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Using the CAHPS Database to Compare, Report, and Improve Organizational Performance

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Speakers

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Moderator

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Dale Shaller

Shaller (opening), Slide 1

Good afternoon, and good morning to our West Coast participants. And welcome to our Webcast on “Using the CAHPS Database to Compare, Report, and Improve Organizational Performance.” My name is Dale Shaller, and I will be the moderator for today’s Webcast.

Today’s Webcast is one in a series of Webcasts on CAHPS, which stands for Consumer Assessment of Healthcare Providers and Systems produced by the CAHPS User Network. I’m pleased to inform you that we have over 900 participants with us today, which certainly suggests a high level of interest in CAHPS and the CAHPS Database. We know from the Webcast registration that many of you are familiar with CAHPS surveys, but for those who aren’t, just a few words of background on the CAHPS program.

Shaller (opening), Slide 2

Funded primarily by the Agency for Healthcare Research and Quality or AHRQ, the CAHPS program develops standardized surveys and related products, including the CAHPS Database. CAHPS surveys are the most widely used tools in the public domain for assessing the patient’s experience with health care. All CAHPS surveys have been developed according to established principles for both ambulatory and facility-based care and the family of CAHPS surveys continues to grow.



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Shaller (opening), Slide 3

A large consortium of organizations contribute to the CAHPS program. The CAHPS User Network, sponsor of today's Webcast, is administered by Westat, under contract to AHRQ. The Consortium also includes the RAND and Yale grantee research teams, as well as many other government and private stakeholders, all with a common interest in measuring and improving the patient care experience.

Shaller (opening), Slide 4

Our agenda for today is divided into two major parts. Part one will consist of a general overview of the CAHPS Database and a demonstration of the Database's Online Reporting System. We'll pause after the demonstration for questions and answers. Part two will focus on how the CAHPS Database has been used by two types of survey consortia, or sponsor organizations, to produce comparative reports for their members.

The two examples will feature applications of the CAHPS Health Plan Survey Database and the CAHPS Clinician & Group Survey, or CG-CAHPS, Database. We will pause again at that point for questions and answers, and then wrap up with a few comments on the CAHPS Database schedule for 2014.

Shaller (opening), Slide 5

We're delighted to have a really terrific lineup of speakers to help us work through this agenda. Janice Ricketts, CAHPS Database Senior Director at Westat, will cover the part one overview and demonstration. We'll then turn to our guest speakers, starting with Deborah Kilstein, Vice President for Quality Management and Operational Support at the Association for Community Affiliated Plans or ACAP, who will describe her organization's use of the CAHPS Health Plan Survey Database.

And then we'll have a trio of speakers related to the University HealthSystem Consortium's pilot projects with the CG-CAHPS Database, including Francis Fullam, who is Senior Director of Marketing Research and Patient Relations at Rush University Medical Center in Chicago; Ed Karls, Director of Customer Performance Metrics and Improvement at the University of Michigan Health System in Ann Arbor; and also Gladys Epting, who is Director of Research and Evaluation at the University HealthSystem Consortium based in Chicago. Bios for each speaker are available by clicking on the Speaker Bio icon at the bottom of your screen.

Shaller (opening), Slide 6

We want this Webcast to be a great experience for all of you, so just a few housekeeping details before we get started with the program. If you're having audio trouble, you can join us by phone at any time by dialing 855-442-5743 and entering the conference ID number, 22450570.

Another common problem that you might have is when your computer freezes during the presentations. If that does happen, you can hit your F5 button on your keyboard to refresh your screen. But remember that you may be experiencing just a lag in the advancement of the slides because of your own internet connection speed. You can also try logging out and logging back in to the Webcast.

Shaller (opening), Slide 7

If you have any other problems, or to ask a question at any time during the Webcast, you can click the Q&A icon at the bottom of your screen to get the Q&A box to appear. And then all you need to do is type your question in the text box and select Submit. So please feel free to send in your questions during the presentations, and we'll address them during the Q&A sessions that I mentioned as part of the agenda. And we'll try to get to as many questions as possible.

Shaller (opening), Slide 8

You can access the Webcast slides by hitting the Download Slides icon, again at the bottom of your screen.

Shaller (opening), Slide 9

And you can access other resources that are related to the Webcast by clicking on the Resources icon, also shown at the bottom of your screen. And that includes links to the CAHPS Database Web site and the Online Reporting System and several other resources that we will be discussing during the program.

Shaller (opening), Slide 10

So let's begin now with our part one overview of the CAHPS Database. The CAHPS Database is the national repository for selected CAHPS surveys, currently consisting of two major components that support users of the CAHPS Health Plan Survey and the various versions of the CAHPS Clinician & Group Survey, or CG-CAHPS.

The CAHPS Database is designed to support two major applications. The first is to provide comparative data to health care organizations for their use in assessing their performance. And secondly, to develop data sets that can be used upon request for focused research studies on consumer assessments of care. As noted earlier, the CAHPS Database is part of the overall CAHPS program funded by AHRQ and administered by Westat through the CAHPS User Network.

Shaller (opening), Slide 11

It's really important to emphasize that the CAHPS Database, just like this Webcast, is a free service open to all survey users on a voluntary basis. We may compare the results available to users in several ways.

The major reporting platform is the Online Reporting System, which Janice will describe in just a moment, which includes both a public site and a private site. The public site is available to anyone that has access to the internet and presents summary-level results that have no identifying information as to respondents or to the health care organizations that have contributed data. The private site is available only to organizations that submit data. And they're given access through a secure password-protected portal that allows them to view their own results compared to selected benchmarks

In addition to the Online Reporting System, we produce annual Chartbooks which are PDF summary documents with comparative results for the Health Plan and CG-CAHPS Surveys. And you'll find links to those Chartbooks, the most recent Chartbooks, in the Resources icon at the bottom of your screen.

We also make research data files available to individuals upon request who sign the data use agreement to protect the confidentiality and security of the data files that they receive. And finally, we do offer customized analyses and reports upon request as time and resources allow.

So let me now turn things over to Janice Ricketts for a brief demonstration of the Online Reporting System.

Janice Ricketts

Ricketts, Slide 12

Hi, I'm Janice Ricketts, and I manage the CAHPS Database. Today I'm going to say a few words about the CAHPS Database, and then provide you an overview of the CAHPS Database Online Reporting System.

Ricketts, Slide 13

The CAHPS Database receives data voluntarily submitted by users that have administered either the CAHPS Clinician & Group Surveys or the Health Plan Surveys.

The survey data, along with survey administration information and a copy of the questionnaire, are submitted annually through an online data submission system. They're two separate systems. One designed for Health Plan data and one to intake Clinician & Group data. Once the data is submitted, it's cleaned and processed and then reported in a Web-based reporting system. This CAHPS Database Online Reporting System is a Web-based platform reviewing summary level results of CAHPS surveys. Any identifying information is removed from the data before the results are made available to the public.

