



Robert Wood Johnson Foundation

# Leverage Existing Efforts or Use a Centralized Approach?

## Two Strategies for Community-Wide Implementation of the CAHPS Clinician & Group Survey

**All Aligning Forces for Quality communities are expected to ensure public reporting of data assessing patients' experiences with ambulatory care. The clinical and business case for measuring and reporting ambulatory patient experience is considerable (see companion document for a detailed description of this case). However, implementing a standardized community-wide approach to collecting and reporting patient experience data poses choices and challenges.**

This brief outlines two major strategies for Alliance implementation and financing of a standardized approach to measuring ambulatory patient experience using the CAHPS Clinician & Group Survey (CG-CAHPS). First, in communities where multiple medical practices already engage multiple survey vendors to survey patients, one community-wide approach leverages that existing survey use. By incorporating a common set of core CG-CAHPS questions into each practice's survey, the **leveraged approach** allows for direct comparison between practice sites' results, while retaining individual practices' customized questions for use in analyzing trends. On the other hand, communities without widespread existing patient experience survey efforts may be poised to adopt a **centralized approach**, in which a single vendor administers a standardized survey community-wide. This document identifies advantages, concerns and considerations, financing models and cost implications for each of the two approaches. The primary cost component of either strategy lies in the data collection process.

The experiences of Aligning Forces to-date offer examples of financing models and Alliance involvement in implementing community-wide collection and reporting of ambulatory patient experience data. A community's existing survey landscape, financing options and political considerations may influence the choice of a strategy for standardized implementation of CG-CAHPS. Alliances play a critical role in coordinating implementation of either strategy in order to ensure comparability of survey methods for public reporting of results.

### The National Context for Implementation

The current national context for implementing CG-CAHPS is in a formative stage, as compared to the well-entrenched use of standardized measures for assessing health plan enrollee experience using the CAHPS Health Plan Survey and for inpatient experience using the CAHPS Hospital Survey (HCAHPS). In both the health plan and hospital settings, national implementation was primarily driven by requirements from either accrediting organizations such as the National Committee for Quality Assurance (NCQA) or by contracting and payment requirements of large public and private purchasers, including Medicare, Medicaid, and employers.

There is increasing momentum to build ambulatory patient experience measures into public reporting, pay-for-performance, and certification programs for medical practices. However, these initiatives are still relatively localized and varied in nature. The absence of a central, unifying approach to national implementation means Alliances must craft and coordinate a viable strategy for community-wide implementation that fits the characteristics of their local markets and that can be sustained over time.

### The Leveraged Approach: Building on Existing Survey Activities

- **Many health systems and larger medical groups currently use some type of patient survey.** While a growing number of groups are adopting CG-CAHPS, the majority uses either a “home-grown” patient satisfaction survey tool developed to meet internal needs, or a proprietary instrument supported by one of the large national survey vendor organizations. The shift from “satisfaction” surveys to “experience” as measured by CG-CAHPS is an important distinction, as measures of experience provide more objective and actionable data for improvement.
- **A leveraged strategy encourages practices to incorporate a standardized set of survey questions into their existing surveys.** This strategy can be an effective approach in markets where a large number of medical practices currently field their own surveys. The approach allows practices to retain some or all of their current survey questions for purposes of trending while adding the core CG-CAHPS questions for comparability. The national HCAHPS implementation program operates under this model, though hospitals participate in HCAHPS by CMS mandate, and no corresponding mandate yet exists for CG-CAHPS. Several national vendors have already modified their proprietary instruments to integrate the core CG-CAHPS questions at the front end of their tools, thereby facilitating the transition to a common set of patient experience questions across multiple practices in a given market.
- **A strategy of leveraging existing survey activity can begin incrementally.** A community can start with medical practices whose survey vendors have already modified survey instruments, and gradually expand by encouraging other medical groups and their vendors to follow suit. Some groups may decide to completely replace their current survey with CG-CAHPS or, if they do not have an existing survey, to begin using CG-CAHPS to facilitate comparing their results to other practices in the market, as well as in other markets

