Aligning Forces for Quality | Improving Health & Health Care in Communities Across America

Robert Wood Johnson Foundation

HOW TO

Leveraging Existing Patient Survey Efforts: A Decision Guide

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One of the Robert Wood Johnson Foundation's expectations for the *Aligning Forces for Quality* communities (the Alliances) is the public reporting of standardized measures of patients' experiences with ambulatory care from the CAHPS Clinician & Group Survey (CG-CAHPS). One way to satisfy this requirement is to take advantage of existing but separate patient surveying efforts in the community and combine the results to produce a community-level public report. This "leveraged approach," which has unique benefits and challenges, requires many decisions along the way to aggregate the results of the CG-CAHPS Survey appropriately for public reporting. This decision guide offers a detailed discussion of the issues and choices stakeholders typically will face when using the leveraged approach. It is designed to inform leaders of health systems and medical practices in the community and the Alliance staff working with them to support the decision-making process. There are no right and wrong answers, and the best approach for one community may not work for another. While the considerations are similar, each community's leveraged approach will be different depending on the current survey activities and preferences of stakeholders.

Issues addressed in this guide include:

- » Understanding the Current Survey Environment
- » What Version of the Survey to Use
- » How Often to Sample Patients
- » The Level at Which to Collect and Report Data
- » Which Populations to Survey
- » How to Administer the Survey
- » How to Prepare Data for Public Reporting
- » How These Decisions Play Out in Three Alliances

About Aligning Forces for Quality

Aligning Forces for Quality (AF4Q) is the Robert Wood Johnson Foundation's signature effort to lift the overall quality of health care in targeted communities, as well as reduce racial and ethnic disparities and provide real models for national reform. The Foundation's commitment to improve health care in 16 AF4Q communities is the largest effort of its kind ever undertaken by a U.S. philanthropy. AF4Q asks the people who get care, give care and pay for care to work together to improve the quality and value of care delivered locally. The Center for Health Care Quality in the Department of Health Policy at George Washington University School of Public Health and Health Services serves as the national program office. Learn more about AF4Q at www.forces4quality.org. Learn more about RWJF's efforts to improve quality and equality of care at www.rwjf.org/goto/af4q.

About the Author

The Shaller Consulting Group provides technical assistance to *Aligning Forces for Quality* by helping regional Alliances support patient experience measurement and improvement. This paper was written by Carla Zema, PhD, a member of the technical assistance team.

Unsure about terminology? Readers who are not familiar with the details of surveying patients may find it helpful to refer to the *Glossary: Patient Experience of Care* for definitions of some of the terms used in this guide.

Understanding the Current Survey Environment

To decide whether to move forward using the centralized or leveraged approach, Alliances typically reach out to local health systems and medical groups to identify what, if any, patient experience surveying activities are taking place already. In addition to determining whether or not practices are surveying patients, the Alliance's survey team needs to gather the following details about current surveying activities:

- What surveys are health care organizations using? If a CAHPS survey is in use, which version is it?
- How frequently is sampling for the survey taking place (e.g., continuously or once annually)?
- What is the level of data collection (i.e., provider, practice site/clinic, group)?
- Which patient populations are being surveyed? Are any populations excluded? If so, why?
- How is the survey being administered (e.g., by mail, telephone, email, or some combination)?
- Are other initiatives or requirements driving the survey activity (e.g., state requirements, payer initiatives, or practice recognition programs, demonstration projects)? (See box at right.)
- How are data reported? Are results available publicly? If not, why?
- Which survey vendor companies are involved, if any?

Once this information is gathered, the process of reconciling differences in surveying activities across medical practices can begin. The tasks associated with surveying patients are interrelated, so decisions regarding one aspect of surveying may have an impact on other aspects. For example, differences in the level of data collection will influence what needs to be done to prepare the data for public reporting.

Two Approaches to Implementing the CAHPS Clinician & Group Survey

This decision guide builds on an earlier brief, *Leverage Existing Efforts or Use a Centralized Approach?,* which discusses two methods for implementing the CAHPS Clinician & Group Survey (CG-CAHPS) in a community:

- The **centralized approach** refers to implementing the survey community wide, where a single vendor administers a common survey to all practices.
- The **leveraged approach** refers to incorporating a common set of core CG-CAHPS questions into the survey that each practice is using already.