The Health Plan submission system, the Clinician & Group submission system, and this Online Reporting System are all available on the CAHPS Database Web site at <http://CAHPSDatabase.ahrq.gov>.

Ricketts, Slide 14

There are two components of the database. The CAHPS Health Plan Survey component has been around since 1998. That database contains 15 years of data, over 5.6 million survey responses for adult and child, Medicaid, CHIP, and Medicare. The Clinician & Group database was developed in response to growing demand for comparative results for the various versions of the CG Surveys. The Clinician & Group component currently contains three years of data for over 1 and 1/2 million survey responses across Adult and Child, 12-Month Survey, PCMH Survey, and Visit Survey.

Ricketts, Slide 15

The CAHPS Database Online Reporting System has a public component as well as a private component. And today, I'll show you a little bit of both. The public site contains aggregated survey results, and is available to anyone with internet access, and allows users to view aggregate level results for the two most current years of data.

There's also a private portal. This portal allows organizations that have voluntarily submitted their data to the CAHPS Database to view their own survey results compared to relevant benchmarks. Both the public and private portals look very much the same. And I will point out a few differences in the screen shots as we go along.

The differences between these two are that when a participating organization logs into the private portal, that user will not only see the aggregated benchmarks that the public sees, but they'll also see their own survey results. The Online Reporting System contains separate components for the Health Plan Survey results and a separate component for the Clinician & Group Survey and is updated annually. CG results are released in the late spring and Health Plan results are released in late fall.

The next few slides will give you an overview of the various sections and features of the Online Reporting System.

Ricketts, Slide 16

There are several basic features to the site. At the top right, there are links for participating organizations to login, which takes them to their private portal where they can view their own results. There's a help link to information on how to contact the CAHPS Database with questions, suggestions, or other feedback, and a print link, which allows the user to print the page that they're on.

Then below the tabs, there are also links to view results in table format, export results to Excel for later use, and then Add To My Report link. This link allows you to save specific results you're currently viewing to the Report Builder section for downloading later during your session.

Ricketts, Slide 17

So once you're in the reporting system, and you've selected which year and survey version in steps one and two that you're interested in seeing results for, the user can view results in various ways. Top box score would show the percent of respondents reporting the most positive response for composites, ratings, and survey items.

You can also see one way and two way frequencies that show the distribution of scores by percent and number of respondents for all response options. Users can run customized frequencies by selected survey items and health plan or practice characteristics.

Bar charts, they show the graphical distributions of survey results of the top, middle, and bottom response categories. You can also view percentiles, which show the percentage of health plans or practice sites that scored at or below a particular top box score. And our final Report Builder section, where users can create customized, download-able reports.

In the health care plan component, there's also two additional sections. One for trending, which displays results across the two most recent years, and a Chartbook section, which displays cross-sector comparisons of Medicaid and Medicare in the bar chart format.

Ricketts, Slide 18

Here's an image of the top box scores. This displays the percent of survey respondents who chose the most positive score for the "getting timely appointments and care and information" composite. The public site will display the CAHPS Database overall score, the 90th, the 75th, the 50th, and the 25th percentiles. And you can scroll down the page to see additional results. When a participating organization is logged in, the table will show those names, columns, and will also display their own score as seen here in the first column.

Ricketts, Slide 19

You can also view frequencies. The frequencies tab shows the distribution of scores by percent and number of respondents for all response options. This section allows a user to run customized one-way or two-way frequencies by selecting a question item and/or health plan characteristic or practice characteristic.

Remember that you can save results of these displays to your Report Builder section at any time. So once you've selected items and ran a two-way frequency, you can save that to your report till download later on. You can also export these results to Excel.

So here you see a two-way frequency-- and I know it's going to be hard to see-- but it's by question six and by rating of the overall health. And this gives the break out of the N and percent for each.

Ricketts, Slide 20

Bar chart section. This section displays a graphical distribution and survey results that shows the top, middle, and bottom response categories. Here you see results displayed in a three-part bar chart, for the "getting timely care" composite, which combines the responses from five questions regarding how much of a problem, if any, consumers had with various aspects of getting timely care.

As a participating organization that is logged into their account, they will see their group's result, each practice site within the group, and then the national distribution as well as the regional or other characteristic for Clinician-Group. In addition to the bar chart, the private users will also see up and down arrows that show the test of statistical differences for individual health plans for practice sites.

Ricketts, Slide 21

There's also a percentile tab. This percentile section displays the percentage of health plans or practice sites that scored at or below a particular top box score. This table shows the CAHPS Database overall along with the lowest score, the highest score, and the average score for the "getting timely appointments, care, and information" and the survey items that make up that composite. And again, you can always scroll down to see additional composites, ratings, and item results.

Ricketts, Slide 22

And then Trending. As I mentioned, only the Health Plan component contains trending across the years. Under the trending tab, results are displayed for the two most recent years of data for the composites, ratings, and individual survey items. The user can select which composite, rating item, or individual item they would like to see displayed, or they can view all. Results are displayed for the national, regional, and product type characteristic.

For participating organizations, when they are logged in, in addition to the national, regional, and product type, they also see their sponsor line of results and each health plan that is under their sponsor now. As a participating organization, they also see the two most recent years of data that that organization submitted to the CAHPS Database. Whereas the public will see the current two years of data, an organization, say, if they did not conduct a

survey every year, and they only submitted data in 2013, and then the last time they submitted data was back in 2010, then they would see their results for 2013 and 2010.

Ricketts, Slide 23

The CAHPS Database produces a Chartbook report that presents highlights of the survey results in narrative summaries and a few bar charts. These documents are available, as Dale said, as PDFs for easy downloading on the Web site. But the Online Reporting System also contains a Chartbook section, which displays results in bar chart format for all composites, ratings, and individual items. This shows cross-sector comparisons of results for the “getting needed care” composite and displays the top, middle, and bottom results in bar chart format for the two most recent years of results across Adult Medicaid, Child Medicaid, CHIP, and Medicare.

Ricketts, Slide 24

The last section is the “Report Builder.” This section, you will find documentation such as information about the CAHPS Database, the composition of the database, definitions of regions, definitions of composites and items that make up those composites, and documentation on how the results are calculated.

Under the “Results” area, you can select files of results such as for the characteristics or top box scores, bar chart results. And for the Health Plan component, there’s also a Chartbook result available for download.

You’ll also see at the bottom Your Analysis Results. This lists any page or file that you saved to your report during your session. These reports are only available for the duration of your current session. Once you leave the session, those are no longer available. You would have to go back and run the two-way frequency again or do the particular items again.

You simply select each piece you would like to download, and select the “Download Selected Files” button at the bottom of the page. This will bundle the selected files into one zip file, which will be downloaded to your computer along with a list of the files.