- **A leveraged approach requires standardizing protocols as well as survey questions.** Encouraging practices to adopt a common set of CG-CAHPS questions is a necessary first step, but equally important for comparability is the specification of common protocols for sampling and data collection. The community Alliance can play an important role in establishing and enforcing these protocols, as illustrated by the example of MN Community Measurement (see insert).
- **Advantages of a leveraged strategy:**
- Data collection can be integrated into a medical practice's existing internal survey operations, making it more salient to the providers and staff, and therefore potentially more likely to be used for quality improvement.
  - Practices can build collection of standard CG-CAHPS items into their existing surveys at little additional cost, and without financing a separate survey.
  - The patient population used to draw the survey sample can include all of the practices' patients, including commercial, Medicare, Medicaid, and even the uninsured.
  - Over the long term, this strategy also promises to provide a sustainable approach since it builds the use of CG-CAHPS into ongoing practice operations, rather than adding an external requirement.
- **Concerns and considerations for a leveraged strategy:**
- As noted above, this approach requires careful attention to using the same or comparable sampling and administration protocols across all practices.
  - Some smaller practices may not be able to afford an internal survey and will therefore require supplemental funding strategies to help them participate.
- **Financing a leveraged strategy:**
- Individual practices assume the costs of sampling, data collection, and submission of their results to a neutral organization such as the CAHPS Database that can create site-specific scores for all participating practices, as well as an aggregate report for public reporting (see insert at end of brief).
  - As in the centralized strategy, the Alliance typically undertakes the public reporting and project management roles. In the leveraged approach, project management costs to the Alliance may be higher since greater coordination is required to assure comparability of the process followed by each practice.

### The Minnesota Experience

In 2008, Minnesota Community Measurement (MNCM) piloted a leveraged model of patient experience survey implementation at the practice level, allowing medical groups to use their existing vendor or the services of a common vendor to draw the patient sample and collect the survey data. Of the nine medical groups that participated in the pilot, 5 used a common vendor jointly selected through an RFP process led by MNCM, and 4 used their own vendors. All of the groups followed the same sampling and two-wave mail survey administration protocols, and submitted their data to the national CAHPS Database for aggregation and analysis. Each medical group covered the costs of its own participation. Vendor costs to medical groups averaged approximately \$8 per completed survey.

In 2010, MNCM is expanding its leveraged implementation model to include multiple methods and survey modes. Groups may embed the required CG-CAHPS Visit Survey core questions into their existing surveys, or collect the required number of survey responses using the approach tested in the pilot phase. In addition to traditional mail and telephone survey modes, MNCM is also allowing groups to test the use of a common protocol for handing out the standard survey in the office. Results of the 2010 project will form the basis of recommendations to the State of Minnesota for mandated statewide collection and reporting of CG-CAHPS in 2011.

## **A Centralized Approach: Using a Single Survey Vendor**

- **A centralized approach involves organizing and funding survey sampling and administration using a single vendor.** Instead of comparing a common set of questions across individual practices' surveys, the entire community is part of a large, coordinated survey process, using the same tool administered by the same vendor.
  
- **In a centralized strategy, the Alliance must determine what data source will provide the list of eligible patients to survey.** The “sample frame” is the list of eligible patients from which a random sample is drawn for surveying. In an individual practice's survey (as in the leveraged strategy), the sample frame is fairly straightforward: it may consist, for example, of all of a practice's patients with a visit in the past year. In a centralized approach, however, individual practices do not sample their own patients, so the means for identifying and sampling patients must be clear. The basic information needed for the sample frame includes patient contact information (e.g., mailing address), gender, age, and visit date(s) at specific practices.
  
- **There are two major options for creating the centralized sample frame:**
  - Sample from health plan enrollment files: In this option, the survey vendor or Alliance works with multiple health plans in the market to create a combined list of eligible patients. Since most health plans use the same or similar provider network, but only a portion of a medical practice's patients are enrolled in any given health plan, enrollment records must be merged across plans to create a comprehensive patient list. To be effective, this approach requires the cooperation of at least the dominant health plans in the market.
  - Sample from medical practice records: The most complete picture of a medical practice's patients comes directly from the visit records of the practice. Although practice information systems vary, most are capable of generating a list of patients that meet specified sampling criteria.
  
- **Advantages of a centralized strategy:**
  - Survey administration is consistent community-wide, since the sample selection and data collection functions are controlled by a single vendor.
  - There is potential to achieve savings through economies of scale.
  - There is potential to include smaller practices that cannot afford to survey on their own.
  
- **Concerns and considerations for a centralized strategy:**
  - Since the survey sampling and data collection processes are separated from medical practices' operations, a practice's providers and staff may be disengaged from the data, making them less likely to use the survey results for internal quality improvement. Although the immediate goal is public reporting, a centralized strategy must be accompanied by a clear plan for communicating results to individual practices and providers, to ensure the data are available and useful for quality improvement purposes.

- When health plan data are used as the source of the sample frame, only a portion of the total patient population will be included, unless all commercial, Medicaid, Medicare, and other plan enrollment data can be obtained; even then, the uninsured will be excluded from the sample.
- With a centralized approach, it is far more difficult to add customized questions for individual practices, since the aim is to use the same survey for all practices and to achieve uniformity of administration.

➤ **Financing a centralized strategy:**

- Funding generally comes from a source outside of the medical practices (e.g., health plans or other sponsors)
- Funds are used to engage a central vendor responsible for implementing all of the cost components above except for public reporting and project management, which are typically undertaken by the Alliance.