Other External Initiatives and Requirements

Some medical practices in Alliance communities are participating in other survey-related initiatives or have other external requirements for patient experience surveys. Examples of organizations that have called for use of the CG-CAHPS Survey are the Centers for Medicare & Medicaid Services (CMS), National Committee for Quality Assurance (NCQA), American Board of Medical Specialties (ABMS), state agencies, and insurers. Their requirements continue to evolve rapidly and expand, and some are still in the pilot or testing phases. But these demonstrations likely will have a significant impact on the use of the CG-CAHPS Survey in the near future.

These requirements can help motivate practices to collect and report patient experience information. However, to minimize the burden on health systems and practices, stakeholders must work together to align requirements as much as possible.

For information on national external requirements that practices may face, read *Forces Driving Implementation of the CAHPS® Clinician & Group Survey*.

What Version of the Survey to Use

To meet diverse user needs, the CG-CAHPS Survey has three versions: 12-Month, Visit, and Patient-Centered Medical Home (PCMH). While there are some differences across the versions, they all include the same set of "core" questions, or items, so the results measure the same concepts across all versions of the survey. The only difference is the timeframe for which some of the concepts are measured. Table 1 summarizes the differences in the CG-CAHPS Survey versions.

Table 1. Differences in CG-CAHPS Survey Versions

	12-Month	Visit	PCMH
Description	Asks about experiences with ambulatory care in the last 12 months	Some items ask about experiences in the last 12 months; others ask about the most recent visit	Same as the 12-Month version, plus additional items to measure medical home concepts not covered by the core items
Number of questions in adult survey	34 items	47 items	52 items
Timeframe by domain:			
Access	12 months	12 months	12 months
Provider communication	12 months	Most recent visit	12 months
Office staff	12 months	Most recent visit	12 months
Provider rating	Not time-specific	Not time-specific	Not time-specific
Additional domains:			
Recommend provider	Can be added	Included	Included
Attention to mental health	Can be added	Can be added	Included
Self-management support	Can be added	Can be added	Included
Shared decision-making	Can be added	Can be added	Included

For the purposes of public reporting, the 12-Month and PCMH versions of the survey are completely compatible; the PCMH version is simply the 12-Month version plus some additional items. Therefore, the use of different survey versions matters only if some practices are using the 12-Month or PCMH version while others are using the Visit version.

The choice of survey version is highly connected with sampling strategy, use of the results, and other possible external initiatives and requirements in the community. Practices that survey primarily to support their own internal quality improvement (QI) efforts are more likely to use the Visit version, while practices that are surveying to meet other external initiatives or requirements are more likely to use the 12-Month or PCMH version. External stakeholders that require or are conducting pilot testing for future requirements of patient experience surveys, such as the Centers for Medicare & Medicaid Services (CMS) and the National Committee for Quality Assurance (NCQA), generally prefer the 12-Month or PCMH versions over the Visit survey.

Considerations for Reconciling the Use of Different Survey Versions

If practices are using different versions of the CG-CAHPS Survey, different patient experience surveys, or not surveying at all, Alliances could work with them to consider three alternative paths.

1. **Practices change from their current survey to the CG-CAHPS Survey version selected by the Alliance**. Practices that are using a different survey, such as a proprietary survey, or those not yet surveying may be willing to switch to the particular CG-CAHPS Survey version selected. In some cases, they may come to appreciate the benefits of using a CAHPS survey (read: The Benefits of CAHPS®). For example, one benefit of using the CG-CAHPS Survey is the availability of benchmarks from the CAHPS Database, which is the national repository of CG-CAHPS data. This free resource sponsored and funded by the Agency for Healthcare Research and Quality (AHRQ) provides data that organizations can use for benchmarking, quality improvement (QI) efforts, and public reporting.

Others may anticipate that the CG-CAHPS Survey will evolve into an industry standard for ambulatory care, much in the same way other CAHPS products, such as the CAHPS Health Plan Survey and Hospital Survey (HCAHPS), have done.