So as you can see, there are many sections and many features to the Online Reporting System. So please feel free to go online and browse through the site any time.

Ricketts, Slide 25

So for 2014, the CAHPS Database team is currently developing a video on using the CAHPS Database Online Reporting System. And this video will walk you through the various sections and features of the site. Once the video is completed, you’ll be able to view it on the CAHPS Database Web site in early 2014 at <http://CAHPSDatabase.AHRQ.gov>.

And in 2014, the Clinician & Group Database will accept data submissions through the online submission system from February 24 through March 14. Announcements will be sent out prior to that, announcing to vendors and participants and anyone on GovDelivery that has signed up for announcements. An email announcement will go out with the information specifying the dates of submission.

Ricketts, Slide 26

So now we can address questions you have about the CAHPS Database or the Online Reporting System. To ask a question, please click the Q&A box and type in your question in the text box and select “Submit.”

Dale Shaller

Great, Janice. Thanks so much for the overview of the Online Reporting System. And we do have a few questions that have come in that I’m going to field. Some I’ll direct to you; some I’ll answer straight out. Just a couple of logistics kinds of questions initially-- access to the data that Janice has described is available through the CAHPS Database Web site. And we have given that URL several times. And we will give it again at the end of the Webcast. Again, it’s a public site where summary level results are available. And then there’s a private site that is available to

organizations that submit their data. Which leads to another question that has been submitted that asks, “If you are a vendor that submits the data on behalf of an organization, would you be able to access the online tool as well?”

And the answer is not unless you actually have been given authorization by the organization that is your client. It is possible for an organization to confer access rights to other organizations. But that’s something that would have to be worked out as a special request within the Online Reporting System. And we have done that in various ways, but have to have the agreement in place to do that.

Let me answer another question related to survey versions that are required by CMS, the Centers for Medicare and Medicaid Survey Services. The CAHPS Database currently supports the CAHPS Health Plan Survey results submitted by Medicaid and CHIP programs. We get Medicare data directly from CMS for the Health Plan Survey. Summary level results for the CAHPS Health Plan Survey are, therefore, available on the CAHPS Database site.

With respect to versions of the CAHPS Clinician & Group Survey, it’s a little more complicated. We support the comparisons related to the 12-Month and the Visit version of CG-CAHPS. Versions of CG-CAHPS that Medicare is now using for either the ACO, Accountable Care Organization Program, Medicare Shared Savings Program, and the PQRS Program are not submitted. They’re not supported by the CAHPS Database because that is a separate enterprise that Medicare is working on. So those data are not available for ACO CAHPS or the PQRS CAHPS Survey on the CAHPS Database Web site.

Janice, I’m going to let you answer this question. “Where can we request additional login IDs for a Health Plan?”

Janice Ricketts

You can send an email to the email box or call 888-808-7108. And we can provide you with the password and ID that you need.

Dale Shaller

Here’s another question for you, Janice. “Do the CAHPS vendors automatically send health plan data to us, or do the vendors have to request that through the vendor? Do the health plans have to request that through the vendor?”

Janice Ricketts

Vendors do submit the data and upload information in the submission system. However, the sponsor does set up the initial account. And they also submit the signed data use agreement. And then you can pass along the login to the vendor. And then the vendor can proceed from there.

Dale Shaller

“What vendors are approved to use CG-CAHPS, to vend CG-CAHPS?” I’m not sure that’s a verb. AHRQ does not certify survey vendors. Other organizations do, such as CMS and NCQA. Vendors that are approved by those organizations are generally the ones that do send data to us on behalf of their clients. But the real requirement for submission is being able to satisfy the submission requirements that we have set for both the Health Plan and CG-CAHPS Surveys. And those are really independent of whether a vendor has been certified or not. It’s whether the vendor can actually comply with our submission specifications.

Here’s a question, Janice, in terms of the timing for submitting data. I think you reviewed that. Do you want to just address that really quick, in terms of time frame for submission for CG and Health Plan?

Janice Ricketts

We have a three-week window that we intake data submissions. And so for Clinician & Group, it will be February 24 through March 14. And then for Health Plan, that will be in the summer of 2014-- in June. And emails will go

out. So make sure that, if you're interested in submitting or information on the CAHPS Database or CAHPS, that you are signed up for the GovDelivery messages, so that you will receive those updates.

Dale Shaller

A couple of clarifying questions now, in terms of comments that have been made. Clarifying that the CAHPS Database does include CMS summary level data from Medicare health plans. Those are the Medicare Advantage plans. That is the only data that we have from CMS. It's at, again, a summary level along the lines that Janice was showing in the Online Reporting System demo.

There's another question about the PQRS CAHPS Survey, and what I was trying to say there is that in addition to the Health Plan Surveys, Medicare is requiring other CAHPS surveys for various organizations. That includes ACO, the Accountable Care Organization, participating in the Medicare program, as well as the new PQRS version of CG-CAHPS that affects the large group-level medical groups that are participating in the GPRO program.

We do not accept those two versions of CG-CAHPS. We do accept, again, the 12-Month version of CG-CAHPS and the Visit version of CG-CAHPS. And remember that there is a version of the 12-Month Survey that includes the Patient Centered Medical Home supplemental questions. And so that, known as the PCMH CAHPS Survey is a survey that we do include. And at the end of the Webcast, we will review specifically again the CG-CAHPS Survey versions that we will be accepting for submission in 2014.

And I believe we are at the point in the Webcast-- we will come back to as many of these questions as we can, but in order to move along to the second part of the Webcast, we'd like to now focus on the user applications that are going to be presented by our guest speakers.

Shaller, Slide 27

Users of the CAHPS Database and Online Reporting System that Janice has just described.

What we want to highlight in this segment is how the CAHPS Database can serve as a platform to aggregate or combine survey data that are submitted by members or participants in consortium projects where there are multiple health plans or medical groups or practice sites all using different survey vendors.

The CAHPS Database has provided this service on many occasions. For example, to state and regional public reporting collaboratives consisting of hundreds of medical practices in a given state or region, that have agreed to report their survey results on an apples-to-apples basis. Examples include the work that we've done to support public reporting in Minnesota, through Minnesota Community Measurement. As well as in the state of Maine through a state-wide implementation of the CG-CAHPS PCMH Survey in 2013.

The CAHPS Database has also worked in a similar way with member organizations in California, the California Safety Net Institute. As well as ACAP, the Association for Community Affiliated Health Plans and the University HealthSystem Consortium, who will be joining us just now to talk about how their members and participants have used this service in order to compare their results.

Shaller, Slide 28

This diagram illustrates, in a general way, how this aggregation and scoring process works. It shows that in a given region or within a national level consortium, diverse practice sites working with different survey vendors can receive reports directly from their vendors as their clients. But can also instruct their vendors to submit data according to our data submission specs to the CAHPS Database.