**Summary Comparison of Implementation Strategies**

	Leveraged	Centralized
Approach	Individual medical practices sample patients and implement survey (through their contracted survey vendors).	A party external to medical practices samples patients and implements survey (through one survey vendor).
Source of Sample Frame <i>(the list of all patients eligible to be selected for the survey)</i>	Encounter records from each participating medical practice.	A single sample frame is created. Data sources could include pooled health plan enrollment files or compiled medical practice records.
Funding	Costs are borne by each participating medical practice.	Funding is provided by a party external to medical practices (e.g., health plans, other funding organization) or shared in part by medical practices.
Pros	<ul style="list-style-type: none"> <li>• Sample frame can include all patients.</li> <li>• Allows medical practices to integrate CG-CAHPS core items into current survey operations.</li> <li>• Costs can be built into already existing budgets.</li> <li>• Direct participation by medical practices may foster greater use of survey results for improvement.</li> </ul>	<ul style="list-style-type: none"> <li>• Uniform control over sampling and survey administration.</li> <li>• Possible savings through economies of scale.</li> <li>• Potential to include smaller practices that cannot afford to survey on their own.</li> </ul>
Cons	<ul style="list-style-type: none"> <li>• Significant coordination needed to ensure consistency in sampling and survey administration protocols.</li> <li>• Cost of survey operations may be prohibitive for smaller medical practices.</li> </ul>	<ul style="list-style-type: none"> <li>• Sample frame may be restricted to only certain patients (e.g., those covered by certain health plans), based on the data source.</li> <li>• By removing the process from medical practices, may limit the practices' use of data for quality improvement.</li> <li>• Sustainability of funding not as stable.</li> </ul>

## **Financing Models for a Centralized Strategy**

- **A centralized strategy requires a separate financing mechanism to cover the cost of the central vendor.** As explained above, this structure differs from financing for the leveraged strategy, in which participating medical groups each bear the cost of sampling and data collection. Alliances using a centralized vendor strategy have used a variety of financing approaches. For example:
- **Massachusetts:** Since 2005, Massachusetts Health Quality Partners (MHQP) has sponsored a biennial statewide patient experience survey at the practice site level using a central vendor paid for almost exclusively by the participating health plans. Medical practices have the option of paying an incremental cost to obtain more detailed, physician-specific data. A small amount of funding also has been obtained from the Massachusetts Medical Society, to help cover the costs of including smaller practices not covered by the plans.
  - **Kansas City & Memphis:** The Kansas City Quality Improvement Consortium and the Healthy Memphis Common Table participated in a 2009 pilot project sponsored by Consumers' CHECKBOOK, a nonprofit organization that served the central vendor role for collecting and reporting CG-CAHPS data at the physician level. CHECKBOOK assumed the financial risk and charged a license fee to participating health plans for use of the data; each plan paid a fixed cost and a variable cost assessed on the basis of their respective market share. A no-cost license was granted to the Alliances for using the data published by CHECKBOOK. Another feature of the CHECKBOOK model, which significantly reduced the overall cost, was the use of non-profit mail rates approved by the U.S. Postal Service.
  - **California:** The Pacific Business Group on Health (PBGH) sponsors an annual patient experience survey of virtually all of California's medical groups in a statewide pay-for-performance initiative sponsored by the health plans. The PBGH survey is financed through a 70/30 split between the health plans and medical groups, respectively. Medical groups pay according to a three-tier fee system based on medical group size.
- **In all three of these examples, the major source of funding for a centralized strategy is the health plans.** However, the health plan share can vary, and can be supplemented through various additional sources of funding, including contributions from medical groups, state medical societies, and other sources such as federal, state, and foundation grant funds. In markets where health plans have agreed to share the majority of the cost, they have been motivated to do so in order to obtain consistent information for comparing performance at the practice or individual physician level, for use in their provider directories and, in some cases, as one of several metrics in pay-for-performance programs.
- **A central issue facing all financing models is the long-term sustainability of the financing mechanism.** While it may be possible to come up with funding for a one-time project, or even for multiple rounds of surveying over several years, the advantage of the leveraged strategy of implementation is that the cost of surveying becomes built into the operating costs of medical groups themselves, and the survey data can be used for internal improvement as well as public reporting.