2. **Practices conduct a one-time administration of the CG-CAHPS Survey.** Practices not using the survey version chosen for the Alliance's community-wide effort may be willing to administer the survey once to meet the reporting requirement. Some may choose to do so in support of the community's collaborative effort, while others may be motivated to gain experience with a survey that could become a future requirement for them. This willingness also can apply to practices that are not surveying at all. They may be interested in gaining experience through a one-time administration before making an organizational commitment to ongoing surveying. Moreover, practices that are not surveying patients currently may be able to do so as part of the community-wide initiative at a cost that would be less than if they were to initiate their own separate surveying effort.

   For practices that currently use the Visit version, a one-time administration of the 12-Month or PCMH version of the survey can be accomplished in two ways:

   - **By temporarily suspending current surveying efforts**. Practices that suspend current survey efforts may be concerned about the impact on trending, which may affect their ability to track the effects of quality improvement efforts, or that the use of the 12-Month Survey will not provide them with actionable information. Practices may be willing to use the 12-Month or PCMH version for internal reporting once they become familiar with the overlap in content despite the differing timeframes, as well as the resources that are available to support improvement for all CG-CAHPS versions, including the 12-Month or PCMH versions.

   - **By adding questions from the 12-Month version to the Visit version**. If practices choose to expand their existing survey, they must have a sufficient number of patients in their sampling frame (i.e., the list of patients eligible to receive a survey) to meet both sampling requirements. In this case, the sample needed for the public report at the community level should be drawn first to ensure comparability of survey results across all participating practices. Research is being conducted currently to examine the comparability of the survey version using this approach.

Aligning Survey Versions: An Illustrative Example

An Alliance is working with four medical groups that have agreed to publicly report quality measures for AF4Q. Two of these groups are already conducting patient experience surveys using the Visit version, one uses the PCMH version, and another is not surveying at all. The medical group that is using the PCMH version participates in the NCQA PCMH Recognition Program.

After several discussions with the medical groups, the Alliance has decided to use the 12-Month version for publicly reporting patient experience measures. One of the medical groups currently using the Visit version is interested in seeking recognition through the NCQA PCMH program; as a result, that group is willing to conduct the 12-Month Survey and will add supplemental items to make it the PCMH version. The other medical group that is currently using the Visit version and the medical group that is not surveying are willing to conduct the 12-Month version for a one-time administration because they would like to gain experience with the survey in anticipation of a future reporting requirement.

3. **A public report is created from a subset of the questions from practices' surveys.** Despite the best of intentions, the Alliance and its stakeholders may not reach an agreement to field a common survey version. If practices are using different versions of the CG-CAHPS surveys, the Alliance can opt to publicly report only the Access measure, which is the same across all versions. While this does not technically meet the AF4Q requirement for community-wide patient experience reporting, this initial step toward satisfying the requirement moves the community forward and supports continued collaboration. Discussions among stakeholders about expanding the reporting of survey results in the future can then continue.

How Often To Sample Patients

Sampling involves generating a list of all patients who are eligible to receive the survey. This list is known as the sampling frame. From this sample frame, a selection of patients (known as the sample) is drawn randomly. These selected patients will be the ones surveyed. How often the sample frame is generated tends to drive how it is constructed, which can affect the comparability of survey results.

There are two general timeframes for sampling: continuous sampling and point-in-time sampling.

- With ***continuous sampling***, practices send their list of patients to their survey vendor on an ongoing basis. This data submission can occur as often as "real time," with data feeds on a daily, weekly, or monthly basis. The sampling frame becomes a rolling file that gets refreshed each time new data are added and generally contains visits covering approximately three to four months. If, for example, data are added monthly, the data from the oldest month in the file are replaced with the new month's data.

For sampling, a portion of the overall annual sampling target based on the number of completed surveys needed is pulled on a continuous basis. (See Table 2 for sample size requirements.) For example, if the overall goal is to obtain 300 completed surveys per year, the vendor will send the survey to a sample of at least 70 people each month (assuming a 35 percent response rate) to achieve a target of 25 completed surveys per month (i.e., 300 distributed equally across 12 months).

- With ***point-in-time sampling***, practices send a sampling frame to their vendor at a particular point in time for visits that occurred over the past 12 months, six months, or quarter. Point-in-time sampling tends to cover visits that occurred over a longer time period than continuous sampling.

The sample is pulled once for the entire timeframe. For example, a survey that is administered once per year would have the sample frame generated based on the visits that occurred over the past 12 months, and the entire sample for the year would be pulled at the same time.

Unique Records Within the Sampling Frame

It is possible to compare results from continuous sampling to results from a point-in-time approach. The unique records within the sampling frame are what make these approaches different. In continuous sampling, unique records tend be unique visits, meaning each record in the sampling frame represents a visit, and patients with multiple visits have multiple records within the sampling frame. Consequently, patients with more visits appear in the sampling frame more often and have a higher probability of being sampled. Point-in-time sampling generally tends to be at the patient level, meaning each record in the sampling frame represents a patient who has been seen by the practice, regardless of how many times. Each patient has the same probability of being sampled regardless of the number of visits.

To compare results from these two sampling methods, they must be made equivalent. One option is to roll up the visit-level sampling frames into patient-level files for sampling. Another is to make the patient-level sampling frames equivalent to visit-level files by including the number of visits the patient had in the file. Patient records can then be weighted using the number of visits, thus making the sampling of a visit-level file and a weighted patient-level file equivalent.

At this time, it is not known whether or how these different approaches affect the comparability of the results. The research team responsible for the CAHPS surveys, known as the CAHPS Consortium, currently is investigating the equivalency of continuous sampling and point-in-time sampling; based on that investigation, the Consortium will develop guidance on a standardized method for using these different approaches to obtain comparable results. In the interim, Alliances that identify differences in sampling approaches within the community may contact the Shaller Consulting Group for advice on how to proceed.

Sampling Timeframe

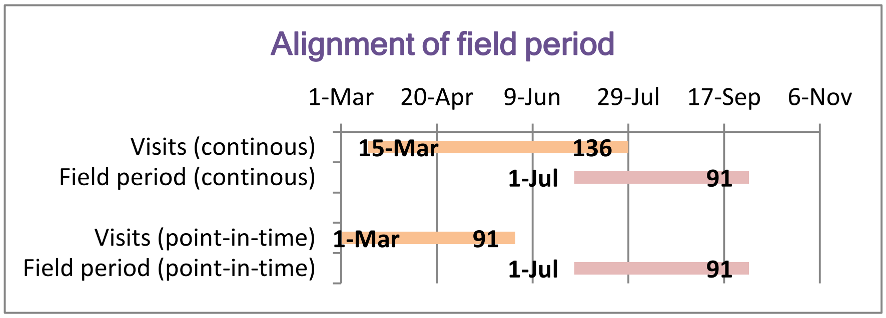
The timeframe covered by the sampling frame, and thus the time period being measured by the administered survey, also differs depending on the sampling approaches. To align with the community-level reporting, practices administering a

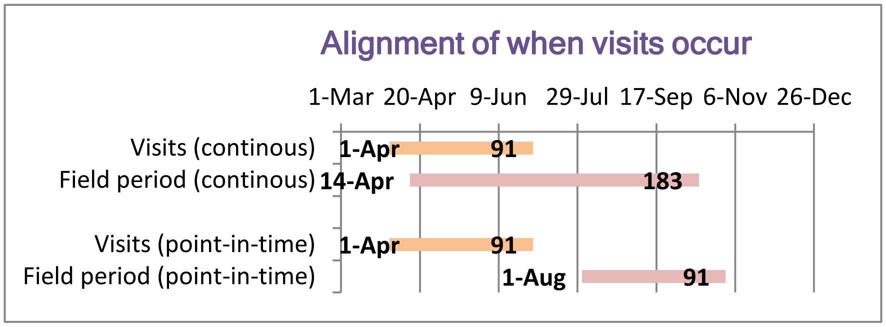
Does the Time of Year Matter?

At this time, there is no definitive evidence of differences in patient experience based on the time of year. Are patients' experiences with a provider and the office basically the same no matter the time of the year? Or do experiences vary seasonally because the types of visits change throughout the year? For example, in pediatric practices, summer months tend to have more preventive visits such as sports physicals, while winter months are dominated by visits for colds and flu. Practices that survey continuously throughout the year have anecdotally reported subtle fluctuations in their patient experience results at different times of the year; however, a formal study to confirm this hypothesis has not been conducted.

survey using continuous sampling may need to make slight modifications in how the sampling frame is generated and implement those changes for the sampling frame that will be generated from that point forward. (Note: It is possible for organizations with advanced information systems to add information to the records that are already part of the continuous sampling frame.)

Figure 1. Examples of sampling timeframe and field period alignment





If practices in the community are using the two sampling methods, it is feasible to align the timeframe for the sampling frames within the leveraged approach. Aligning the sampling timeframe means that the sampling frame would have patient visits from the same time period. Because of the way that the sampling frame is generated, practices that use continuous sampling would need to begin data collection first followed by practices using a point-in-time approach. However, if the timeframe for the sampling frame is aligned, the timeframe for when the survey is administered (i.e., the field period) will be different. The field period refers to the months when the surveys are actually being sent to and completed by patients. When practices are using different sampling approaches, there is no way to align the field period and the sampling timeframe simultaneously. Figure 1 shows two potential scenarios that illustrate the differences between the sampling timeframe (i.e., when the visits actually occur) and the field period for continuous and point-in-time sampling. In the first scenario, the timeframes for the visits are aligned; the second scenario aligns the field periods.

As Figure 1 indicates, aligning the timeframe when the visits occur results in differences in the field period, and aligning the field period means the timeframe for the visits in the sampling frame are different. Moreover, many scenarios are possible because a sampling timeframe depends on a number of factors, such as:

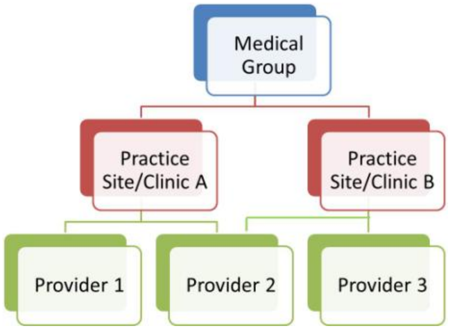
- How quickly the sampling frame can be generated after the visit occurs. This can be as soon as the next day and up to more than a month later.
- Practice volume. How long does it take for a practice to generate the number of visits to meet the minimum sampling requirements?
- How long patients are retained in a continuous sampling frame. With continuous sampling frames, patients generally are retained in the sampling frame for a specified amount of time, such as a quarter. If patients are not sampled in the quarter following their visit, they are dropped from the sampling frame.
- The ability of the organization to regenerate a sampling frame. If additional information is necessary in the sampling frame for the community initiative, organizations may be able to regenerate their continuous sampling frame and add the information retrospectively. If not, a greater amount of time may be necessary to build the appropriate volume of visits for sampling.

Given the lack of definitive evidence on the impact of these differences, stakeholders may not mind the differences in the timeframes. However, a community should discuss these factors when pursuing a leveraged approach.

How to Think About Levels

For the purposes of this decision guide, site/clinic level refers to a single geographic location. The medical group level can include multiple sites/clinics. These terms often are used differently by stakeholders. The medical group is considered the "highest" level, with the individual provider being the "lowest" level. Figure 2 illustrates the relationship between these terms. In this example, the medical group has two practice sites/clinics: Practice site A has two providers, Provider 1 and Provider 2, and Practice site B has Provider 2 and Provider 3. Note that Provider 2 sees patients at both Practice site A and B.

Figure 2. Example of levels of data collection and reporting



The Level at Which to Collect and Report Data

Communities need to decide at what level they will report results. When using the leveraged approach, the level of data collection may be different than the level of reporting.

Research has shown that consumers generally prefer provider-level information when comparing alternative sources of health care,[i] and many experts agree that provider-level information also is very useful for supporting internal quality improvement efforts.[ii] However, reporting data at the level of the individual provider requires collecting data at that level as well. Because data collection at the individual provider level has the largest sample size requirements (see table), it is the most costly and difficult to implement community wide.

While patients and providers agree that provider-level information is useful for many purposes, patient experience information at the practice-site level also can be very useful for assessing aspects of care delivery that are more "team-based" than dependent on individual providers. Examples of team-based patient experience topics include access to appointments and information, courtesy and responsiveness of office staff, and coordination of care. Therefore, communities that choose to publicly report patient experience information at the practice site level are still providing important and useful information, while at the same time laying significant technical and political groundwork that will be helpful for achieving provider-level reporting at some future point.

Data collected at a higher level, such as practice site level, cannot be reported reliably at a lower level, such as the provider level. Unless practices are willing to increase sample sizes for data collection at a lower level, the community will be limited by the highest level of data collected by participating organizations for public reporting. For example, if one organization surveys at the provider level, another at the site/clinic level, and a third at the group level, public reporting can be only at the group level.

On the other hand, data collected at a lower level can always be "rolled up" or aggregated to a higher level, such as the site/clinic or group, for reporting purposes. Options

Table 2. Sample size requirements based on level of data collection

The level at which the results are reported affects the sample size required for the survey.

	Required # of Completed Surveys*	Estimated Sample Size**
Provider level sampling		
For each provider	45	129
Site level sampling based on number of providers at site		
1	50	143
2	100	286
3	150	429
4-9	175	500
10-13	200	571
14-19	250	714
20+	300	857
Group practice level sampling		
For each group	300	857

*Based on AHRQ guidelines for practice site sampling
**Based on an estimated 35% response rate

for aggregating data to a higher level include equal weighting or proportional weighting:

- *Equal weighting*—Results across providers are averaged so each provider contributes equally to the average, regardless of patient volume.
- *Proportional weighting*—Provider results are weighted according to some measure, such as patient visit volume, so providers who see more patients contribute more toward the average.

There is no right or wrong answer when deciding on weighting. Most often, stakeholder opinions drive the type of weighting used. If the stakeholders think all providers should be represented equally, equal weighting is the right option for your community. However, if they think site/clinic results should reflect the volume of patients seen by providers, proportional weighting makes sense for your community. If proportional weighting is chosen, all sites will need to provide additional information, such as patient visit volumes by provider.

Which Populations to Survey

For the purposes of public reporting, comparable patient populations must be included in the survey results.

Adults Only vs. Adults and Children

The Alliance and its stakeholders must determine whether the survey will be administered to adults (ages 18 and older) or to both adults and parents of children. Excluding children means site/clinics and providers that serve only pediatric populations would not be included in the data collection or the report.

Communities that decide to include children should use a child version of the CG-CAHPS Survey. The Child Survey is completed by a parent or guardian on behalf of the child. The survey also includes specific items to determine if the child was able to communicate with the provider and if the respondent accompanied the child in the exam room during the visit. It is not appropriate to use the Adult Survey for children. Practices that serve both adult and pediatric patients should use the versions appropriate for each patient population.

Chronic Condition vs. General Population

While most practices draw samples from their entire patient population, some practices target specific groups of patients, such as those with chronic conditions. To ensure the comparability of results, the survey population should represent the general patient population of the practice. Specific subgroups should not be the only patients in the survey sample. If some organizations are interested in results for specific subgroups, they can use oversampling methods to supplement the sample of the general population for subgroup analyses.

Mode-Specific Subgroups

In some cases, the survey administration mode may limit the representativeness of the patient population. (See discussion of modes below.) The most common example is email. At this time, practices that use email as the only mode of survey administration are unlikely to capture a representative sample of the patient population.

How to Administer the Survey

The recommended administration modes (that is, ways to administer surveys) are mail, telephone, mail-telephone mixed mode, and email-mail or email-telephone mixed mode. A mixed mode is a combination of modes where one mode is followed by another. For example, an email-mail mixed mode would mean a survey is administered first online via an email invitation and then followed by a mailed survey for anyone not reached via email. Before recommending a mode of administration, the CAHPS Consortium confirms sufficient testing has been performed to evaluate potential mode effects—differences in survey results based solely on the mode of administration. To preserve the comparability of the results, practices must use comparable modes, but not necessarily the same modes.

There are other administration modes that are used for patient surveys. For the HCAHPS Survey, the Centers for Medicare & Medicaid Services also include active Interactive Voice Recognition (IVR), an automated telephone survey, as a recommended administration mode, although a mode adjustment must be made during analysis. The CAHPS Consortium continues to evaluate the use of IVR but has not determined it to be a comparable mode at this time.

In an effort to reduce survey administration costs, many practices are turning to administering patient surveys by email. This option is especially attractive to practices that communicate with patients through an online patient portal. Unfortunately, practices do not communicate with the majority of their patients electronically, either through a patient portal or via secure email. Consequently, the CAHPS Consortium recommends email as a mode of administration only with mail or telephone follow up. As patient communication through electronic media increases, the viability of email as a stand-alone survey mode will increase.

Some practices currently administer patient surveys directly in their offices. