CALIFORNIA
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Feedback Loop:
Testing a Patient Experience Survey in the Safety Net

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by

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About the Foundation

The **California HealthCare Foundation** works as a catalyst to fulfill the promise of better health care for all Californians. We support ideas and innovations that improve quality, increase efficiency, and lower the costs of care. For more information, visit us online at www.chcf.org.

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I. Introduction

PROVIDING PATIENT-CENTERED CARE HAS emerged as a central element in efforts to improve the quality of health care in the United States. A vital component of developing patient-centered care is the gathering of patient experience of care (PEC) feedback to help health care providers more comprehensively understand the quality of care they deliver. PEC surveys focus on aspects of the care experience that are important to patients and their families, such as access to care, communication with providers, and helpfulness of office staff. PEC surveys allow patients to report objectively on specific aspects of the care process and on clinician and staff behaviors. This distinguishes them from patient satisfaction surveys, which focus on more subjective measures. PEC surveys are typically less biased and more actionable than assessments of satisfaction and are an important source of information for the development of quality improvement (QI) initiatives.

In recent years, the consistent use of PEC data has allowed practices that serve commercially-insured and Medicare populations to improve the quality of care they provide. Similarly, the improved collection of PEC data by safety-net organizations could allow those practices to improve the quality and efficiency of their services. It could also assist them in cost-efficiently tailoring services to their patient populations. Unfortunately, to date few safety-net clinics have been able to perform such data collection, due to the absence of a central source of information and guidance about the importance and use of PEC data in QI, limited access to standardized tools for the collection of PEC data, and limited in-house expertise in implementing PEC surveys.

In response to this gap in PEC data for safety-net providers, the present project was undertaken by a team composed of participants from the Stoeckle Center, the RAND Corporation, the Center for Survey Research at the University of Massachusetts, Boston, and Shaller Consulting Group, with support from the California HealthCare Foundation. The project team:

- Developed a tool kit to help safety-net practices conduct PEC surveys on their own; this tool kit was based on the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Clinician and Group survey, as tailored to the specific capabilities and needs of safety-net clinics
- Designed and tested in-clinic distribution and Internet-based survey implementation protocols specific to safety-net providers
- Compared these two survey methods to an existing CAHPS mail survey protocol in order to assess aspects of survey implementation, including feasibility, cost, response rates, data quality, and whether patterns of response vary by mode.

The results of this project's implementation testing are presented in this report. They include a comparison of in-clinic distribution and Internet-based surveys to a vendor-administered survey conducted through the mail. The in-clinic distribution and Internet-based surveys were handled by temporary external hires rather than by clinic staff, in order to avoid several problems that can occur when staff are asked to implement a handout survey themselves. The response rate for the Internet-based survey proved too low (14%) to suggest that it would be an effective protocol. The response rates for the in-clinic distribution and mailed surveys were also both low, with in-clinic doing slightly better (36%) than mail (29%). The mail survey was 36% less costly overall than the in-office survey distribution, and slightly less costly (8%) per returned survey. However, a proposed adjustment to the mail survey to raise its response rate would also raise its costs.

The report also includes suggestions regarding supplemental and alternative methods of PEC data collection. Appendices A through C to this report provide examples of scripts used in survey administration, sample supplemental letters, and a sample visit-based PEC survey modified for use in safety-net clinics. Appendix D presents an analysis of the overall substantive patient responses for the in-clinic and mail protocols, and as compared with national and regional scores. Finally, Appendix E offers a demographic comparison of the patients participating in the in-clinic and mail surveys.

Separate, stand-alone visit-based PEC surveys for use in safety-net clinics are available to download in English, Spanish, Vietnamese, Korean, and Chinese at www.chcf.org.

II. Development of PEC Surveys

Measuring Patient Experience of Care via CAHPS

Significant resources have been expended designing and implementing surveys to evaluate PEC in various health care settings. In particular, the federal Agency for Healthcare Research and Quality and the Centers for Medicare and Medicaid Services (CMS) support the CAHPS consortium surveys, which are some of the most widely-used standardized PEC instruments currently available to the public.[1]

Stemming from a growing interest in measuring the quality of care provided by medical group practices, in the late 1990s the CAHPS consortium began to develop and test a standardized, evidence-based survey instrument for measuring patients' experience of care at the group level. The interest in such a group-level instrument reflected several developments, including: (1) overlap among health plans' provider networks, which diminished the usefulness of plan-level assessment of quality; (2) increased financial risk by medical groups in many health care markets and an associated shift in responsibility for critical aspects of care management from health plans to medical groups; and (3) the salience of medical groups to consumer choice, especially for the large share of employees (35% in 1999) who are offered no choice of plans by their employer.[2] The group-level instrument was intended to contribute to meaningful comparisons of medical groups. This, in turn, would help consumers and purchasers make more informed health care choices and facilitate QI efforts.

The CAHPS Clinician & Group survey modified the earlier Group-Level CAHPS survey to assess consumer experience at the levels of individual medical groups and individual clinicians. The Group-Level CAHPS survey instrument assesses doctor/patient communication, getting needed care, getting care quickly, coordination of care, preventive counseling, experience with office staff, and global ratings of care (for personal doctor or nurse, specialists, all care, and overall experience with the group).

Development work for the Group-Level CAHPS survey and its expansion to include clinician-level measurement involved both qualitative and quantitative research, including focus groups, in-depth cognitive testing, national field studies, and methodological experiments. In 2001, the Group-Level CAHPS instrument was submitted to and endorsed by the National Quality Forum (NQF). In July 2007, the NQF endorsed the CAHPS Clinician & Group Survey as a measure of patient experience with ambulatory care. The survey has also been endorsed by the Ambulatory care Quality Alliance.

Prior Research on Measuring PEC Within the Safety Net

To date, most PEC data collection has been funded by health plans, insurers, and CMS, and therefore has focused on the Medicare and commercially-insured populations. Very little systematic data has been generated about the experience of care among patients who are served by safety-net providers. Federally Qualified Health Centers (FQHCs), which provide care to safety-net patients, have a government mandate to collect patient feedback.[3] However, FQHCs receive no federal support to do so, whether in the form of standardized survey instruments, funding, or uniform reporting standards. Some state

Medicaid programs use the CAHPS Clinician & Group Survey or the CAHPS Health Plan Survey to monitor PEC in ambulatory settings, but there are no national mandates or guidelines for the use of CAHPS in health centers or other ambulatory settings.[4]

To address this gap in measurement of PEC, in 2009 the Stoeckle Center and the RAND Corporation conducted a qualitative study of safety-net health organizations in California.[5] That study's primary questions were: (1) How do safety-net organizations measure PEC? (2) How do they use PEC data to improve health care quality? and (3) What specific barriers exist to the collection and use of PEC data in the safety net? The study results showed that safety-net providers are strongly committed to improving their patients' experiences of care. However, they are greatly challenged by the absence of funding for reliable PEC data collection, by the lack of information about patient-centered survey and QI resources, and by the unique problems associated with surveying the safety-net patient population. As a result, many of these organizations are devoting their limited resources to collecting data that is biased or difficult to interpret, or that fails to include the experiences of substantial portions of their patient populations. The present study is one step in beginning to address these problems, examining the ways in which safety-net clinics might best implement the surveys they develop.

In-Office Survey Administration as an Alternative Method

As large-scale implementation of patient surveys for measuring clinician- and medical group-level performance is pursued, the high cost of data collection is an important concern. For safety-net providers in particular, cost is an acute problem. In-office distribution of survey instruments ("handout") by office staff members has been proposed as a possible approach to reducing costs and increasing response rates compared to traditional mail or telephone administration methods. In determining the viability of handout methods, however, it is important to evaluate whether this method alters the response rates, data quality, or performance results obtained. To this end, a multi-site investigation — the Anastario study — was conducted in a large multi-specialty medical group to determine whether performance on PEC measures varies between in-office handout by staff members and mail modes of distribution.[6]

The Anastario study made several important findings regarding performance measurement. First, in-office questionnaire distribution rates decreased over time across all sites for handout surveys, suggesting process fatigue among office staff. This decline over time also exacerbated uneven distribution rates by site, which had been evidenced from the beginning of the survey. Taken together, these findings suggest that in-office handout distribution of surveys by office staff may introduce bias into results, owing to differing attentiveness to the protocol by different sites. In contrast, protocols for mailed surveys are more easily standardized when managed outside of the practice setting, as demonstrated in the Anastario study results. Also, patient assessments of care in the Anastario study were significantly more favorable when questionnaires were distributed by in-office handout than by mail. This effect is not entirely accounted for by the shorter lag time between the office visit and the survey completion date for handout respondents. This finding suggested that the mode of survey distribution differentially affected the ranking of individual clinicians.

Another problem uncovered in the Anastario study was that the site with the lowest mail survey performance had the largest positive handout mode effect. Coupled with the lower distribution rates observed there, this suggested that the practice may have selectively chosen the patients asked to complete the handout survey. Finally, the possibility of clinician-mode or site-mode interaction effects could not be discounted. This suggests that a simple correction for the "mode" effects associated with handout may not be possible given the potential need to correct or adjust the data at both the clinician and site levels. These effects may be exacerbated in a context in which there are high stakes (e.g., reporting, financial) associated with the survey scores.

Designing the Current Safety-Net Study

As noted above, the handout mode suggests the potential for reduced costs, and is therefore financially attractive to safety-net organizations. However, given the bias difficulties encountered with the in-office handout in the Anastario study, the question arises whether an in-office handout distribution protocol might be developed that does not require direct survey administration by clinic staff members. That was the fundamental task undertaken by the present study: to develop an in-office handout protocol for use by non-staff, and to compare it to both Internet-based and traditional mail survey protocols.

The safety-net provider protocol developed for this study had two experimental approaches. One consisted of in-office distribution, by non-staff, of a survey to adult ambulatory care patients as they exited a primary care visit. The other approach was in-office distribution of instructions for accessing a web-based survey to adult ambulatory care patients as they exited a primary care visit; this mode also included delivery of a paper survey to patients who reported they did not have Internet access. These two experimental arms were tested, in the same safety-net clinic sites, against the CAHPS mail survey protocol as implemented by an experienced vendor. The different methods were implemented sequentially, for roughly three weeks each.

The sections of this paper that follow describe how this study was implemented through each of the three study protocols at each of the clinic sites, sample yields (response rates) for each study protocol, and challenges identified during implementation.