## What Does It Cost to Implement CG-CAHPS?

- **Whether an Alliance follows a leveraged or centralized survey approach, the major cost components are the same:**
  - Sampling (compiling a list of all eligible patients and randomly selecting the desired number to survey)
  - Data collection (using one or more modes of survey administration, such as mail, telephone, interactive voice recognition, or web-based completion)
  - Data aggregation and analysis (assembling survey results from each participating practice to develop site-specific scores)
  - Reporting (including detailed reports to individual practices as well as a combined report for public reporting)
  - Project management
- **In either model, the most significant cost component is data collection.**
  - Based on the experience of previous survey projects undertaken by Alliances, data collection based on a traditional two-wave, mailed survey ranges from \$8 to \$15 per completed survey.
  - Based upon previous testing, the estimated number of completed surveys needed to achieve adequate reliability for public reporting ranges from 200 to 250 at the practice site level, and from 40 to 50 at the provider level.
  - Therefore, a reasonable estimate of surveying costs range from \$1,600 to \$3,750 at the practice site level, and from \$320 to \$750 at the provider level. Actual costs will vary according to mode of administration, vendor pricing, and other variables unique to each application.

- **Some researchers and communities are experimenting with lower-cost means of gathering patient experience survey data, though no such methods are yet in widespread use.** Experimental lower-cost methods include email or in-office kiosk. Survey distribution via email requires practices to collect patients' email addresses, and most do not do so. The increased emphasis on and use of health information technology may signal a shift toward greater use of email for communicating with patients, including for survey purposes. Once an Alliance establishes a system for surveying patients on their care experiences, it could later shift to a less resource-intensive data collection method.

### The CAHPS Database Can Serve as an Implementation Resource

The national CAHPS Database can provide a useful source of comparative data for benchmarking performance. For Alliances using a leveraged strategy, the CAHPS Database can serve as an aggregator of data collected and submitted according to standard specifications. Individual medical groups can submit their data and view their results compared to national benchmarks via an online reporting system.

The CAHPS Database is provided as a service to survey users through funding from the Agency for Healthcare Research and Quality (AHRQ). Further information is available at: [www.cahps.ahrq.gov](http://www.cahps.ahrq.gov)



### The Coordinating Role of the Alliance

In the absence of established national drivers for measuring ambulatory patient experience, the coordinating role played by Aligning Forces Alliances (or another selected coordinating body) in each market is critical. To help determine an appropriate implementation model, Alliances can explore the following questions with key stakeholders:

1. Are a sufficient number of medical practices already engaged in some type of patient experience survey activity that can form the basis for a leveraged strategy? Which survey vendors are practices currently using?
2. Is there any precedent for health plans in the local market to pool resources in support of a centralized approach to patient experience measurement?
3. What potential drivers could be leveraged in the local market to build interest and momentum toward community-wide implementation? Possible drivers to consider include:
  - the appeal of national benchmarking;
  - the ability to eliminate redundancy in current patient survey activities sponsored by different stakeholders;
  - the opportunity to be out ahead of an emerging national movement;
  - pressure from local patient advocacy organizations for comparable data on patient experience;
  - evolving pay-for-performance or practice recognition programs.
4. Whose expertise can be utilized to ensure consistency in survey methodology and objectivity in public reporting? What type of steering group will be most effective in guiding the implementation process?
5. What are the public reporting objectives for the community? How will public reporting of ambulatory patient experience measures mesh with other reporting currently underway?
6. How will medical practices be supported in their improvement of ambulatory patient experience?

### Implementation Tactics and Assistance

This brief provides guidance in determining whether a leveraged or centralized strategy of CG-CAHPS implementation is best suited to a given Alliance. Regardless of the approach selected, implementation includes many tactical steps that comprise a complex process. Sampling, data collection, data aggregation, analysis and reporting are all complex activities unto themselves, and informed, effective project management is needed to monitor and shepherd the process. At the outset of the project and at various steps along the way, fostering engagement from medical providers and other stakeholders is critical to ensuring effective implementation. The time required is highly variable, based upon the local market. Depending upon the level of stakeholder engagement, available expertise, market structure, and other local factors, full implementation and public reporting of CG-CAHPS may take from as little as three months to more than a year. Technical assistance is available from Aligning Forces for Quality to navigate this process. Contact the Aligning Forces National Program Office for more information.



## Additional Resources

- CAHPS Clinician & Group Survey and Reporting Kit:  
<https://www.cahps.ahrq.gov/cahpskit/CG/CGChooseQX.asp>
- The Case for Measuring Patient Experience:  
[http://forces4quality.org/sites/default/files/Case%20for%20Patient%20Experience5\\_0.pdf](http://forces4quality.org/sites/default/files/Case%20for%20Patient%20Experience5_0.pdf)
- How to Report Results of the CAHPS Clinician & Group Survey (to be released July 2010):  
[www.forces4quality.org](http://www.forces4quality.org) resource library.
- Free technical assistance is available from the CAHPS User Network:  
[cahps1@ahrq.gov](mailto:cahps1@ahrq.gov) or 1-800-492-9261
- Free technical assistance is available under Aligning Forces for Quality. Contact the Aligning Forces for Quality National Program Office through your Alliance's Regional Support person, or via  
[info@forces4quality.org](mailto:info@forces4quality.org)