The CAHPS Database would then clean, and combine, and then score the survey data received from these multiple vendors and practices to create a consortium or sponsor report. As well as provide individual practice sites the access to the Online Reporting System that Janice has just described. So to illustrate how this scheme or process has played out in an actual practice, let me now turn to Deborah Kilstein, from ACAP, the Association for

Community Affiliated Plans, who will describe how the CAHPS Database has supported her and her member health plans in creating and using a comparative response report of the CAHPS Health Plan Survey. Deborah?

Deborah Kilstein

Kilstein, Slide 29

Thank you, Dale. First I want to say it's a pleasure to be on the call today.

Kilstein, Slide 30

And I'm going to talk a little bit about first, to explain who is ACAP. Then I want to talk about the growing role of health plans-- What is a sponsor report? How do the ACAP plans utilize this sponsor report? And then talk a little bit about how ACAP, as an organization, uses the sponsor report.

Kilstein, Slide 31

So first, let me start by saying that ACAP stands for the Association for Community Affiliated Plans. We are a trade association for Safety Net Health Plans. They're not-for-profit or owned by a not-for-profit, and serving the public low-insured.

We have 58 member plans operating in 25 states and serving approximately 10 million lives.

Kilstein, Slide 32

To understand the importance of Managed Care in the Medicaid Program, as you can see in this slide, actual Managed Care enrollment in the Medicaid program, as well as the proportion of individuals enrolled in Medicaid Managed Care, continues to increase each year.

Kilstein, Slide 33

This next slide shows that as of 2011, over half the Medicaid beneficiaries in 26 states were enrolled in risk-based health plans. We believe that these numbers will continue to grow as managed care is adopted in additional states and increasingly utilized by state Medicaid programs to coordinate services for expanded populations.

Kilstein, Slide 34

In fact, currently, 24 of the ACAP Health Plans are now operating as Medicare Special Needs Plans serving the dual eligibles. Ten operate managed long-term care plans. Eighteen will be participating in the dual demonstrations that are now being rolled out in a number of states. And 16 are participating in the first year of the federal and state-based marketplaces.

Kilstein, Slide 35

So I've been asked to talk to you about our use at ACAP of the CAHPS Database sponsor report capabilities. Let me start by answering, so what is a sponsor report? It is a report that consolidates responses for a specific sponsoring agency. Since 2006, ACAP worked each year with Westat, the AHRQ vendor, to obtain the necessary authorization to produce the report.

As we will discuss more in a minute, it allows ACAP to provide benchmarking data to our member health plans as to how they are doing as a group, and how each plan is doing individually compared to the rest of the group and national averages.

Kilstein, Slide 36

This year, 31 ACAP Health Plans participated in the Adult report, and 29 Health Plans participated in the Child CAHPS reports. Note that some of the plans actually participate in both the Adult and Child reports.

ACAP Health Plans use a variety of survey vendors to complete the survey. I think this year the number was seven. The CAHPS Database folks then took the data for each of the individual plans and combined it into a single ACAP

report that allowed ACAP and ACAP plans to compare their results to each other, to the ACAP sponsor report averages for life plans, and to the national Medicaid plan average.

Each submitter, whether it's a state that's submitting for a number of health plans or a plan that's submitting individually, each submitter to the database also gets their own report.

Kilstein, Slide 37

So here's a sample view of what the ACAP sponsor report looks like. This happens to be the page that deals with the composite question about getting needed care. And you can see that it compares the ACAP sponsor data to the national data in an easy-to-read graphical representation.

While you don't see it here, what would follow is then the same information for each of the participating health plans.

Kilstein, Slide 38

So why is CAHPS and the benchmarking data important to health plans? It provides a source of data for health plans to see how they are doing on a number of issues from the consumer perspective, including the overall consumer experience with their doctor, specialist, health plan and health care generally. By asking questions such as, did your doctor listen to and treat you with respect? Did your health plan's customer service desk treat you with respect? Did they provide you with information or help that you needed?

In terms of consumer engagement, it provides information or questions such as, did your doctor explain things in a way you can understand? Or did he or she spend enough time with you? It provides information on access by using questions such as, how easy was it to get appointments and needed tests? In terms of screening, prevention, and education, it asks questions about certain health conditions and whether the doctor talked about specific things to prevent illness such as smoking cessation and taking aspirin after a heart attack or stroke.

It provides health plan information on post-treatment support. Does your personal doctor seem informed about your care? And were they informed about care you were getting from other doctors and other sources? And then finally, it provides plans with information about potential disparities by looking at the results in light of the demographic data of the response.

Kilstein, Slide 39

As an organization, ACAP also finds the sponsor report very useful. It allows us to evaluate performance based on comparable quality information, to focus on specific areas that need improvement, to identify which plans are doing well on specific measures and best practices that led to those results, and to work together as an organization to improve quality. It also helps us to identify issues of concerns to our member health plans. For example, the need to translate and validate CAHPS in additional languages is a significant concern to safety to health plans that came through by looking at the data. And it also allows us to utilize the data in broader communication efforts.

Kilstein, Slide 40

As you'll see on this slide, we actually did a ACAP fact sheet last year, using the calendar year 2011 data, that showed that members enrolled in Medicaid health plans actually rated their health plans higher than members enrolled in commercial plans. And if you're interested in that analysis, by the way, you can find that on the ACAP Web site.

So as you can see, we've been a long time user of the sponsor reports, and we clearly find the data important to ongoing quality improvement efforts.

Dale Shaller

Shaller, Slide 40

Thank you so much, Deborah.

Shaller, Slide 41

We are now going to turn to an example of a consortium use of the CG-CAHPS Database presented by the University HealthSystem Consortium and two of its members, Rush University Medical Center, and the University of Michigan Health System. Gladys, happy to turn the program over to you to kick this segment off.

Gladys Epting

Epting, Slide 41

OK. Thanks, Dale. Well I want to talk about how members of University HealthSystem Consortium have used the CG-CAHPS Survey.

Epting, Slide 42

Probably a question a lot of you have is who is University HealthSystem Consortium? And it is not an insurer that has similar initials. It is, in fact, a partnership of academic medical centers. These would be the flagship hospitals affiliated with medical schools. So we have 120 of those principal members. And they, in turn, have brought in about 300 of their affiliate hospitals where they do teaching, and where their faculty provide care to patients.

UHC is a partnership and they pool their data together. So we have powerful databases to look at best practices. After we see how we compare to each other, we have meetings and list-servers that people can collaborate and find who's doing what, and how they can improve to bring up the level of care across the entire membership.

Epting, Slide 43

These are names of hospitals that you know, medical schools and their hospitals. We certainly have the large bed hospitals that you know, but we also have lots of outpatient clinics. And we estimate that our principal members have probably 60 to 80 million clinic visits per year.

Epting, Slide 44

So when we heard that CG-CAHPS was starting to come about, and there were surveys to be piloted, UHC sent out a query to our members and said, who would like to be part of this? Get in early experience with the process of the survey, and then of course get early experience with your results and start on your performance improvement efforts.

So in 2010, we put out a call to test the Visit version of the survey. It was version 1.0 in 2010. We had 28 members join that pilot. They could use any vendor they wanted. It turned out we had three vendors that were used by the various members. And at the end of it, we submitted data to the Database from 119 different clinic sites, for about 79,000 patient surveys.

In 2012 we did another pilot. The version 2.0 was available by then. So we did a pilot of version 2.0. In the first pilot in 2010, we had tried to focus on primary care clinics because we thought that might be a simpler place to start.

But in the 2012 pilot of version 2.0, we opened it to primary as well as specialty care clinics. So in that second pilot, we ended up with two vendors submitting data on our behalf. We had 141 clinic sites and submitted about 114,000 patient records. We were then able to log on, as Janice showed us a minute ago – we were able to log on and see how we compared nationally. Also start looking at some specialty care, which our members are very interested in.

As part of our agreement for the pilot, we agreed we could see each other's data. That is consistent with UHC's partnership philosophy and our use of our other databases in house. So the CAHPS Database allowed us to see our own data, our own clinic, and the clinic of our peers that were in the UHC pilot.

We obviously weren't seeing patient-identified data at all. And we weren't seeing identified from clinics that were not in the UHC pilot. But we were able to see these 141 clinic sites, for instance. We were able to see each other's data. And that facilitates our sharing and performance improvement.

Epting, Slide 45

To talk a little more now about how CG-CAHPS is used, I'm going to turn to two of my members that are my mainstays whenever we do collaboratives here at UHC. These two members are always willing to learn and help. So the first one who will be talking to you will be Francis Fullam from Rush, talking about lessons learned from the 2010 pilot. And after Francis talks, then Ed Karls, from the University of Michigan will talk about how they are using the data at Michigan. Francis?

Francis Fullam

Fullam, Slide 46

Thank you, Gladys. This really was a great example of the power of collaboration that you really can only get from being a member of an organization like the Consortium. As Gladys explained, I'm just going to summarize the lessons learned from the 2010 project with primary care practices.

Because we had so many organizations and clinics involved, it really gave us a good sense of what our experience would be like. The big lessons are that when we compared Consortium hospital results to the national averages from the main databases that for elements, domains like doctor communication, the overall ranking of the practice in "9 and 10"s, and the "Recommend" scores, we were about equal to the national averages at that time. That is, some scores were slightly higher. Some were slightly lower. But we were generally at the national average.

The "Office Staff" questions were a little below the national average. And "Access" was well below the national average at academic medical centers. This was a real important learning for us, because it gave us a preview of what would happen, what was coming up, and how that might work.

As you know, we were all using slightly different surveys from different vendors. This allowed us to get true national comparisons on a different kind of survey that had a different kind of emphasis than we were using. The other big learning was that because, as Dale described it, there is a CAHPS family of surveys, we all had experience with HCAHPS at the time. And so there's a logic and link between HCAHPS and CG-CAHPS.

So what we knew at that time among academic medical centers, some of the individual domains that some of our scores were lower than national averages. But for academic medical centers, we all did quite well on that nine and 10 rating question, and the "Recommend" question. We did better at those questions than other ones, which told us that you know, that the sum was more than just the sum of the parts that patients really appreciated. There was something special about academic medical centers. There was kind of a halo effect.

When we looked at our primary care practices, we did not see that halo effect among those questions. That is, the overall rating and the "Recommend" questions. So that was really a heads-up for us, an important lesson.

Fullam, Slide 47

The rest of the slides in here just provide a little bit more detail of what I just covered. So you can see on the "Doctor Communication" questions, we show the total Consortium scores and then the non-Consortium scores, the differences. And about where the Consortium came out on these questions. So you can see they're all the range of 40 to 60. Most of them are in the 50th percentile. And you know, the one thing the Consortium hospitals believe is that their doctors are not average.

Fullam, Slide 48

For the follow-up tests and treatments and staff, you can see that again we were generally lower than these national averages. And you can also see there's a different mix of questions. You saw lots of "Doctor Communication" questions on the previous slide, and there are not many on the staff. And of particular concern was the question about when the doctor ordered a blood test, x-ray, et cetera, how often did someone follow up with you to give you the results? So this was the question where there was the largest gap between our performance and the national averages. And it put us in the 30th percentile.

Fullam, Slide 49

On “Access” – again, there are quite a few “Access” questions on the CG-CAHPS – and again, we were in the range of, on average, between the 30th and 40th percentile. That is, how easy it was to get hold of a practice, how easy it was to get an appointment, and how well they got back to you.

Fullam, Slide 50

And then, this is where I show on the global ratings. This is where we didn’t see that halo effect. We were at the 60th percentile as a group on that nine in 10 question. And then on the recommendation, we are only at the 40th percentile as a group.

Fullam, Slide 51

So the lessons learned were that A, we learned what we needed to do to submit this data. We got an idea about performance on access should be something we should be concerned about, as we enter this new world of health care. And that this was the challenge for academic medical centers. Because with comparative study, we did find out that there were some practices doing better than others on it. So we were able to confer and get some idea of what they were doing.

And participation did allow us to get started on the improvement efforts that we knew were necessary and would be coming along. So I’ll now pass things on to Ed Karls at the University of Michigan.

Ed Karls*Karls, Slide 53*

Good afternoon. Thank you for this opportunity to speak with you.

Karls, Slide 54

I would like to share with you a little bit of our experience with CG-CAHPS and how we are making use of the public domain database for both internal quality improvement purposes as well as trying to keep an eye on the outside world to keep with the times, as it were, and work toward evolving national standards and quality improvement in outpatient care.

University of Michigan Health System, at a glance, is a fully-integrated academic medical center. We are located in Ann Arbor, Michigan. We also have a number of satellite facilities within about a 30-mile radius of here across southeast Michigan.

We see roughly 1.9 outpatient visits annually at about 40 different distinct locations, representing about 200 distinct clinics and this would include both primary and specialty care. We also, of course, have three inpatient hospitals, totaling 990 beds with approximately 45,000 discharges annually.

Karls, Slide 55

Our history with CG-CAHPS parallels what Gladys has explained to you previously, with respect to the UHC trials. We were participants in both the 2010 and the 2012 trials. In 2010, we had three primary care clinics that participated. And in 2012, we had one specialty care clinic that participated.

We knew, of course, that the future does appear to lie with CG-CAHPS. And for that reason, we’ve worked very steadfastly for the last couple of years to implement CG-CAHPS measurement programs on a continuous basis within the health system here. We began our program actually in May of last year and we implemented the base version 2.0 Visit-specific CG-CAHPS Surveys for approximately 170 clinics.

We actually use both the adult and the pediatric version of the surveys as appropriate. Our CG-CAHPS Survey does replace a previous in-house survey that had been in place for over 10 years. As an internal survey, it had no external benchmarking capability. And this proves obviously to be a fatal point to any kind of an in-house survey and we know that we need to see how things are looking externally.

Karls, Slide 56

We had several reasons to adopt the CG-CAHPS. As I just mentioned, we need the ability to benchmark externally on measures of access, provider communication, and office staff. I think we've long held the philosophy that continuous improvement is important and we've always emphasized being able to demonstrate that we were better than we were the year before.

But I think it's becoming increasingly clear, especially with various pay-per-performance programs coming on the horizon, that we need to know how we are comparing nationally and this is where the CG-CAHPS Database becomes very important for us. As a participant in a Medicare Shared Savings ACO, we also felt it necessary to be able to align our clinics to the same patient experience measures by which our ACO will be measured going forward.

Even if a lot of them don't quite realize yet that this is why they're being aligned, this is one of our objectives to get everybody singing from the same sheet of music. We also know that we have a lot of unmet need in terms of assisting our faculty group practice and its physicians with their maintenance and certification requirements for the respective accrediting boards going forward.

And each of the 24 boards of the American Board of Medical Specialties are still evolving and discussing what the requirements will be for measuring patient experience or what kind of information that will need to be submitted. One thing is clear, and that is that CG-CAHPS will serve as a very able source of data for these maintenance and certification needs.

We also want to be positioned for any other public reporting or pay-per-performance needs that may yet come. And then, of course, eventually, because CG-CAHPS surveys are in fact attributable to individual specific providers, we wanted to put into place a mechanism that was going to allow us to eventually report provider-specific reports internally for quality improvement purposes.

Karls, Slide 57

Just a brief note about the mechanics of our survey, because it is a visit-specific survey, it is triggered by the patient encounter. We do target more than just simply clinic visits that are physicians, but we are also focusing on other encounters that are involving mid-level providers such as nurse practitioners. We are currently using the U.S. mail as the mode of survey distribution. We are working to operationalize e-serving, although that is not yet operational at this point. We are serving at different sampling rates with the objective of being able to complete 30 completed surveys per clinic per quarter across our health system. And with that, we have a fairly complex and dynamic sampling system that is constantly evolving in order to hit that achievement.

We have on average about a 26.7 single mailing return rate for the CG-CAHPS Surveys. And with eight months of operation with this program underway, we have almost 16,000 total responses as of last week.

Karls, Slide 58

As I mentioned before, our focus on measuring the outpatient experience has been typically internal up to this point. But we are rapidly going into an era where we are trying to get the organization focused on how we look compared to the outside world.

This is where the CG-CAHPS comparative database becomes so important to us. This is a screenshot of some things that I think were shown previously by Janice and others. But this is our go-to page, as it were. This is the first page that we would go to for our CG-CAHPS comparative data. And you could see down there on the bottom, it's a little bit fuzzy, but there are several different choices that you can focus on.

Karls, Slide 59

So obviously if you were to look at the top box, you have a choice of looking at different survey versions that would make use of, say, the four point scale, the survey version with the PCMH four point scale, and a couple of the other variants of version 2.0 that exist.

Karls, Slide 60

We prefer to look at the top box scores. Again, the resolution here is a little bit not clear. But across the top here, there are different choices that were pointed out before about looking at top box and frequencies. But we prefer to look at the top box scores, because this is something that most people are used to looking at when CAHPS surveys are concerned. So in the CG-CAHPS Database, this is where we typically go to select what we want to look at.

Karls, Slide 61

This is also where it is possible to select the three different years that are available for the data. 2010, 2011, and 2012 are all available in this database. And it is very interesting to see how the sheer number of cases in the database has, in fact, grown from year to year. So this is obviously a sign that the database is growing. And as it grows, it continues to become more valuable to all of us going forward.

Karls, Slide 62

This is also where one would go ahead and select the different survey versions that are available. Because we are using the Visit Adult version of the survey for the majority of our clinics, this is where we would actually select benchmarking data that comes specifically from that survey version. So if you are using a different survey version, you could certainly choose to use a different one as well.

Karls, Slide 63

And down here-- this was pointed out previously-- if you access the publicly available database, you have these different percentile rankings where the different cut points are. This is also very useful to us. Internally, we have not yet quite determined whether or not we want to benchmark to one or the other of these. But for the time being, we have focused mostly on presenting what the 50th and the 75th percentile figures look like for each of the CG-CAHPS measures when we are doing our internal reporting.

Karls, Slide 64

I'm going to move ahead a little bit here.

Karls, Slide 65

If you were to go to this page, you would also note that there are a considerable number of different kinds of tables that are presenting your top box results in a number of different ways. If this were a live page and you were to scroll down for more options, you would be able to go down and, in fact, see that you can look at your data any number of different ways.

Karls, Slide 66

If, for example, you wanted to look only at the national percentiles-- that's what was apparent in the page that you saw immediately before. It is also possible to compare the results to these different survey versions between the different regions, broken out into Midwest, Northeast, South, and West. It's possible to look at differences by physician specialty, according to those categories listed on the bottom left. It's also possible to look at practice ownership and affiliation.

To Francis' point a minute ago, because academic medical centers sometimes think of themselves a little bit differently, there's a tendency for them to want to be able to compare themselves against each other. The CG-CAHPS Database does allow us to do this by filtering and focusing on university or academic medical centers. And it is also possible, of course, to look at your database according to the actual survey mode that was used to collect the data.

Karls, Slide 67

As previously pointed out by Janice, there are other ways of looking at the data as well. I don't need to go into too much more detail. But just to point out again that in addition to top box, you do have the options of using the frequencies, bar charts, percentiles, and of course the report builder, as she pointed out earlier.

Karls, Slide 68

The percentile rankings and the top box ratings are also available for each question in here. So you can see on the national benchmark only, you could see the fine gradation between 20th, 30th, 40th percentile as the case may be.

Karls, Slide 69

So for our purposes, as I mentioned before, we are really trying to change our internal conversation to be a little bit more aware of what's going on in the outside world. Francis, a minute ago, pointed out that one common issue that many academic medical centers seem to have is with respect to "access." And without exception, our own data to date really show that we, in fact, are having much the same problem as many other academic medical centers. So this is just simply an example of the access-related measures that we are reporting internally.

The blue bar here represents some of our more recent data to date. And you can see, by comparing it to both the 2011 and 2012 National CAHPS Database for these access-related measures, we are in fact below the curve on this. That's again in common with what we've seen with the rest of the University HealthSystem Consortium.