Recruitment of Study Sites

Over a period of several months, the project team recruited six California safety-net clinic sites to participate in the study. The goal was to recruit a mix of sites representing different geographic regions, rural and urban settings, large and small practices, and different patient racial and ethnic backgrounds. Recruitment documents included a short project description, a flyer, and list of frequently asked questions (FAQs) to describe the study, its benefits, and requirements for participation. These materials emphasized that the study would include free data collection services, access to free online reports to compare results to national benchmarks, and a cash award of $1,000 to help defray administrative costs of participation. In addition, the project team held several conference calls to explain the study to potential participants and to answer questions.

Table 1, below, summarizes the characteristics of the six participating clinics.

Table 1. Characteristics of Participating Clinics

	REGION	TYPE	SIZE	WEEKLY HOURS OF SERVICE	LANGUAGES
Clinic 1	South	Urban	Small	43	English, Spanish
Clinic 2	Central	Rural	Large	72	English, Spanish
Clinic 3	South	Urban	Large	57	English, Spanish
Clinic 4	North	Urban	Large	43	English, Spanish
Clinic 5	North	Urban	Large	65	English, Spanish
Clinic 6	North	Urban	Large	42	English, Spanish

Source: Project team and participating clinics.

III. Surveying Safety-Net Provider Patients via In-Clinic Distribution of Surveys

Overview of the Survey Protocol

One of the drawbacks of in-clinic distribution of a PEC survey is that clinic staff are called upon to implement a sampling procedure while carrying out their ongoing clinic responsibilities, which produces conflicting time demands and the potential for process fatigue. Moreover, because those same staff are also the subject of the survey, this mode raises the risk of selective survey distribution. To avoid these problems, the present protocol employed survey administrators who were not directly involved in patient care and who thus could present themselves to patients as independent of the clinic and its staff.

Independent survey administrators approached adult primary care patients as they exited a visit. Each patient was invited to take a survey packet that contained a cover letter (in English on one side, Spanish on the other), a survey (in English and Spanish), and a business reply envelope. Completed paper surveys could be dropped in a locked box inside the clinic, or mailed directly to RAND via a postage-paid envelope.

The script used to approach and recruit patients for this in-clinic distribution can be found in Appendix A.

Recruitment and Training of Survey Administration Staff

The project goal was to test the implementation of a model or protocol that could be replicated by clinics. Therefore, rather than send in experienced RAND data collection staff, the project team hired individuals in each location, recruited through a temporary agency, who had experience appropriate to the task (e.g., prior experience working in a clinic or doctor's office, work that required detailed recordkeeping, or experience in customer service or other job that required contact with the public). References were contacted and a Megan's Law background check was conducted.[7] Based on the languages spoken by clinic patients, the project hired individuals fluent in both English and Spanish.

Each hired survey administrator was sent an implementation manual that included scripts for approaching and recruiting patients, an FAQ document, samples of all survey materials, and daily log sheets (for reporting study progress), all of which were in English and Spanish. The survey administrators were trained via web-based seminar and teleconference. Training was conducted in English and Spanish and included review and discussion of study materials, as well as practice and mock exercises in which survey administrators role-played approaching and recruiting patients.

Patient Sampling and Data Collection

The sampling approach for this protocol was a census. That is, during study hours — those clinic hours during which the administrators were present to conduct the survey — all adult primary care patients were to be approached and invited to participate in the survey as they exited a visit.

Clinic 1 and Clinic 6 study hours were all hours of clinic operation, with one or more survey administrators present. Hours of operation for the remaining clinics were too extensive for a survey administrator to be present at all times; for those sites, hours of operation were divided into slots by time and day, with study hour slots randomly selected for survey administration.

Challenges in Implementing the Protocol

The project team identified several challenges during the implementation of this in-clinic handout survey protocol. Some challenges were experienced only by the survey administrators while others arose from the clinics themselves.

Administrator-based Challenges

Monitoring the administrators' work from the beginning of the survey distribution proved to be important. Before the study began, the project team collected reports from the clinics on the volume of their primary care patient visits. Based on these figures, it was determined that a two-week period (10 to 12 clinic days) should provide sufficient volume to generate 250 to 300 completed surveys per clinic. Four days into the protocol, however, monitoring of survey and visit volume made clear that the protocol period would need to be extended by an additional week (five to six clinic days) in order for the administrators to meet the volume goal.

Also, within 48 hours of the start of the protocol, it became clear that a survey administrator in Clinic 2 had survey refusal rates that were well above the group average. That survey administrator was removed and existing personnel were rescheduled while a replacement administrator was trained.

Clinic-based Challenges

The project began to encounter clinic-based challenges early in the process. The study design included development and implementation of a web-based data-entry tool, so that data from surveys dropped in a lock-box at the clinic could be entered by the clinic-based survey administrators during the period of time devoted to accruing the mail survey sample. During recruitment, participating clinics were asked to provide some level of computer access to survey administrators. However, two clinics were unable to provide computer or Internet access; two other clinics initially agreed to provide computer access but ultimately did not make a computer available; and two clinics did not offer computer access but offered free wireless connectivity should the study provide a laptop to the survey administrator. As a result, all surveys were data-entered centrally by project team staff.

The most significant clinic-based challenge, which had a large impact on the project effort, was the failure by each clinic to provide updates to its daily appointment list. Specifically, the project requested an updated appointment list or a staff member to communicate updates at two or three points in the day so that survey administrators could identify newly added same-day appointments, cancellations, and no-shows. This information was to be used to determine what proportion of patients eligible for approach was missed by survey administrators. Senior clinic or medical system staff agreed to provide such information, but during the course of the study front line staff were unable or unwilling to do so in any of the clinics.

Additional challenges needed to be overcome in individual clinics to assure that survey administrators received a daily list of eligible visits. In Clinic 1, the daily visit list did not distinguish between adult and pediatric patients. Survey administrators thus had to approach any patient who "looked 18" and ask first if he or she was an adult. In Clinics 5 and 6, the daily visit lists included a text field that indicated reason for visit, which clinic staff determined to be protected health information. Clinic 6 worked out a solution in which they manually deleted the visit reason each time the list was printed. Clinic 5, however, was unable to implement a consistent solution and on several days its staff would not provide survey administrators with the daily appointment list; the administrators had to create their own lists on those days, by approaching patients one by one. Identifying and implementing a solution at Clinic 5 was difficult because the front-line clinic staff member assigned to be the study's point of contact expressed very negative views about the project and its survey.

Unannounced changes in clinic scheduling were also a problem. At the beginning of the project the team reviewed, with the contact at each clinic, the weekly and monthly schedules for specialized, non-adult and adult non-primary care clinics or group sessions. As the study progressed, however, survey administrators would sometimes arrive at a clinic at a time scheduled for individual primary care visits only to find that the time period was now devoted instead to a specialized clinic or group session. Clinic staff would report that the change was a last-minute decision, or that they had meant to communicate the change but had neglected to do so.

Some of the clinics in the project used in-clinic distribution as the primary mode for conducting all of their patient surveys. Because patients often had long wait times prior to their visit, these clinics distributed their in-house surveys while patients were waiting to be seen. Staff in these clinics repeatedly asked this project's survey administrators to employ the same approach and distribute surveys to waiting patients. Patients in these clinics also asked this project's survey administrators to let them fill out the survey while they waited. Administering a post-visit experience of care survey in advance of the visit, however, would invalidate the data.

Prior to agreeing to participate in this project, Clinic 4 had scheduled its own internal patient experience survey. That survey was to be distributed to patients during the same weeks as this project's Protocol 2 (in-clinic distribution of Internet-based survey instructions; see Section IV, below). As a consequence, the project team changed the schedule for Clinic 4 so that the project's survey administrators would not be present during the clinic's own survey implementation. Clinic 1 also had an internal survey, and initiated data collection during the third week of this study's protocol. The project team had no prior knowledge of the clinic's planned survey, and only learned about it from patients. The project team then contacted the clinic CEO, who agreed to delay the clinic's own survey until this project concluded its study protocols.

Cost of Protocol and Response Rates

The per-clinic cost of the in-clinic handout protocol was $9,050, which included all labor costs to distribute surveys at clinics, printing of materials, postage for paper surveys returned by mail, labor costs for data entry, and estimated costs of clinic staff time to liaise with survey administration staff. The protocol achieved an overall response rate of 36%.[8] Table 2 summarizes survey administration staff contact with patients and the resulting response rate (see page 11). The goal was to achieve 250 to 300 completed surveys per clinic during the survey administration period, based on CAHPS sampling guidance for clinic-level samples. Only three of the six clinics achieved this goal.

A key variable for measuring the quality of the sample generated by this survey protocol is percentage of patients "missed," meaning patients who were not approached by the survey administration staff. This figure would be the difference between the number of patients reported as approached and the total number of adult primary care visits during survey distribution hours. None of the clinics, however, was able to provide the total visits data, so this variable could not be determined.

Table 2. Outcome of Patient Contact Efforts

	PATIENTS APPROACHED*	ACCEPTED SURVEY	REFUSALS	NOT ELIGIBLE	OTHER	SURVEYS RECEIVED	RESPONSE RATE
Clinic 1	911	592	239	64	16	294	35%
Clinic 2	761	306	291	136	28	169	27%
Clinic 3	1,262	702	132	418	10	273	32%
Clinic 4	525	313	93	111	8	262	63%
Clinic 5	784	619	46	119	0	182	27%
Clinic 6	584	465	65	53	1	243	46%
TOTAL	**4,827**	**2,997**	**866**	**901**	**63**	**1,423**	**36%**

*Total number of patient visits is unknown for each of the six clinics.

Source: Project team.

IV. Surveying Safety-Net Provider Patients via the Internet

Overview of the Survey Protocol

The Internet-based survey protocol was designed to serve two purposes: collect information on the extent of patient access to the Internet, and invite patients to participate in a PEC survey. Independent survey administrators were to approach adult primary care patients as they exited a visit. Each patient was asked about access to the Internet and invited to report, via a survey, on his or her experience with the just-concluded visit. Patients with Internet access were invited to complete a visit-based version of the CG-CAHPS survey via the web; patients without Internet access were given a survey packet of printed materials.

The web instruction sheets and all survey packet materials were printed in English on one side and Spanish on the other; the patient could elect to complete the web-based or the printed survey in either language. Each survey packet contained a cover letter, a survey, and a business reply envelope. Completed paper surveys could be dropped in a locked box inside the clinic, or mailed directly to RAND via a postage-paid envelope.

The script used to approach and recruit patients during the Internet-based protocol can be found in Appendix A.

Recruitment and Training of Survey Administration Staff

The same survey administrators from the in-clinic handout protocol (see Section III, above) also implemented the Internet-based protocol. Throughout this protocol, survey administrators had a weekly check-in call with the RAND survey coordinator to review clinic activity. In addition, when a problem was encountered in the field, survey administration staff could phone the RAND coordinator.

Patient Sampling and Data Collection

The sampling approach for this protocol was a census, conducted during study hours. That is, the survey protocol required all adult primary care patients to be approached as they exited a visit during study hours and to be invited to participate in the survey.

In Clinics 1 and 6, one or more survey administrators were present during all hours of clinic operation. Hours of operation for the remaining clinics were too extensive to allow for a survey administrator to be present at all times. For those sites, the hours of operation were divided into slots by time and day, with slots randomly selected for survey administration.

Challenges in Implementing the Protocol

All of the same challenges that arose regarding the in-clinic handout protocol (see Section III, above) were applicable to this protocol as well. Also, Clinic 4 had previously scheduled the administration of its own internal survey for the same period as this project's Internet-based protocol. In response, the project team reallocated survey administration personnel to other clinics during this time and used the three-week period for accrual of mail survey samples for this clinic.

Cost of Protocol and Response Rates

The per-clinic cost of the Internet-based protocol was $8,760, which included all labor costs for distributing surveys and web instructions at the clinics, the printing of materials, programming costs, postage for paper surveys returned by mail, labor costs for data entry, and estimated costs of clinic staff time to liaise with survey administration personnel. The protocol achieved an overall (Internet plus paper) response rate of 14%, with none of the clinics achieving the target number of completed surveys. The proportion of patients reporting access to the Internet varied by clinic (from 7% to 26%), with an average of 17%. Of patients reporting Internet access, only 3% completed the web-based survey. Table 3 summarizes the outcome of patient contact activity during the protocol. Table 4 provides clinic-level information on patient-reported Internet access and the proportion of patients with Internet access who completed the web-based survey.

Table 4. Internet Penetration and Web-Based Survey Participation by Clinic Patients

	PERCENTAGE OF PATIENTS	
	REPORTING INTERNET ACCESS	WITH ACCESS COMPLETING WEB SURVEY
Clinic 1	26%	4%
Clinic 2	27%	3%
Clinic 3	17%	1%
Clinic 4	7%	17%
Clinic 5	11%	1%
Clinic 6	21%	3%
AVERAGE	**17%**	**3%**

Source: Project team.

Table 3. Outcome of Patient Contact Efforts, Internet-Based Protocol

	PATIENTS APPROACHED*	ACCEPTED SURVEY / WEB INSTRUCTIONS	REFUSALS	NOT ELIGIBLE	OTHER	SURVEYS RECEIVED		RESPONSE RATE
						PAPER	WEB	
Clinic 1	1,088	531	436	121	0	42	10	5%
Clinic 2	1,869	796	175	874	24	82	10	9%
Clinic 3	1,619	687	344	581	7	165	2	16%
Clinic 4	735	190	504	26	15	80	8	12%
Clinic 5	1,081	580	186	315	0	229	1	30%
Clinic 6	575	335	166	63	11	56	5	12%
TOTAL	**6,967**	**3,119**	**1,811**	**1,980**	**57**	**654**	**36**	**14%**

*Total number of patient visits is unknown for each of the six clinics.

Source: Project team.

V. Surveying Safety-Net Provider Patients via Mailed Survey

Overview of the Survey Protocol

The CG-CAHPS mail survey protocol is described in detail in the Clinician & Group Survey Administration and Reporting Kit 2008. This kit is available free of charge at the CAHPS website.[9] The protocol requires up to three mailed contacts: an initial survey (containing a personalized cover letter, the CG-CAHPS survey, and a postage-paid return mail envelope), a reminder postcard, and a second or non-response survey packet (containing a modified cover letter, another copy of the CG-CAHPS survey, and a postage-paid return mail envelope).

For the present project, the survey was conducted by an outside vendor selected through a competitive bidding process. Mailings for this project occurred at two-week intervals. The packets were customized for each clinic: The cover letter had the clinic's name printed at the top, and was signed by a clinic representative; the survey had the name of the clinic within the first question; the reminder postcard had the name of the clinic printed at the top; and all materials (letters, postcards, survey) included a toll-free number patients could call to ask questions or get more information about the survey. The field period from first mailing to close of receipt of survey returns was eight weeks. The text of the survey cover letters and postcard can be found in Appendix B to this report.

Patient Sampling and Data Collection

Each clinic was given specific dates during which all adult primary care patients were to be included in the sample frame. For most clinics, this period comprised a three-week window during late November to mid-December. For Clinic 4, the dates were shifted to November, and for Clinic 1 the dates had to be extended through December and into the initial weeks of January.

A number of patients had multiple visits during the survey frame, so duplications had to be removed from the data files. Duplications within households were also removed from the sample, with one patient per household selected at random. Once a file of unique patients was compiled, the sample was randomized and 625 patients per clinic were selected to achieve 250 to 300 responses per clinic based on CAHPS clinic-level sampling guidance (a target completion rate of 40% to 48%). Clinic 1 had an insufficient sample to achieve 625 patients, so all unique patients in the visit file were included in its mail survey sample (531 patients).

Challenges in Implementing the Protocol

At Clinic 4, the visit dates for accrual of the mail survey sample had to be shifted by three weeks to work around the clinic's existing schedule for its own internal survey. Clinic 1 had difficulty generating a sufficient sample with home addresses, and after seven weeks had only 531 patients with an address of record.

All clinics had difficulty generating a sample file, and half the clinics required multiple attempts to provide a file in a format that the project team could read, and that included visits for the full range of identified dates. Patient visit data are finalized based on billing records, but billing records were not finalized until the middle of the following month, so for each clinic an additional two to four weeks were required to generate a sample file. All files required some level of cleaning and reformatting to correct problems or to fill in missing information.

During discussions with clinic staff, all reported the ability to provide patient gender information and preferred language. However, only three clinics wound up providing preferred language, and only two clinics provided patient gender.

Cost of Protocol and Response Rates

The per-clinic cost of the mail survey protocol was $5,777, which included all vendor costs (including production of clinic-specific reports of scores), and estimated costs of clinic staff time to produce a sample file and liaise with the vendor. The protocol achieved an overall response rate of 29%, with only Clinic 4 achieving the target number of completed surveys.[10] Table 5 summarizes the sample outcomes by clinic.

Because only one clinic achieved the goal of 250 to 300 completed surveys, the project team conducted a small round of follow-up calls to non-responders to try to determine the factors contributing to non-response. Five of the six participating clinics gave consent to contact sampled patients by phone.

The full sample file was sent to a "look-up" vendor to link a telephone to the patient name and address. The vendor found numbers for 29% of the sample. The survey vendor provided identifiers for non-responders and the team attempted to contact by telephone a random sample of 20 non-responders per clinic (with a maximum of eight attempts). Tables 6 and 7 summarize the outcome of telephone follow-up.

Table 6. Outcome of Telephone Follow-Up, Mail Survey

	CLINIC NUMBER				
	1	3	4	5	6
Complete	7	6	13	11	6
Deceased	0	0	1	0	0
Away duration	0	0	0	0	2
Wrong number	4	7	3	3	5
Max attempts	9	7	3	6	7
TOTAL	**20**	**20**	**20**	**20**	**20**

Note: Clinic 2 did not participate in the telephone follow-up.

Source: Project team.

Table 5. Mail Survey Sample Outcomes

	SAMPLE	RETURNED SURVEYS	UNDELIVERABLES	REFUSALS	RESPONSE RATE
Clinic 1	531	156	115	1	38%
Clinic 2	625	118	43	0	20%
Clinic 3	625	137	50	0	24%
Clinic 4	625	278	13	3	45%
Clinic 5	625	144	30	1	24%
Clinic 6	625	154	27	0	26%
TOTAL	**3,656**	**987**	**278**	**5**	**29%**

Source: Project team.

Table 7. Reported Reason for Non-Response, Mail Survey

	CLINIC NUMBER				
	1	3	4	5	6
Too busy/Forgot	2	1	3	2	1
Don't remember getting survey	0	3	5	5	2
Didn't visit clinic	0	0	0	1	1
Threw survey away	0	0	0	0	1
Sampled patient is a child	0	0	0	0	1
Switched to another clinic	1	0	0	0	0
Address problem	2	0	2	0	0
Received and completed a survey at the clinic	1	0	0	1	0
Don't do surveys	0	0	0	1	0
Too ill to complete	0	0	1	0	0
Not sure who survey from	0	0	1	0	0
Mailed survey back	1	2	1	1	0
TOTAL	**7**	**6**	**13**	**11**	**6**

Note: Clinic 2 did not participate in the telephone follow-up.

Source: Project team.

The project team spoke with 43% of the 100 patients with whom follow-up was attempted. The most common reported reason for non-response was that the patient did not remember receiving a survey from the clinic (35%), followed by too busy or forgot to return the survey (21%), survey was returned (12%), survey was mailed to an incomplete or out of date address (9%), patient received and filled out a survey in-clinic (5%), and patient had no visits to the clinic (5%), with the remaining patients reporting individual reasons for non-response.

VI. Comparison of Experiment Methods

This section addresses the comparative advantages and disadvantages, and the implications, of the three approaches to collecting data about patient experience in safety-net clinics based on the surveys conducted by this project.

Getting Samples

For all three approaches to collecting data, getting a reliable list of eligible patients from which to sample was a challenge. For the protocols that involve sampling all those who get care in a clinic while they are there, the inclusion of new appointments and walk-in or same-day appointments and the inability to exclude missed or canceled appointments made it difficult to assess how many patients were missed. On the other hand, getting lists of patients seen in a given period in a form suitable for sampling for a mail survey is also complicated. Eliminating individual and household duplications is a necessary and time-consuming but manageable step.

Even with such steps, however, it is difficult to be confident that the lists are accurate. Mail procedures require a good mailing address but 5% to 10% of the patient surveys in the present mail study were returned as undeliverable, while a third of the non-respondents to the mail survey who were later contacted by phone did not remember receiving a survey. Thus, clinics face serious challenges in getting complete and accurate lists for sampling regardless of which method they use.

