actually exceed that. So he is trying well, let's see if we can simplify the wording to this, and when he does, what we see at the bottom here, a different wording with fewer words and fewer syllables, the readability estimate comes out more like 6th grade or elementary school reading level.

Now you may question whether it's really equivalent or not, but this is sort of the experiment that we're doing just to say, well, can we make it so that it's somewhat equivalent or as equivalent as possible, and simplify the wording so that maybe we'll get better response rates and less missing data in more difficult to reach populations.

The other thing he's doing, not just simplifying, you know, in terms of number of syllables, he's actually trying to array the item when you look at it on a paper and pencil version or on the Web so that it's in the chunks that make logical sense.

So the standard CAHPS approach is just, you kind of wrap around when you run out of space. Well, he's trying to chunk it here into three separate thoughts, so you have the item stem, and then you have, did you contact the this doctor's office, there's another slot, and then finally to get care, you needed right away, to potentially make it easier for people to actually read the item.

Hays, Slide 41

Okay, the third area is incentives. So we have a submitted paper, Julie Brown is the first author in this that we've done based on analysis of existing data. So we actually wrote this paper with Kaiser colleagues and we looked at the impact of a $5 incentive on response rates and based on the CAHPS field test with the Health Information Technology Item Set.

So we randomized people to either have no incentive, which is the usual thing that's done, or to receive a $5 incentive. And the $5 incentive could be either cash or a Target e-certificate for completing the CAHPS survey. And we found in this case the incentive increased response rates by 7%, 7 percentage points and that when offered an incentive, respondents preferred cash over an e-certificate by a sizable margin.

We also got an estimate of the unit cost, it costs more to actually send out the cash incentive than it did the e-certificate.

Hays, Slide 42

Okay. So the next area that you've been looking at is different ways of collecting data. So these are alternatives to the standard mail and phone method for data collection.

And one of the things we're looking at is tablet computers. We've heard from other people that they're interested in that possibility, and so we started to explore it. In this particular effort, we used Open Data Kit which is a free and open source software that Google essentially has put out there.

And we're looking to see if we can use that to administer the CAHPS Clinician & Group Survey on tablets and even on smartphones. So this is a screenshot of how an item would look using this technology.

Hays, Slide 43

What we found is, we did a very small pilot, a feasibility study with 63 patients with two sites in the west coast. And we found, to do this, we were using the CG-CAHPS Visit Survey. So this was being administered at the site of care. And what we found is that the majority of the people that were approached at the time of the visit, completed the CG-CAHPS Visit Survey so it was about 70% of those did. And we got generally positive responses to using this mode of administration. People seem to like doing it and they were able to understand how to use it and to provide meaningful data back.

Hays, Slide 44

Another mode of data collection experiment we did was in collaboration with Allina Health. So Allina Health is very interested in Web-based administration of CAHPS surveys and so they administered the CG-CAHPS Visit Survey, randomizing people to either Web or main survey administration.

And we helped in analyzing the data and writing it up and this article here describes the details of those results. But what we basically found is that Web surveying was less expensive, and it produced quicker returns of surveys than the standard mail survey approach. But the response rate was higher by mail.

Apparently, over time, the response rate to the Web surveys has increased in Allina, but at this time, it was considerably lower than by mail.

When we compared the CAHPS survey answers that we got back, they were similar between modes, you know, mail versus Web, for the communication and office staff composites, but Web respondents were reported less positive reports about access to care.

Hays, Slide 45

The final thing I want to note is, we have a paper, another paper that's in press in Medical Care, that looks at Asians, compared to Whites in terms of their proclivity to respond to CAHPS survey items.

So we know from a lot of work, that Asians typically report worse experiences with care, than other race, ethnic subgroups. So we conducted an experiment using vignettes of doctor-patient encounters to see if reports by Asians differed from Whites when we held the scenario constant. So one of the problems when you're looking at real world data is, you don't know if the experiences are really different or not.

So in this case, we described vignettes to everyone, same vignette, and we wanted to see then if we saw differences in the way they used the response scale.

So we found that Asians were less likely to use the extremes of the response scale. So that meant, they gave more positive responses for vignettes that depicted doctors who were less responsive to patients' concern. So actually doctors that were not as good in terms of responding to patients' concerns, but they gave more negative responses for vignettes where the doctors were more responsive to patients' concerns.

So overall, that means they were less likely to use the extreme ends of the response scale. Because both CAHPS data and other patient experience data is generally positive, it's skewed in the direction where you're going to get more positive reports than negative reports, these finding are suggestive that what we see in terms of less positive reports about care by Asians, could be due in part to their tendency to avoid the extreme ends of response scales.

So this would suggest that maybe some case-mix adjustment would be important in making comparisons.

Okay. So I'm going to stop right there for our Q&A.

Dale Shaller

Hays, Slide 46

All right, Ron. Thank you so much. I think it's very helpful to let the user community know even just a portion of some of the research that's still underway that will continue to inform the development of not only CG-CAHPS, but other CAHPS instruments. So I really appreciate the review of some of these ongoing studies.

Just really, a quick question came in right at the tail of what you were presenting regarding the ethnicities that were included in the Asians Category. Can you clarify that?

Ron Hays

Yes. That's a general issue, is that we often don't break into subgroups of Asians, and of course, there could be variation and type of Asian subgroup. So typically, in CAHPS surveys, we don't split out Asians into subgroups, but in some cases like in California, they want to know every subgroup of Asians.

So when I was presenting those results, it was really kind of lumping them all together, but recognizing that they're not all the same, not all Asians are the same, but still, the general phenomenon is there that for a lot of surveys, when all you know is Asian, more globally, you do tend to see less positive reports about care.

Now there could be variation within that, but we weren't able to address that so far in this particular experiment.

Dale Shaller

Okay, great. Thank you. I also just want to mention another area of research underway within the CAHPS team has to do with the collection and reporting of patient narrative information. And we've not included that in today's Webcast because we're really focusing on the 3.0 version of CG-CAHPS and what that includes and how that differs from 2.0. But there's a whole other sort of field of research underway with respect to collecting patient narrative comments and adding them potentially to CAHPS surveys to complement the close-ended questions. And we'll be publishing and talking about that more in the future.

I want to go back to a theme that continues to I think require some further clarification. And that has to do with the sampling guidance.

And I'm going to ask if perhaps Julie and/or Ron, or Lee, clarify what is the -- first of all, is the guidance for sampling according to the size of a site, is that changing at all as we move from 2.0 to 3.0?

Julie Brown

Hey, Dale. This is Julie. I'll go first, and then Ron can correct me. Earlier, you heard Ron mention the target of 300 completes per site, and 45 completes per provider, and those were kind of our standard of default sample guidance for CG-CAHPS. But if you're familiar with the AHRQ Web site , you know that we also provide more

detailed guidance with regard to, say, if you're a smaller practice, maybe you only have two or three docs, maybe 300 completes is not appropriate in that context. And so that guidance is not changing at this time.

But when we talk about CAHPS in front of a large audience, we tend to mention the 300 completes per site, or the 45 per provider, because that's the standard or default. But again, there's more refined guidance based on the number of providers associated with your site of care.

Dale Shaller
Okay. Thanks.

Ron Hays
And there is an article, again, in Medical Care, that the CAHPS team wrote where there's information about reliability and how it varies by number of providers.

Dale Shaller
And there's also, on this CAHPS site, which the URL is available on these slides at the end before we sign off, the guidance in the CAHPS implementation kits does include information regarding sampling at the various -- at the site level according to the number of providers assigned to a particular site.

Ron, before we leave, the research that you had just highlighted, there's a question here regarding, is there a plan to explore use of tablets for real time collection of patient experience of care?

Ron Hays
Real time, does that mean visit-specific? Is that -- I assume it's something like that.

Dale Shaller
I think it means point of care collection.

Ron Hays
Yes, well, so far in our pilot testing, it was at the site of care. We've done other studies that Julie can comment upon about potential difficulties of collecting data at the site of care. So you know, at this point in time, we're not saying that site of care is necessarily something we're recommending in general, but we're still interested in testing to see when it's feasible and what you know, you actually get in terms of responses back and how that compares to offsite administration.

So this is just an attempt to say, well, if this is a good option for people, can you do it, and down the line, testing to see how it compares to other ways of collecting the date?

Dale Shaller
Any further comment?

Ron Hays
Julie, I don't know if you want to say anything about the work with Susan that you've done before at site of care?

Julie Brown
Well, we've done some work. You mean with regard to alternative methodologies, Ron?

Ron Hays
Well, just what was found when you know, collecting data at the site of care and some of the potential costs that people may not anticipate.

Julie Brown
Yes. Thank you. I apologize for not fully tracking that. We have been, and I'll do it very quickly Dale because I know there's lots to talk about. We did an experiment collecting data at the site of care, and different models to implement it, and how best to do it in a way in which the results weren't influenced by how the survey was distributed.

And all of these things there are some challenges and I think for us, the biggest hurdle is figuring out how to get the survey to all the patients who have had it. We have a real challenge in making sure that everybody who should receive the survey or the invitation to do the survey when you're feeling it at the site of care gets it. And the concern is that we're biasing the sample by not reaching all the people that we should.

The other thing we found is that when we did a cost analysis of how much it costs to hand out the survey to staff, to patients on site as they're exiting their visit versus a more standard methodology such a mail survey, it actually was more expensive to hand out the survey on site because the cost of labor to monitor who was getting the survey and that they got the survey and to follow up and hand it out, was not something folks anticipated, and it was greater than the cost per case for a mail survey.

Dale Shaller
Very good. So we do have a number of studies that have been done on different modes and the mode research will continue along the lines that Ron has mentioned. And I think the point is to maximize efficiency of data collection in new and important ways and using a variety of approaches. So we'll continue that research.

And I just want to ask another question, Ron, just on the issue of reaching Asian patient populations. Is the English version of the survey being used for collecting data from Asian respondents?

Ron Hays
Yes, I see that question. That's a really good question. Typically, if the preferred language is what's administered, so there are a lot of cases where you know, there would be a translation into whatever Asian language is appropriate for the respondent, not in every situation, some places you know, they only administer English, so they only do English and Spanish, but specially in California, there've been a lot of studies of administering the survey in the preferred language.

And one thing we do find there is that when Asians report -- actually complete a survey in English versus complete it in an Asian language, that when they complete it in the Asian language, it's actually more negative in terms of the reports about care. So the phenomenon of Asians having the tendency to report less positive experiences is even greater when they complete the survey in their preferred language, and it turns out to be Asian, as an Asian language.

Julie Brown
Ron, can I make one comment on that? Isn't it true though that many users who use an Asian language, administer the survey in an Asian language often control for completion in an Asian language is part of the case-mix adjustment?

Ron Hays
I would not necessarily say it's common, but definitely in California, there has been more emphasis on that. For example, Pacific Business Group on Health and whatever they're called now, but for years, they have been concerned about making comparisons and not case-mix adjusting.

So based on input from people like Marc Elliott who's in the CAHPS team, they ended up adjusting for subgroups of race ethnicity. But across the board, that's not necessarily the case. In fact, for a long time, you know, people have thought that well, you shouldn't be adjusting for that. Everybody should be getting the same level of care, and you have to treat your population whatever it happens to be.

The problem with that argument of not adjusting for it is, it's not a good argument if it's just a response difference, so tendency to respond differently when everything is the same. And that's why we did this experiment to show that yes, it looks like there is a different way that the scale is being used, and that doesn't necessarily reflect true differences in care.

So in that case, it probably is a good idea to case-mix adjust.

Dale Shaller
Okay. There are a couple of other really specific questions, Ron, that maybe we can answer offline with respect to some of the research that you just reviewed. In the time we have which is about five minutes before we close and do some wrap up, I want to address some other questions that have come in. One has to do with -- if we have any evidence or thoughts about the impact of using a 6-Month Survey in the context of rural health clinics, given that there may be smaller respondent Ns that sites may be experiencing, any thoughts on, if there would be any sort of reason to suspect that the CG-CAHPS 3.0 Survey would perform differently in the context of rural health?

Ron Hays
Is that a question for Lee?

Dale Shaller
I think it's a question for anyone who wants to take it.

Ron Hays
I think it's dangerous for us to say no, we don't -- I mean I don't think we know for sure. I mean the results we have from Lee's experiment. Can we generalize? Well, maybe, I mean I think we would suspect it's not a huge problem, but we don't know until it's actually explored.

And another option is that you continue to collect data over a longer period of time if you're having difficulty. That may not suit everyone's needs, but if you accumulate enough data at some point, you'll have reliable enough information.

Dale Shaller
Yes.

Lee Hargraves
The answer may be true that an annual survey may not be the way to go there. I mean I wouldn't expect rural/urban to be that much different, but I expect the size of practices as the key variable there in how many patients are being seen and the pool that you have to sample, so you might again, might want to do more frequent surveys.

Dale Shaller
Right. And to the extent that there may be potential differences in the patient characteristics, that information is collected and can be adjusted for. But I think this really has to do with the volume of patients. And that can be addressed by extending the field period.

Here's a question, kind of going back to some of our earlier conversations about provider level data. In this case, provider level data is used for provider compensation. And even with identifying the focal provider on the survey, the question is, are results potentially affected by visits that that respondent might have with other providers including specialists? Do we have any evidence that responses are affected by a patient's experience with other providers when they're presented with the survey?

Ron Hays
Well, Julie may have more to say about that, but I mean of course, anything is possible. To some extent, it's logical, you could be affected, but one of things we're doing in analyzing the data over and over again is to see if we're getting reliable enough variance so that people who are visiting and attributed to the same provider,

they're agreeing to a substantial extent, about what they're saying about their provider. So as long as you have enough observations, then you're getting some common variance and common perception of the care that that particular provider is giving.

Dale Shaller
Yes, I think that's very helpful, Ron. So there's no reason to think that, I mean the whole point of anchoring this survey respondent on the focal provider is to actually direct their reporting of their experience with that individual provider. And that seems to work quite well with the CAHPS.

Julie Brown
That's correct, Dale. And we have no evidence from our long history of qualitative or quantitative testing that this approach doesn't perform as intended.

Dale Shaller
Okay. We've talked about comparing the 6 months, and the 12 months, as questions asked, have we done any comparison that would allow us to look at 6-Month to 12-Month to the Visit Survey in terms of effect on survey responses?

Ron Hays
Can you repeat the first part of the question?

Dale Shaller
Are there studies comparing the survey responses completed in terms of the visit-specific survey, compared to 6 months, compared to 12 months?

Ron Hays
Well, I know for sure that back in the medical outcomes study, that people who've had a visit and compared that with a longer assessment of care, the correlation between the two is really low, it's about 0.3 where correlation ranges from 0 to 1.

So one of the issues is, if you're looking at a specific visit, that's not really representative of care overall. So that's why we're saying, you know, if you do a Visit Survey, you have to sample a lot more visits and a lot more people because each visit could have unique characteristics to it.

Dale Shaller
Here's a question I think kind of prompted by the movement from 12 to 6. Is there any thought that we're going to go from 6 to 3 to 1 in the future? I mean it's hard to sort of project what may be, but Julie, did you want -- I mean I think the reason for moving to 6-month is a lot about alignment and if we expect CMS to stay with that for the duration, and I can't imagine we're going to be doing any further changes to shorten the recall period. Would that be correct?

Julie Brown
I agree with you 100%, Dale. I just think I agree.

Dale Shaller
Okay.

Lee Hargraves
Because I actually -- when we were thinking about this I went back and did my little history lesson and it was always between 6 and 12 months. That's what has been the thought in CAHPS and this is an effort to make it uniform and not have, well, not having different versions out.

Dale Shaller
Right. So I know we've covered a lot of ground today, and it's been very helpful. I want to thank Julie and Lee and Ron for sharing their expertise. And we got to quite a number of the questions. We haven't addressed them all, but we will have opportunities to do that always through the CAHPS email and technical assistance hotline.

Dale Shaller

Shaller (closing), Slide 47
So before we end, I just want to highlight a few things that are coming up with respect to a session that we're specially doing. And it might be of interest to many of you attending today in the context of the AHRQ 2015 Research Conference that will be held from October 4 through October 6 in Crystal City, Virginia, we're hosting a special session on Sunday, October 4 from 4:00 to 5:30 in the afternoon on "CAHPS Research Tools and Resources." And you can RSVP for that by hitting the URL available on this slide.

And again, the slides are available for downloading. And if you have any questions about that, again, you can be in touch with us through the CAHPS TA line.

Shaller (closing), Slide 48
We're also doing a number of sessions at the actual conference.

One will be a retrospective presentation marking the 20th anniversary of the CAHPS Program, from 1995 to 2015, 20 years. And we're very excited about that and the progress that we've made collectively with all of you working together and using and reporting survey results.

We're going to have a session addressing some common concerns about CAHPS and clarifying some of the underlying science and evidence supporting patient experience measurement which is something that I think will be of great interest to a number of attendees.

And finally, I mentioned a bit earlier some of the research we've been doing in addition to instrumentation development and improvement with close-ended questionnaires advancing the science of obtaining paired patient narrative information and reporting that information as a complement to CAHPS close ended questions.

So these are all three great sessions and we think you will not want to miss them if you can attend again the 2015 AHRQ Research Conference in early October.

Shaller (closing), Slide 49
So as I mentioned, we are continuing our work, and we often post new developments. We encourage you to visit the CAHPS site, shown here is the landing page. And if you are interested in receiving regular email updates which we send our quite periodically, you can sign up for those email updates through the AHRQ Web site which is available in the upper right-hand corner of the home page of the CAHPS site.

Shaller (closing), Slide 50
And finally, we've come to the end of the hour. And I want to thank again, each of our speakers, Julie, Lee and Ron, and to thank all of you for attending today's Webcast. The evaluation survey will pop up in a new window, so please complete the survey because your feedback is very important to us. And remember to click on the "Submit Survey" when you're done completing it.

Again, please contact the CAHPS User Network anytime via email or the toll free number, and again, you can go to the CAHPS Web site at the URL given.

And we really appreciate your attendance today, all of your great questions, and your continued work together with the CAHPS team in advancing the measurement and improvement of patient experience. Thanks again, and have a great rest of your day.