Karls, Slide 70

We're trying to make use of this information in a way really to try to change the internal conversation that we have, more than just about quality improvement, but also realizing and trying to focus on the fact that there is really quite a large gap analysis that we do. This is an example of an internal report card that we do for our CG-CAHPS. And it shows here just some of the access-related questions.

And running down the left couple of columns, these would be all of our local sites, essentially. So each one of these is an independent site. And we are comparing their individual site scores on these access-related questions, as well as the other provider-related questions, which would extend to the right of what's visible here. And we're comparing them to be available 50th and 75th percentiles from the CG-CAHPS Database.

And again, this was taken from the 2012 CAHPS Database. We color code our reports. So each individual clinic and location can see whether or not they are surpassing either the 50th or 75th national percentile. Prior to having this information, most of our individual clinics really had no idea whether their CG-CAHPS data were relevant or not. Many of these numbers exist in a vacuum without the ability to externally benchmark. So, for the first time, we are able to change the conversation and get people's attention to realize that we have a lot of work to do in many areas, including with respect to "Access."

Karls, Slide 71

So with that, we anticipate continuing and evolving future use of the CG-CAHPS Survey. I would say that we are in a high touch and intensive educational period right now within the organization about what the survey means, what the national database means, and what it portends for our quality improvement initiatives. I think the greatest value of the external database has been that it's allowed us to change the internal conversation. We are now getting a lot more serious attention to topics that were previously dismissed as not being a problem. And for that reason, it's been extraordinarily valuable to us.

We're also still in active discussions to be able to set appropriate targets. One thing that we will likely consider doing in this calendar year is setting appropriate external benchmarks based on the individual specialties of the clinics, rather than simply taking the overall national database. We also hope to become contributors to the national database this year ourselves. We are not yet contributors from our current survey program.

We also do hope to be able to use the CG-CAHPS external benchmarks as part of our application for hospital magnet status that will come in 2015. So with that, I'm going to turn it over to-- I think we're at the next point for questions-- and I'll turn it over to the facilitator.

Dale Shaller*Shaller, Slide 72*

OK. Ed, thank you so very much. And let me also again thank your colleagues, Gladys Epting, and Francis Fullam as well as Deborah Kilstein from ACAP for those very excellent and informative presentations.

We have been answering questions. As the Webcast has proceeded, we've actually got quite a few here. We're going to continue to respond to as many of them as possible in the time remaining. I want to start with those questions directly related to the examples that we were just presented with. And I'm going to direct the first question, Francis, to you. It asks, "What did you do to improve? And how did the scores change?"

Francis Fullam

I can answer generally for Rush. And I do have some insight, I think, of what some other places did. It certainly got our attention on the issues of access. And that began sort of a long term look at process and flow within the programs. Really better understanding our templates for scheduling, and really beginning to focus attention on it. So it did that.

We continue to work on it. We are seeing improvements in access. But it's still something to work on, both what we learned from comparing ourselves to these national results, but just basically reading the handwriting on the wall on national trends, and what the government is looking for, and what consumers are looking for.

Dale Shaller

Great. Thank you, Frances. I guess in some ways, Ed, the same question could be addressed to you in terms of your experience at the University of Michigan.

Ed Karls

I would say that our experience to date, it's almost a little too early to tell. Our reporting cycle, we've only really been through one iteration of it already. Because we are still in what I would call a high educational period, trying to educate the organization around what these numbers mean, it's a bit early at this point to see what good have come out of this. I can say that there are active discussions to focus on how to improve our access.

We previously had other data that suggests that we do have access problems. But this is simply adding a lot more weight to the argument, and one that I trust will accelerate the organization's attention to trying to address our access issues.

Dale Shaller

OK. Great. Thanks, Ed. We've had a number of questions that have inquired about the 6-Month version of CG-CAHPS, which as many of you may know is a proposal that was recommended by the CAHPS Consortium and is still under consideration by the CAHPS Consortium. And the idea would be to move from the 12-month reference period currently in the CG-CAHPS 12-Month version to a 6-month reference period in order to become more aligned with the versions of CG-CAHPS that I mentioned before, for ACO assessment and for PQRs assessment. Both use a 6-month reference period, meaning that their questions are framed in terms of the respondent's experience during the last six months as opposed to the last 12 months.

We have circulated that proposal for comment, and we've gotten a lot of comments from users. Many are positive in terms of the idea of alignment with CMS requirements for ACO and PQRs surveys. We've also got some very thoughtful questions and concerns on how that would actually be implemented by different organizations. And so we are looking at that question within the CAHPS Consortium very carefully. And no decision has been made at this time as to whether and when a transition from the 12-Month to the 6-Month Survey would take place.

I can say that the CAHPS Database would be willing to accept six month versions of CG-CAHPS that are administered in 2014 or beyond. How we would report that data, we can't determine, because we won't know until further research is done on the compatibility of the six and the 12 month data together, and what kind of volume we might receive of the six month survey, if an organization were to try to get into the field for that.

So with that, let me move on to another question to Ed or to Francis; actually, maybe both. “Within your systems, do you report on an individual practitioner level? If so, how frequently, and with what denominator level? That is, how many questionnaires would you want to see before you actually report at the individual clinician level?”

Ed Karls

This is Ed from the University of Michigan. We do not currently report at the individual provider level. Although the surveys are attributed to the individual provider, and we are well aware that the results could in theory be reported at that level, our current program right now is really focused more at a clinic rather than a provider level. We do believe that at some point in the future, perhaps maybe a couple of years from now, we will have enough information to be able to issue provider level reports, but it is not really our focus at this point.

There are different guides and beliefs about what a minimum “n” ought to be to present results. I think we hew to many of the traditional beliefs about what those ought to be. I personally think 30 would be a minimum for any period of time, say perhaps a 12-month period. I think we would feel more comfortable if there were 50. One of our challenges, of course, is that not all providers see the same volume of patients.

So we do have some providers that might see many, many more, multiples more patients than others that might only be on service a couple of times a year. So we’ve been a little bit cautious about making any promises about reporting at the provider level, simply because we know that we would be able to meet the requirements for some providers, but not for others. And we don’t wish, at this point, to create false expectations for reporting. But we expect that that may change in the future. Perhaps once we are able to implement our e-serving to supplement our current data collection.

Dale Shaller

OK, Ed. Thanks so much. Francis, do you want to take a shot at that, too?

Francis Fullam

Yes. I’ll say that, again, in the pilot, there was really no effort to report it at the practitioner level. We just didn’t have enough. We are planning to begin adopting both the CG-CAHPS version and the electronic version at the same time. But our current practice with our current survey is really to begin to provide greater transparency and ease of getting this data out in front of doctors. So we have the Epic program. And what we’re about to introduce to our physicians is, as part of Epic, as they go into Epic, they go to another module. Where they see, for again the outpatient physicians, they would see how all practices compare to each other on a rolling 12-month basis.

And in another click, they get to see how each physician performs in each of the clinics. And it is transparent. We indicate it’s a rolling 12 month average, and we indicate how many surveys were received. So, again, for some physicians, they get enough results in a quarter to meet Ed’s general guideline of 30 cases. Other ones, it takes a year. So doing a rolling 12-month average really puts as much information out there as we have. And as we go to electronic surveying, we believe there’ll be even more.

So we really are trying to make this, instead of putting the result in a site like our vendor survey site, where doctors generally don’t go, we decided it made more sense to put it on the site where they do go, which is Epic. And at the end of this month, we’re doing a dinner for physicians that are scoring in the top 10th percentile nationally. Just as an acknowledgement, and to basically pick their brains about how they achieve the high levels of communication.

Dale Shaller

Great. Very good. Thanks, Francis. Janice, I’m going to direct this question to you. This has to do with submission of data. The question is, “Are Medicare health plans already loaded into the system? And how do we get private access to our data?”

Janice Ricketts

The Medicare data we get that from CMS and only report aggregated results for that. We do not have individual plan level data. So you would not have access as a Medicare health plan to your own data. That would have to come from CMS.

Dale Shaller

Thank you. Here's another question, I think, in terms of just understanding how the CG-CAHPS Surveys are administered. The question is, "Is the annual survey, meaning, I think, the 12-Month version of CG-CAHPS, supposed to be collected every month and then uploaded once a year? Or just the Visit Survey?" Either the 12-Month version of CG-CAHPS or the Visit version can be used in continuous sampling. So the annual survey idea is that you can do a point in time collection of survey data by using a sample frame that includes patients that have had a visit to a medical practice within the last 12 months.

So the sampling really depends on how you choose to administer the survey. A 12-Month Survey can also be used on a continuous basis, through every month or quarter during a sample. And clearly, the Visit Survey is designed for continuous sampling because it samples patients that have had a visit within the last either-- well, it depends on how frequently the sampling is done-- but it can be up to the last week or month or other time period.

We have another question related to the 12-Month versus the 6-Month CG-CAHPS version. And I just want to clarify generally here that requirements to use and submit data do not come from AHRQ. The Agency for Healthcare Research and Quality is a federal agency that does research and works on best practice and supports improvement through health services research.

As to support of the CAHPS program, we develop and test and disseminate survey instruments. We provide these kinds of services, technical assistance, and the CAHPS Database. So we don't require, I should say, AHRQ through the CAHPS program does not require any mandatory use of any of these instruments. Those requirements come from organizations like CMS or NCQA or state health care agencies or other consortia that have agreed to certain requirements for collection and reporting of data.

So I just really want to separate the fact that what we do through the CAHPS Consortium, supported by AHRQ, is voluntary. And it's all in the public domain. And so any explicit requirements for the use of any of these surveys are really not something that is within our purview.

Let me see. We have a question here in terms of comments that were made about the number of surveys to be collected at the provider level. "What's the basis for determining that it should be at least 30?" Let me just try and answer that. And Ed or Francis, you can weigh in as well because you addressed that question earlier. But 30 is an estimate of what would be useful for internal improvement, give you enough reliability at the individual clinician level, for public reporting or high stakes reporting. The CAHPS Consortium actually recommends 50 completed surveys at the individual clinician level. But that's because of general research that we've done on the reliability at the individual clinician level.

Sometimes organizations will relax that for internal improvements. Ed or Francis do you want to comment on that?

Ed Karls

I think we generally see the way things that Dale just explained it. There's always a cost benefit trade off, the cost of data collection versus the reliability and the actionability of the data. The number 30 also comes from some generally accepted approaches from statistics, meaning that it's often considered the bare minimum sample that can be used to reliably estimate or represent a larger population, provided that it's collected in a germane way with all possible respondents having had an equal chance to respond.

Dale Shaller

Thank you, Ed. The time for questions is coming to a close. I do want to make sure that this question, which is really a very fundamental question with respect to how the database works, is answered. And Janice, I'm going to direct it to you. "Just to clarify how the CG-CAHPS Survey data are provided by each organization. Is it submitted at the patient level? And what organizations are involved? So, if you can clarify how a practice would contract with a vendor to do that?"

Janice Ricketts

Yes. A practice would contract with a vendor. The vendor conducts the survey, and they provide the survey results for each respondent to us in a certain specification that we provide. We provide a data layout specification. We ask for some identifying information about the practice site itself. And then they provide all survey records in the sample, whether they are completes or not. And then those records are marked complete. And then we process and report that data.

Dale Shaller*Shaller (closing), Slide 73*

OK. Great. Thanks, Janice. We're going to move now to our closing segment. We're unable to answer every single question, but I think we got through most of them. We are happy to respond to any other questions that you may have that you would like to submit to us after the Webcast. And you can do that by sending questions either by email or through our toll-free telephone line that I'll show you in just a moment.

But I first want to just quickly review again the timeline for data submission and results reporting for 2014. Starting with the Clinician & Group Database, where we will be opening our submission system at the end of February on the 24th. And have that open until the 14th of March.

And you see here listed the specific survey versions of CG-CAHPS that will be accepted in this 2014 submission period. It includes the 12-Month Adult and PCMH Survey, the 12-Month Child and PCMH Surveys, and the Adult Visit Survey. Our intention would be to report the results after all of the submission is completed, after we've cleaned and processed the data and done all the quality checks that we do in late spring.

For the Health Plan Database, submission will occur in the summer. It's generally late June or possibly July. Specific dates will be posted within the next month or so. We'll support this year submission of Adult and Child Medicaid data and the CHIP data, using the 5.0 version of the CAHPS Health Plan Survey. We would then intend to report the Medicaid and CHIP results based on those submissions, along with the data that we receive from Medicare as part of our Online Reporting System, in the fall of 2014.

Several questions came in regarding access to respondent level data for research purposes. And those research files, again, will be available through authorized access that includes a data use agreement. And the Clinician & Group data files would be available in June of this year. And the Health Plan files in November of this year.

Shaller (closing), Slide 74

So finally, if you're interested in receiving email updates about CAHPS and the CAHPS Database, including announcements of future events, you can always visit the CAHPS Database Web site as shown here, the URL. And select email updates, which you can see circled here in the lower left navigation bar. And that will take you to a site on the AHRQ Web site, where you can choose among a number of different CAHPS-specific updates or other updates that you may want to receive on a regular basis from AHRQ.

Shaller (closing), Slide 75

So that is pretty much going to conclude our Webcast for today. We'd like you to take a few moments to complete the evaluation survey that you'll see as you log off. Your feedback is very important to us. We welcome your ongoing questions or comments by email or phone, as you can see here at the contact information listed. And I just want to thank, again, our excellent panel of presenters, and to all of you for joining us today. Have a wonderful afternoon.