Implementing Data Collection Protocols

Internet Not Viable

One of the goals of this project was to explore the potential of using the Internet to survey patients in the sample clinics. One clear, unfortunate conclusion of the study is that providing patients with a URL and asking them to complete a web survey is not likely to work at present with a safety-net population. To begin with, on average only 17% of the patients said they had Internet access. Moreover, of nearly 1,200 patients who said they had Internet access and were given a URL to use to complete a web survey, only 36 patients — a paltry 3% — actually did so. In this regard, it is important to note that these patients talked with a project representative who explained the purposes of the survey and answered their questions; they were not simply handed a URL.

These figures are similar to, though more extreme than, results from general efforts to get people to go to URLs to do surveys. The numbers accepting and following through on such invitations are routinely extremely low. Results are somewhat better, though still lower than alternatives, when people are solicited directly by e-mail and given a link to click.[11] However, for the populations in this study, having a list of patients complete with e-mail addresses is not likely for the foreseeable future.

Finally, the idea of offering patients two alternative ways — Internet or paper — to do the survey seemed that it might generate more responses. Surprisingly, however, just the opposite occurred: Offering the Internet option actually decreased the number of people who filled out a paper questionnaire. When both Internet and paper were offered, only 14% responded overall, but when patients were only asked to complete a paper form, the response rate was 36%.

In-Clinic Handout Survey Versus Mail Survey

Because of the extremely poor response rate generated by the Internet-based survey, the real comparison to be made is between handing out questionnaires in a waiting room and conducting a mail survey of recent patients.

The hand-out protocol used in this study built on a previous study in which office staff members handed out surveys to a sample of patients. That earlier protocol worked very poorly because office staff members frequently were distracted by other responsibilities and thus were unable to successfully hand out questionnaires to about a third of selected patients. That study also found that surveys distributed by clinic staff tended to create a positive bias in the responses. In an attempt to circumvent both those problems, this project used outside contractors who were trained to contact selected patients, orient them to the study, and hand out survey questionnaires.

Another concern about the handout protocol has to do with the validity of responses. Because patients spent a good amount of time at the clinic waiting to be seen, the easiest time to recruit them to do the survey was before they saw the doctor or other provider. Once patients were ready to leave the clinic after they had seen a provider, it was harder to get them to talk. As a result, a good number of patients were given questionnaires before they saw a doctor, and of these, many filled out the questionnaire (despite instructions to the contrary) before the visit to the provider that they were supposed to be rating. Obviously, the validity of such pre-visit responses — rating a specific experience before it happens — is highly suspect.

The "control" protocol used in this study was a standard mail survey. A sample of patients who had visited a clinic in the reference period were sent an initial questionnaire with a cover letter, followed by a reminder postcard and later a second questionnaire if necessary. Telephone interviewing, which is often used to raise response rates for CAHPS mail surveys but which adds cost to the process, was not included in this protocol, as the goal was to assess relatively low-cost approaches to surveying ambulatory patients.

Response Rates

The response rate was 36% for the hand-out protocol, 29% for the mail protocol. This difference in overall response rate is probably not significant enough to warrant a distinction between the two protocols. Moreover, neither response rate is high enough to have full confidence that the samples well reflected the whole population of patients.

Characteristics of Those Who Responded

The clearest difference in those responding to the two kinds of surveys was that mail respondents were older (77% versus 54% were 45 or older) and more likely to report having a chronic condition (50% versus 42% had a condition that had lasted at least three months and for which they had seen a doctor at least three times in the last year; 69% versus 56% had a condition that had lasted at least three months and for which they took prescription medicine; see Appendix E). The mail respondents also had had more visits to the doctor in the preceding year (45% of the mail respondents had had five or more visits versus 29% of the in-office sample), which is consistent with their higher average age and more prevalent chronic conditions. The only other notable difference was that a higher percentage of the in-office respondents described themselves as Hispanic

(62% versus 56% of the mail respondents). In all other respects, including level of formal education, gender, and self-rated health, the samples resulting from the two modes were quite similar.

Quality of Care Measures

With respect to reports of experience of care, in a previous study using office staff to hand out questionnaires the in-office samples tended to report more positive assessments of their care than a comparable sample by mail. In the present study, in which representatives who were not part of the office staff recruited respondents and handed out questionnaires, that tendency was not evident.

Of the five experience of care measures reported in this study, four were rated slightly more positively by the mail respondents than by the in-office respondents: getting care right away, doctor knowing important information, doctor spending enough time, and recommend clinic to others (see Appendix D). The only measure that was more positive among in-office respondents was whether they received follow-up information on their test results. Notably, the differences in these experience of care measures between the two surveys averaged only 4%, meaning that the results were comparable for the two protocols.

Costs

Prior research on the collection of PEC data by safety-net providers indicates that in-office distribution of surveys is perceived to be less costly than vendor-administered mail surveys. At the clinic level in the present study, the labor, printing, and postage cost associated with three weeks of in-office survey administration was $9,066 per clinic. It should be noted here that this included the cost of outside contractors, rather than existing office staff, to administer the surveys. This figure is 36% more than the per-clinic cost of the vendored mail survey ($5,777, including clinic staff time to generate a sample file), though only 8% lower per returned survey (see below).

Overall Summary Comparison

In the first instance, the project results made clear that use of the Internet in this experiment added nothing of value. Almost no one responded via the Internet (36 out of a possible 3,100). Moreover, offering the Internet option actually greatly reduced the rate of return of those without Internet access who were given a paper version instead.

Comparing the handout and mail options, neither yielded a high response rate. There were also difficulties in getting adequate lists of eligible patients for either protocol, and concerns about selective responses and errors due to non-response are well warranted with both. There were problems in assembling comprehensive lists of patients for the mail survey, and significant problems with having good mailing addresses. However, the challenges and concerns regarding the handout protocol might be considered somewhat more severe. In particular, there was no confidence that the project obtained a full accounting of the number of eligible patients (in order to calculate how many were missed) and there were significant problems with getting updated appointment lists as they evolved during the course of the sampled days.

With respect to non-response bias, because the project was unable to get good statistics about the characteristics of the overall patient populations, it is hard to assess which of the two samples of respondents look most like the populations from which they were drawn.

With respect to the quality of data, the earlier Anastario study (see Section II, above) in which office staff handed out questionnaires provided fairly clear evidence that handout protocols produce more positive ratings of care than mail surveys. In this project, in which office staff were not directly interacting with patients about the survey, no such tendency was observed, suggesting that getting office staff out of the data collection may eliminate the positive bias in answers. On the other hand, there was a serious reliability problem with a significant number of the handout survey answers: Many were filled out before the patients actually saw the doctor, which raises concerns about the validity of those reports.

Finally, the costs per returned survey for the mail protocol ($35.11) were somewhat lower than the costs per returned survey for the hand-out protocol ($38.15). Out-of-pocket costs for a practice would, of course, be lower if they used office staff to execute the survey. However, the superior execution of the sample design by paid outside representatives, compared with a previous effort using office staff, and the reduction of the favorable response bias, seem to make a strong argument for not using office staff for these surveys. On the other hand, telephone follow-up would probably raise the return rate for the mail survey (see immediately below) but would add costs.

The disappointing response rate to the mail protocol no doubt in part reflects the challenges of surveying the particular populations that regularly use safety-net clinics. Surprisingly, however, the response rate was even lower than typically found with Medicaid population surveys, which include analogous patient populations. Given that the patients in this study have an ongoing relationship to the clinics, it might have been expected that the response rate would be as good as or better than for mail surveys of Medicaid beneficiaries. The discrepancy might be explained by the fact that the typical CAHPS protocol, frequently used with Medicaid surveys, entails a phone follow-up to mail non-respondents. With a mail survey like the one in the current study, even if only reminder calls were made, and those who had not received or had misplaced a questionnaire were sent a new one, one could expect a notable improvement in the response rate. Such a protocol would cost more, of course.

Alternatives to Quantitative Data Collection

The practical and methodological challenges of fielding standardized PEC surveys for safety-net clinics suggest the need for other methods of obtaining patient feedback to supplement survey data collection. Less rigorous, qualitative methods can confirm or question survey data results and can offer detailed insights into specific problems and possible solutions. Because they are easier and less expensive, these methods can also be used more frequently, providing valuable real-time feedback. Finally, such methods may also engage patients and families as partners in the QI process, adding not only their voices to assessments but also valuable ideas that may not occur to professionals on their own.

The following are several supplemental patient feedback methods, culled from the CAHPS Improvement Guide, that practices might consider as tools to support their improvement activities.[12]

- **Focus groups:** Staff and/or patients are brought together in a moderator-led discussion group to collect information about a specific problem and new ideas for QI strategies. A focus group allows for in-depth exploration of the drivers of dissatisfaction and can elicit ideas for reengineering services. In addition, videos of focus groups can be very effective at changing the attitudes and beliefs of staff because actually viewing and hearing participants tell their stories often brings to life the emotional impact of excellent service or service failures.
- **Walk-throughs:** A walk-through can be a simple way for clinic staff to get a patient's perspective and to identify system, flow, and attitude problems, many of which may be easily fixed once they are recognized. A walk-through is an effective way of recreating for staff both the emotional and physical experiences of being a patient or family member. Walk-throughs can also bring to light rules and procedures that may have outlived their usefulness.

  In a walk-through, one staff member plays the role of the patient and another accompanies as a family member. They go through a clinic, service, or procedure exactly as a patient and family member do. Throughout the walk-through, they ask attending staff members questions to encourage reflection on processes or systems of care and to identify improvement opportunities. The role-playing staff take notes to document what they see and how they feel during the process, then share these notes with organization leadership and QI teams.
- **Shadowing:** Similar to a walk-through, in "patient shadowing" a staff member accompanies a patient (with permission) through the visit and takes notes on the patient's experience. Since this does not require taking a slot away from a real patient, it can be especially useful in settings where visits are at a premium.
- **Complaint/Compliment letters:** By reviewing these letters systematically, a clinic can get a picture of where it needs to do research with staff and patient focus groups or via walk-throughs, and can be alerted to personnel problems.
- **Comment cards:** Comment cards can be made available for patients to complete prior to and after a visit. Comment cards can include patient ratings of service quality as well as space for feedback on the patient's experience. When changes are in process, comment cards can be particularly useful for eliciting "real time" feedback. Comment card information is not always generalizeable to the larger patient population, however, because patients who are either very positive or very negative about their visit experience are the most likely to fill out the cards.

VII. Conclusion

Other than the inutility of an Internet-based survey for safety-net clinics, the lessons to be drawn from the present study were not definitive. Nonetheless, the study suggested certain things that safety-net clinics may want to consider when determining whether and how to implement their own PEC surveys.

The study's experiment with in-office survey distribution by non-staff administrators encountered the same primary challenge as did prior tests of staff-run in-office administration — the inability to approach 100% of the eligible patient population. Moreover, the project was unable to calculate the percentage of eligible patients missed by the survey administrators because clinics failed to provide daily lists of patients seen. The extent of bias due to non-coverage in the in-office sample is unknown. But any time survey administration procedures include systematic bias, the resulting sample of patients is unreliable. Such survey results may still have some utility to clinic staff, but they should not be fully generalized to the overall patient population served by the clinic.

The project also revealed that the cost of in-office distribution of surveys is not necessarily less than that of vendor-administered mail surveys. Particularly if clinics survey on an annual basis, they might more easily absorb the cost of a mail vendor protocol than an in-office one. On the other hand, given that the experiment yielded a sample via a mailed survey sufficient enough to generate clinic-level estimates in only one site, it is not clear that a mail survey alone will achieve sufficient response in a safety-net setting.

In sum, many of the same serious challenges exist with both in-office and mail surveys. However, the kinds of reliability concerns that arise with in-office survey administration (as discussed herein), plus the somewhat lower cost of mail surveys, suggest that mail surveys may hold a slight advantage for safety-net clinics. Ultimately, clinics may need to employ a mix of modes (mail supplemented by telephone, for example), which may offset some of the cost advantage, in order to achieve sufficient returns for a single, point-in-time survey.

Appendix A. Scripts for Survey Administration

SCRIPT FOR APPROACHING PATIENTS

In-Clinic Survey Distribution

Adult patients will be approached upon completion of a primary care visit at the clinic by a survey administrator employed by RAND, who is handing out experience of care surveys for patients to complete. Survey administrator will be wearing a RAND project id badge. Note that text in all caps is instructional text for the survey administrator.

Introduction

Hello, I'm (first, last) and I'm working with the clinic to hand out a survey to help clinic staff learn where and how they can improve the care you and other patients receive. May I have a little bit of your time?

IF NEEDED: I work for RAND, a research organization working with this clinic to collect patient feedback.

YES, OK TO CONTINUE

PATIENT REFUSES ➨ THANK AND END
(NOTE REFUSAL ON APPOINTMENT LOG)

Request to Participate in Clinic

I have a survey packet that I'd like to give you. The survey takes about 10 minutes of your time, you just fill it out using the pencil in the packet, seal the envelope and there is a locked box (POINT OUT LOCATION) you can drop it into when you are done. I collect the surveys from the box, and I don't show anyone's answers to the doctors or other staff here at the clinic. Would you be willing to complete the survey?

YES, WILLING TO FILL OUT SURVEY AT CLINIC
➨ THANK PATIENT *(PULL LABEL FROM SURVEY PACKET AND AFFIX TO APPOINTMENT LOG, HAND PACKET TO PATIENT.)*

PATIENT REFUSES ➨ THANK AND END
(NOTE REFUSAL ON APPOINTMENT LOG)

Filling Out the Survey at Home

The survey packet has a postage-paid envelope addressed to RAND. Would you be willing to fill out the survey at home?

YES, WILLING TO FILL OUT SURVEY AT HOME
➨ THANK PATIENT *(PULL LABEL FROM SURVEY PACKET AND AFFIX TO APPOINTMENT LOG, HAND PACKET TO PATIENT.)*

PATIENT REFUSES ➨ THANK AND END
(NOTE REFUSAL ON APPOINTMENT LOG)

SCRIPT FOR APPROACHING PATIENTS

Offer Internet Survey

Adult patients will be approached upon completion of a primary care visit at the clinic by a survey administrator employed by RAND, who is handing out the URL for an experience of care surveys for patients to complete. Patients who do not have Internet access will be offered a paper version of the survey. Survey administrator will be wearing a RAND project id badge. Note that text in all caps is instructional text for the survey administrator.

Introduction

Hello, I'm (first, last) and I'm visiting the clinic to invite patients to fill out an Internet survey to help clinic staff learn where and how they can improve the care you and other patients receive. May I have a little bit of your time?

IF NEEDED: I work for RAND, a research organization working with this clinic to collect patient feedback.

YES, OK TO CONTINUE

PATIENT VOLUNTEERS: NO INTERNET ACCESS
➨ SKIP TO NO INTERNET ACCESS SCRIPT
(NOTE "NO INTERNET" ON APPOINTMENT LOG)

PATIENT REFUSES ➨ THANK AND END
(NOTE REFUSAL ON APPOINTMENT LOG)

Request to Participate in Internet Survey

I have instructions for completing a survey over the Internet that I'd like to give you. Do you have access to the Internet?

YES, HAVE INTERNET ACCESS

NO, NO INTERNET ACCESS ➨
SKIP TO NO INTERNET ACCESS SCRIPT
(NOTE "NO INTERNET" ON APPOINTMENT LOG)

PATIENT REFUSES ➨ THANK AND END
(NOTE REFUSAL ON APPOINTMENT LOG)

The survey takes about 10 minutes of your time. The instructions I have here give you the web address you need to enter to get to the survey and a survey access code. Would you be willing to complete the survey?

YES ➨ Thank you. This envelope has the instructions for getting to the survey. I hope you can find time today to answer the survey. *(PULL LABEL FROM ENVELOPE AND AFFIX TO APPOINTMENT LOG, HAND ENVELOPE TO PATIENT.)*

PATIENT REFUSES ➨ THANK AND END
(NOTE REFUSAL ON APPOINTMENT LOG)

If No Internet Access

I have a survey packet that I'd like to give you. The survey takes about 10 minutes of your time, you just fill it out using the pencil in the packet, seal the envelope and there is a locked box (POINT OUT LOCATION) you can drop it into when you are done. I collect the surveys from the box, and I don't show anyone's answers to the doctors or other staff here at the clinic. Would you be willing to fill out the survey here in the waiting room?

YES, WILLING TO FILL OUT SURVEY AT CLINIC
➨ THANK PATIENT *(PULL LABEL FROM SURVEY PACKET AND AFFIX TO APPOINTMENT LOG, HAND PACKET TO PATIENT.)*

NO, NOT WILLING TO FILL OUT SURVEY AT CLINIC

PATIENT REFUSES ➨ THANK AND END
(NOTE REFUSAL ON APPOINTMENT LOG)

Filling Out the Survey at Home

The survey packet has a postage-paid envelope addressed to RAND. Would you be willing to fill out the survey at home?

YES, WILLING TO FILL OUT SURVEY AT HOME
➨ THANK PATIENT *(PULL LABEL FROM SURVEY PACKET AND AFFIX TO APPOINTMENT LOG, HAND PACKET TO PATIENT.)*

PATIENT REFUSES ➨ THANK AND END
(NOTE REFUSAL ON APPOINTMENT LOG)

Appendix B. Mail Survey Letters

TEXT OF COVER LETTER – INITIAL MAIL SURVEY PACKET

(CLINIC NAME)

(DATE)

(PATIENT NAME AND ADDRESS)

Dear (PATIENT NAME),

We care about your experience during each and every visit to (CLINIC NAME) and I am writing to you to ask for your honest opinion about the care you get at our clinic. By completing the enclosed survey, you will give us the information we need to learn where and how we can improve the care we give to our patients.

The survey asks about your experiences with a provider that you have recently visited. The survey also asks about your experience making appointments and your experience with clerks and receptionists at the clinic. It will take about 10 minutes of your time.

We are working with Center for the Study of Services (CSS), an independent survey research organization, to conduct this survey. The survey is completely voluntary. Your decision about taking part in this survey will not affect your care at (CLINIC NAME). The information that you provide will be kept **completely private and confidential.** CSS will not show your individual answers to your doctor or anyone else involved with your care.

Because you are among only a few patients we are asking to help us, we hope you will take this chance to tell us about your experiences at our clinic. If you have any questions about this survey, please call (TOLL FREE NUMBER). We look forward to your feedback!

Sincerely,

(NAME OF CLINIC REPRESENTATIVE)
(TITLE OF CLINIC REPRESENTATIVE)

TEXT OF REMINDER POSTCARD

(CLINIC NAME)

(DATE)

A couple of weeks ago we sent you a survey about your experiences with health care. Your feedback gives us the information we need to learn how to improve the care we give to our patients.

The survey is completely voluntary and will take about 10 minutes of your time. Your decision about taking part in this survey will not have any effect on your care. The information that you provide will be kept confidential. Your individual answers will not be shared with anyone at the clinic.

If you have any questions about this survey, please call (TOLL FREE NUMBER).

Thank you.

TEXT OF COVER LETTER - SECOND MAIL SURVEY PACKET

(CLINIC NAME)

(DATE)

(PATIENT NAME AND ADDRESS)

Dear (PATIENT NAME),

(CLINIC NAME) is committed to ensuring that you get quality health care at each and every visit. A few weeks ago we invited you to share your experiences with our clinic by taking part in a survey. Because your feedback is important to us we are sending you another copy of the survey.

We are asking our patients about their experiences with a provider that they have recently visited. The survey also asks about your experience making appointments and your experience with clerks and receptionists at the clinic. It will take about 10 minutes of your time.

We are working with Center for the Study of Services (CSS), an independent survey research organization, to conduct this study. The survey is completely voluntary. Your decision about taking part in this survey will not affect your care at (CLINIC NAME). The information that you provide will be kept **completely private and confidential.** CSS will not show your individual answers to your doctor or anyone else involved with your care.

Because you are among only a few patients we are asking to help us, it is very important that you complete the survey. Please return the completed survey in the enclosed postage-paid envelope as soon as possible.

We hope you will take this chance to tell us about your experiences at this clinic. If you have any questions about this survey, please call (TOLL FREE NUMBER). Thank you for helping us to learn how we can improve the care we give to our patients!

Sincerely,

(NAME OF CLINIC REPRESENTATIVE)
(TITLE OF CLINIC REPRESENTATIVE)

Appendix C. CG-CAHPS Visit-Based Survey (modified for use in safety-net clinics)

Your Experiences with Health Care

Your privacy is protected. All information that would let someone identify you or your family will be kept private. RAND will not share your personal information with anyone without your permission, except as required by law. Your responses to this survey will be kept confidential.

Your participation is voluntary. You may choose to answer this survey or not. If you choose not to, this will not affect the health care you get.

What to do when you're done. Once you complete this survey, fold it half and place it in the envelope that was provided, seal the envelope, and put it in the "Your Experiences with Health Care" drop box located in the clinic or drop it in the nearest mailbox.

If you want to know more about this study, please contact (NAME) at (TOLL-FREE NUMBER).

SURVEY INSTRUCTIONS

Answer each question by marking the box to the left of your answer.

You are sometimes told to skip over some questions in this survey. When this happens you will see an arrow with a note that tells you what question to answer next, like this:

☐ Yes ➨ IF YES, GO TO #1

☐ No

Your Clinic

1. Our records show that you got care at the clinic named below.

   (Name of clinic label goes here)

   Is that right?

   ☐ Yes

   ☐ No ➨ IF NO, GO TO #30

2. The questions in this survey booklet will refer to the provider you saw on your most recent visit to this clinic as "this provider."

   Is this the provider you usually see if you need a check-up, want advice about a health problem, or get sick or hurt?

   ☐ Yes

   ☐ No

3. How long have you been going to this provider?

   ☐ Less than 6 months

   ☐ At least 6 months but less than 1 year

   ☐ At least 1 year but less than 3 years

   ☐ At least 3 years but less than 5 years

   ☐ 5 years or more

Your Care in the Last 12 Months

Please answer only for your own health care. Do not include care you got when you stayed overnight in a hospital. Do not include the times you went for dental care visits.

4. In the last 12 months, how many times did you visit this provider to get care for yourself?

☐ None ➨ IF NONE, GO TO #30
☐ 1 time
☐ 2
☐ 3
☐ 4
☐ 5 to 9
☐ 10 or more times

5. In the last 12 months, did you phone this provider's office to get an appointment for an illness, injury, or condition that needed care right away?

☐ Yes
☐ No ➨ IF NO, GO TO #7

6. In the last 12 months, when you phoned this provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you thought you needed?

☐ Never
☐ Sometimes
☐ Usually
☐ Always

7. In the last 12 months, did you make any appointments for a check-up or routine care with this provider?

☐ Yes
☐ No ➨ IF NO, GO TO #9

8. In the last 12 months, when you made an appointment for a check-up or routine care with this provider, how often did you get an appointment as soon as you thought you needed?

☐ Never
☐ Sometimes
☐ Usually
☐ Always

9. In the last 12 months, did you phone this provider's office with a medical question during regular office hours?

☐ Yes
☐ No ➨ IF NO, GO TO #11

10. In the last 12 months, when you phoned this provider's office during regular office hours, how often did you get an answer to your medical question that same day?

☐ Never
☐ Sometimes
☐ Usually
☐ Always

11. In the last 12 months, did you phone this provider's office with a medical question after regular office hours?

☐ Yes
☐ No ➨ IF NO, GO TO #13

12. In the last 12 months, when you phoned this provider's office after regular office hours, how often did you get an answer to your medical question as soon as you needed?

☐ Never
☐ Sometimes
☐ Usually
☐ Always

13. Wait time includes time spent in the waiting room and exam room. In the last 12 months, how often did you see this provider within 15 minutes of your appointment time?

☐ Never

☐ Sometimes

☐ Usually

☐ Always

Your Care During Your Most Recent Visit

These questions ask about your most recent visit with this provider. Please answer only for your own health care.

14. How long has it been since your most recent visit with this provider?

☐ Less than 1 month

☐ At least 1 month but less than 3 months

☐ At least 3 months but less than 6 months

☐ At least 6 months but less than 12 months

☐ 12 months or more

15. Wait time includes time spent in the waiting room and exam room. During your most recent visit, did you see this provider within 15 minutes of your appointment time?

☐ Yes

☐ No

16. During your most recent visit, did this provider order a blood test, x-ray, or other test for you?

☐ Yes

☐ No ➡ IF NO, GO TO #18

17. Did someone from this provider's office follow up to give you those results?

☐ Yes

☐ No

18. During your most recent visit, did this provider explain things in a way that was easy to understand?

☐ Yes, definitely

☐ Yes, somewhat

☐ No

19. During your most recent visit, did this provider listen carefully to you?

☐ Yes, definitely

☐ Yes, somewhat

☐ No

20. During your most recent visit, did you talk with this provider about any health problems or concerns?

☐ Yes

☐ No ➡ IF NO, GO TO #22

21. During your most recent visit, did this provider give you easy to understand instructions about taking care of these health problems or concerns?

☐ Yes, definitely

☐ Yes, somewhat

☐ No

22. During your most recent visit, did this provider seem to know the important information about your medical history?

☐ Yes, definitely

☐ Yes, somewhat

☐ No

23. During your most recent visit, did this provider show respect for what you had to say?

☐ Yes, definitely

☐ Yes, somewhat

☐ No

24. During your most recent visit, did this provider spend enough time with you?

☐ Yes, definitely
☐ Yes, somewhat
☐ No

25. Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider?

☐ 0
☐ 1
☐ 2
☐ 3
☐ 4
☐ 5
☐ 6
☐ 7
☐ 8
☐ 9
☐ 10

26. Would you recommend this provider's office to your family and friends?

☐ Yes, definitely
☐ Yes, somewhat
☐ No

27. Please tell us how this provider's office could have improved the care you received during your visit. (PLEASE PRINT)

Clerks and Receptionists

28. During your most recent visit, were clerks and receptionists at this provider's office as helpful as you thought they should be?

☐ Yes, definitely
☐ Yes, somewhat
☐ No

29. During your most recent visit, did clerks and receptionists at this provider's office treat you with courtesy and respect?

☐ Yes, definitely
☐ Yes, somewhat
☐ No

About You

30. In general, how would you rate your overall health?

☐ Excellent
☐ Very good
☐ Good
☐ Fair
☐ Poor

31. A health provider is a doctor, nurse, or anyone else you would see for health care. In the past 12 months, have you seen a doctor or other health provider 3 or more times for the same condition or problem?

☐ Yes
☐ No ➡ IF NO, GO TO #33

32. Is this a condition or problem that has lasted for at least 3 months? Do not include pregnancy or menopause.

☐ Yes
☐ No

33. Do you now need or take medicine prescribed by a doctor or other health provider? Do not include birth control.

☐ Yes

☐ No ➨ IF NO, GO TO #35

34. Is this medicine to treat a condition that has lasted for at least 3 months? Do not include pregnancy or menopause.

☐ Yes

☐ No

35. What is your age?

☐ 18 to 24

☐ 25 to 34

☐ 35 to 44

☐ 45 to 54

☐ 55 to 64

☐ 65 to 74

☐ 75 or older

36. Are you male or female?

☐ Male

☐ Female

37. What is the highest grade or level of school that you have completed?

☐ 8th grade or less

☐ Some high school, but did not graduate

☐ High school graduate or GED

☐ Some college or 2-year degree

☐ 4-year college graduate

☐ More than 4-year college degree

38. Are you of Hispanic or Latino origin or descent?

☐ Yes, Hispanic or Latino

☐ No, not Hispanic or Latino

39. What is your race? Please mark one or more.

☐ White

☐ Black or African-American

☐ Asian

☐ Native Hawaiian or Other Pacific Islander

☐ American Indian or Alaska Native

☐ Other

40. Did someone help you complete this survey?

☐ Yes

☐ No ➨ THANK YOU.
PLEASE RETURN THE COMPLETED SURVEY IN THE CLINIC DROP BOX.

41. How did that person help you? Please mark one or more.

☐ Read the questions to me

☐ Wrote down the answers I gave

☐ Answered the questions for me

☐ Translated the questions into my language

☐ Helped in some other way (PLEASE PRINT)

____

____

____

____

____

THANK YOU.
PLEASE RETURN THE COMPLETED SURVEY USING THE ENVELOPE WE PROVIDED. YOU CAN PLACE IT IN THE CLINIC DROP BOX OR THE NEAREST MAILBOX.

Appendix D. Survey Score Data by Mode of Administration (Mail Versus In-Office)

Table 8, below, compares the CG-CAHPS scores calculated from the survey data by mode of administration (mail and in-clinic handout). The figures are pooled across all six clinics and compared with the overall scores derived from CG-CAHPS data in the national CAHPS database, and also with scores derived from clinics and practices in the western United States.[13]

These are "top box" scores — that is, the percent of survey participants reporting the most positive response for each reporting composite, experience of care question, or rating question. The scores derived from the CG-CAHPS patient experience data for the six safety-net clinics participating in this project are well below the national and regional benchmarks.

In general, patients in this project reported more positive experience with the provider and the clinic staff than with access to care. Of particular note, the rate of follow-up to communicate test results is troubling as it may be an indicator of poor continuity of care (and may also be linked to the quality of the record keeping and documentation of contact information for safety-net patients).

Table 8. Percentile Top Box Scores, Overall Comparisons

COMPOSITE/ITEM	CAHPS DB OVERALL	WEST REGION	6 CLINICS MAIL*	6 CLINICS IN-OFFICE*
Getting Timely Appointments, Care, and Information	**59%**	**51%**	**36%**	**34%**
Got appointment for urgent care as soon as needed	64%	55%	44%	38%
Got appointment for check-up or routine care as soon as needed	68%	60%	47%	44%
Got answer to phone question during regular office hours on same day	59%	49%	36%	38%
Got answer to phone question after hours as soon as needed	59%	53%	34%	32%
Wait time to be seen within 15 minutes of appointment time	43%	37%	18%	17%
How Well Providers Communicate With Patients	**90%**	**88%**	**80%**	**78%**
Provider explained things clearly	91%	89%	77%	80%
Provider listened carefully	92%	91%	83%	83%
Provider gave easy-to-understand instructions	89%	87%	80%	78%
Provider knew important information about medical history	83%	81%	77%	70%
Provider showed respect	94%	92%	87%	87%
Provider spent enough time	90%	87%	74%	69%
Helpful, Courteous, and Respectful Office Staff	**90%**	**85%**	**77%**	**76%**
Office staff was helpful	88%	82%	73%	73%
Office staff showed courtesy and respect	92%	88%	80%	78%
Follow-up on Test Results	**85%**	**73%**	**52%**	**60%**
Patients' Rating of the Doctor	**75%**	**74%**	**65%**	**59%**
Willingness to Recommend	**88%**	**86%**	**77%**	**72%**

*Reported scores are below 25th percentile scores CAHPS DB overall

Source: Project team.

Table 9, below, presents clinic-level top box CG-CAHPS scores by mode of survey administration in comparison to overall scores derived from national CG-CAHPS data.

Table 9. Percentile Top Box Scores, by Clinic and Mode

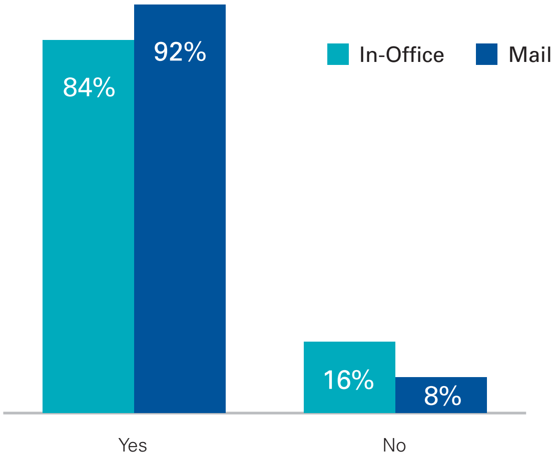
COMPOSITE/ITEM	CAHPS DB OVERALL	CLINIC 1		CLINIC 2		CLINIC 3		CLINIC 4		CLINIC 5		CLINIC 6	
		MAIL	IN-OFFICE	MAIL	IN-OFFICE	MAIL	IN-OFFICE	MAIL	IN-OFFICE	MAIL	IN-OFFICE	MAIL	IN-OFFICE
Getting Timely Appointments, Care, and Information	**59%**	**47%**	**38%**	**30%**	**33%**	**31%**	**37%**	**39%**	**49%**	**29%**	**23%**	**31%**	**28%**
Got appointment for urgent care as soon as needed	64%	61%	51%	38%	40%	41%	39%	47%	57%	30%	23%	37%	29%
Got appointment for check-up or routine care as soon as needed	68%	68%	54%	40%	46%	48%	47%	46%	63%	34%	26%	38%	34%
Got answer to phone question during regular office hours on same day	59%	44%	40%	38%	32%	40%	46%	38%	46%	21%	31%	38%	36%
Got answer to phone question after hours as soon as needed	59%	40%	38%	16%	32%	10%	36%	40%	47%	41%	22%	26%	27%
Wait time to be seen within 15 minutes of appointment time	43%	19%	9%	16%	14%	14%	18%	22%	32%	19%	12%	17%	17%
How Well Providers Communicate With Patients	**90%**	**82%**	**77%**	**77%**	**75%**	**79%**	**75%**	**80%**	**87%**	**84%**	**77%**	**77%**	**77%**
Provider explained things clearly	91%	81%	82%	72%	73%	78%	80%	77%	89%	79%	79%	74%	74%
Provider listened carefully	92%	85%	82%	82%	78%	81%	79%	84%	89%	88%	84%	80%	84%
Provider gave easy-to-understand instructions	89%	82%	76%	78%	76%	79%	78%	79%	86%	88%	76%	75%	77%
Provider knew important information about medical history	83%	79%	72%	71%	67%	78%	66%	76%	82%	78%	66%	76%	72%
Provider showed respect	94%	89%	88%	83%	85%	89%	82%	88%	92%	88%	90%	85%	88%
Provider spent enough time	90%	77%	65%	75%	72%	69%	64%	75%	85%	81%	66%	69%	67%
Helpful, Courteous, and Respectful Office Staff	**90%**	**78%**	**72%**	**68%**	**65%**	**74%**	**80%**	**82%**	**87%**	**77%**	**71%**	**74%**	**74%**
Office staff was helpful	88%	76%	70%	65%	61%	72%	78%	79%	85%	72%	68%	70%	71%
Office staff showed courtesy and respect	92%	79%	75%	72%	69%	76%	82%	85%	90%	82%	74%	78%	78%
Follow-up on Test Results	**85%**	**55%**	**69%**	**49%**	**61%**	**34%**	**56%**	**60%**	**70%**	**52%**	**61%**	**58%**	**49%**
Patients' Rating of the Provider	**75%**	**61%**	**44%**	**68%**	**64%**	**60%**	**57%**	**66%**	**73%**	**65%**	**59%**	**67%**	**63%**
Willingness to Recommend	**88%**	**76%**	**77%**	**73%**	**73%**	**76%**	**72%**	**82%**	**82%**	**79%**	**63%**	**73%**	**69%**

Source: Project team.

Appendix E. Survey Patient Characteristics by Mode of Administration

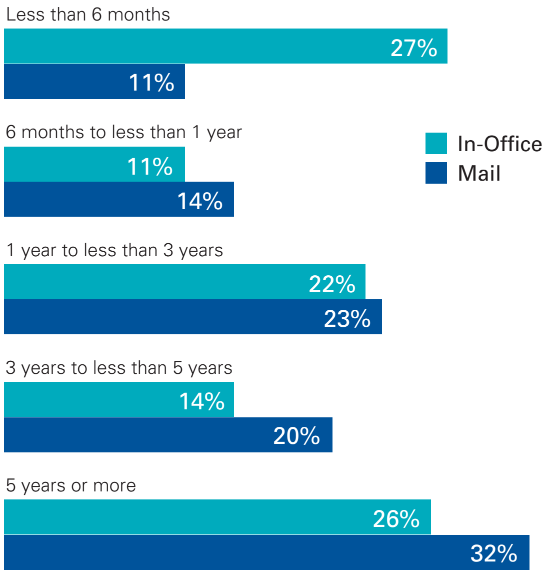
Participants in the mail survey had more established relationships with the primary care providers seen during their visit. In this context, an established relationship is defined in terms of: whether this is the provider they would usually see for a check-up, advice, an illness, or injury (question 2 on the survey); how long the participant has been seeing this particular provider (question 3); and number of visits to the provider in the last 12 months (question 4).

Question 2. Usually See This Provider



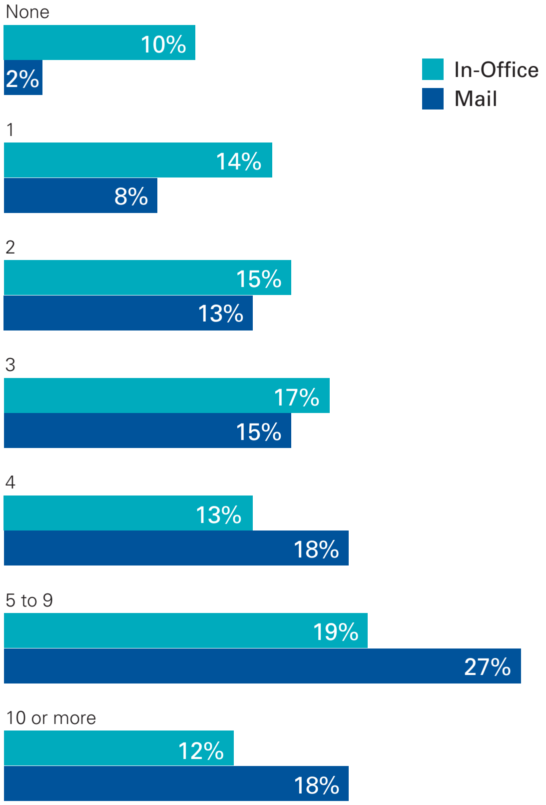
Source: Project team.

Question 3. Duration of Provider Relationship



Source: Project team.

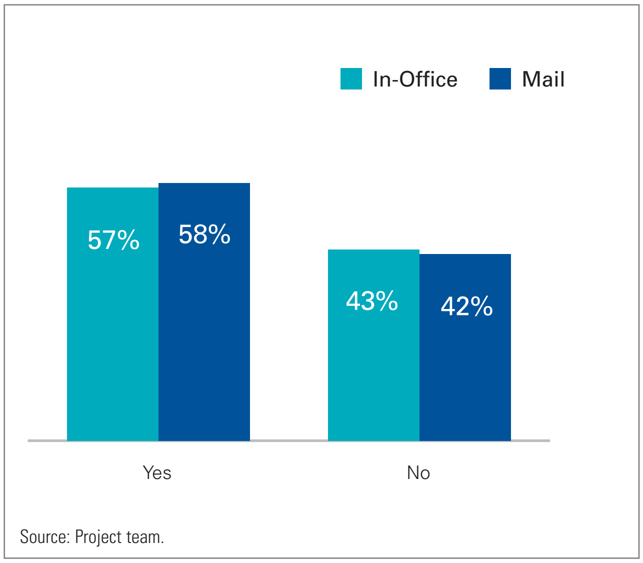
Question 4. Visits to Provider in Last 12 Months



Source: Project team.

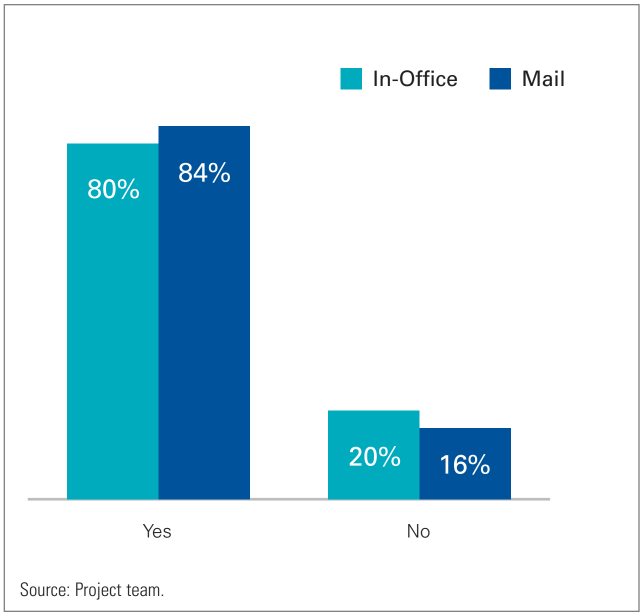
Participants in the in-office and mail samples reported similar rates of appointment-setting (survey questions 5 and 7) with their primary care provider.

Question 5. Made Urgent Care Appointments with This Provider in Past 12 Months



Source: Project team.

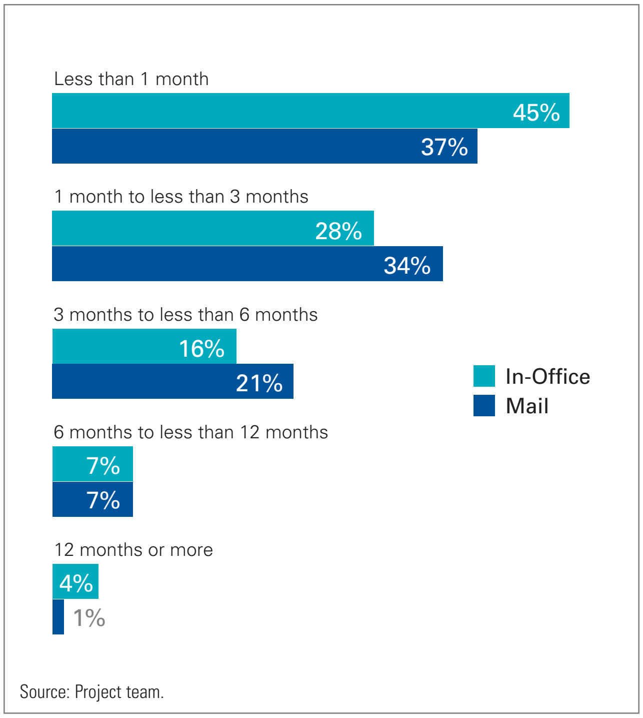
Question 7. Made Routine Appointments with This Provider in Past 12 Months



Source: Project team.

Participant reports of the most recent visit to the primary care provider (survey question 14) are consistent with the mode of survey administration. That is, the fact that mail survey respondents were more likely to have made prior appointments with this provider reflects the longer duration of the relationship reported by the mail survey sample. The in-office sample trends to a visit less than one month ago and the mail survey sample trends to a visit within the last three months.

Question 14. Time Since Most Recent Visit to Provider

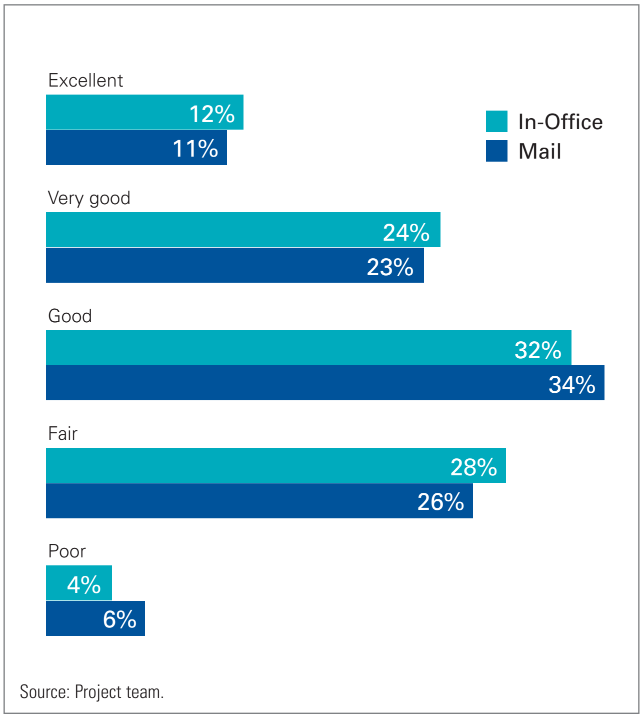


Source: Project team.

The self-reported rating of overall health (survey question 30) is consistent with the higher percentage of participants with chronic conditions in the mail survey sample.

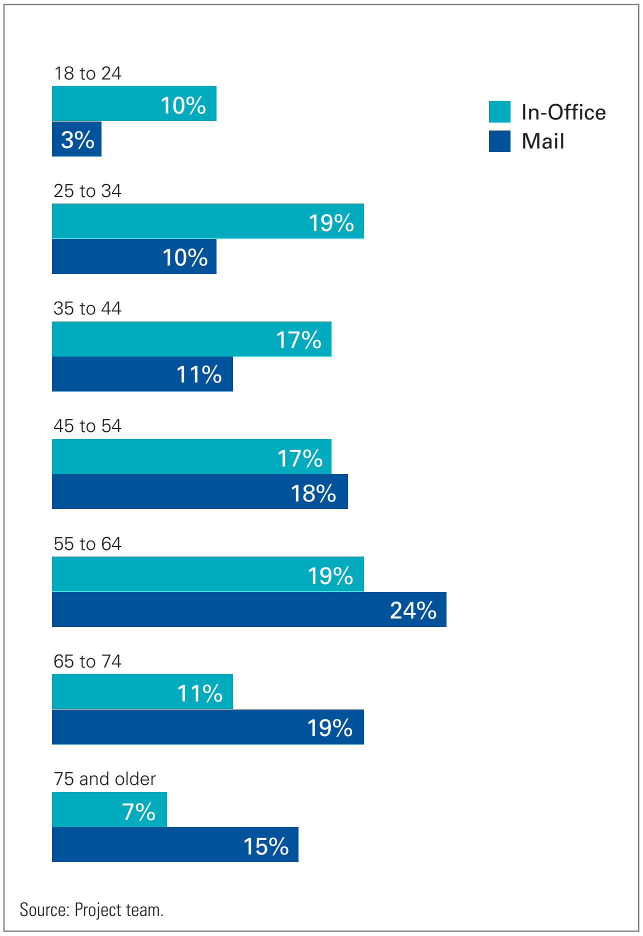
Mail survey participants are older than in-office survey participants (survey question 35), but have similar distributions for sex and education levels (questions 36 and 37).

Question 30. Overall Health Rating



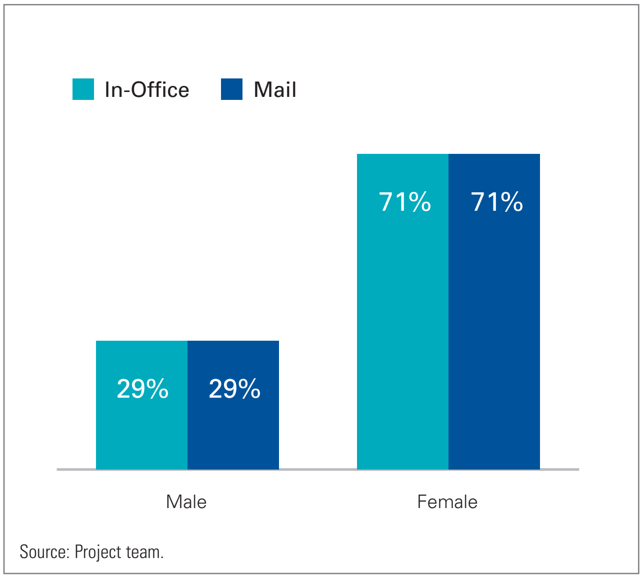
Source: Project team.

Question 35. Participant Age



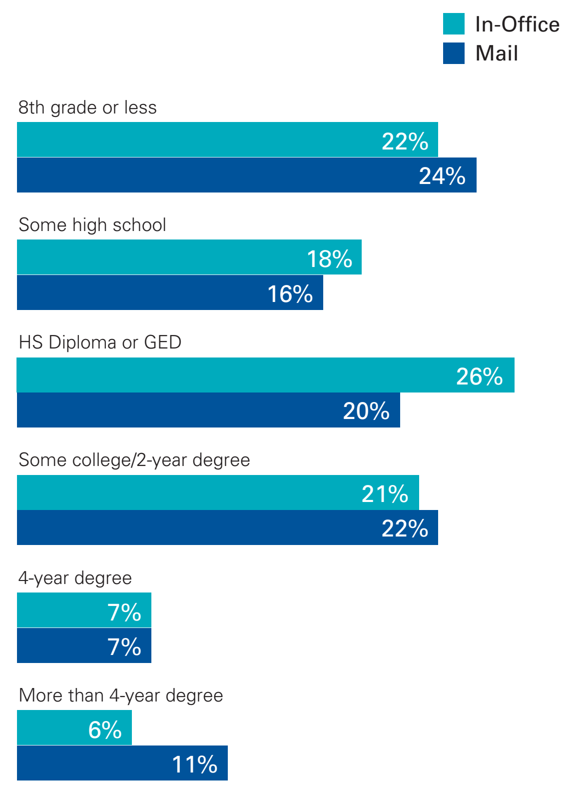
Source: Project team.

Question 36. Sex of Participant



Source: Project team.

Question 37. Participant Education



Source: Project team.

Endnotes

1. US Department of Health and Human Services, Agency for Health Care Research and Quality, CAHPS Overview, www.cahps.ahrq.gov (updated 7/9/2009); L.A. Giordano, et al, "Development, Implementation and Public Reporting of the HCAHPS Survey," *Medical Care Research Review* Vol. 67 (1) (February 2010): 27–37; A. K. Jha, et al., "Patient's Perception of Hospital Care in the United States," *New England Journal of Medicine* 35 (18) (October 2008): 1921–31.
2. *Employer Health Benefits 1999 Annual Survey,* Kaiser Family Foundation, Menlo Park, CA and Health Research and Educational Trust, Chicago, IL (1999).
3. US Department of Health and Human Services, 2004.
4. Giordano, et al., "Development, Implementation and Public Reporting"; Jha, et al. "Patient's Perception."
5. K.E. Zuckerman et al., "Patient Experience of Care in the Safety Net: Current Efforts and Challenges." *Journal of Ambulatory Care Management* (forthcoming, January/March 2012).
6. M.P. Anastario, et al. "A Randomized Trial Comparing Mail versus In-Office Distribution of the CAHPS Clinician and Group Survey," *Health Services Research* 45 (5p1): 1345–59 (October 2010).
7. Megan's Law is a California state law that allows employers access to a state-wide registry that includes offenders convicted of crimes against children and crimes that include sexual violence.
8. Calculated as the number of returns divided by the total number of patients approached minus ineligible patients.
9. US Department of Health and Human Services, Agency for Health Care Research and Quality, CAHPS Survey and Reporting Kits, www.cahps.ahrq.gov.
10. Calculated as the number of returns divided by the total of the sample size minus the undeliverables.
11. Katja Lozar Manfreda and Vasja Vehovar. "Internet Surveys," *International Handbook of Survey Methodology:* 264–85, Edith D. de Leeuw, Joop J. Hox, and Don A. Dillman, eds. (New York: Psychology Press, 2008).
12. US Department of Health and Human Services, Agency for Health Care Research and Quality, The CAHPS Improvement Guide, www.cahps.ahrq.gov.
13. Alaska, Arizona, California, Colorado, Guam, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, and Wyoming.

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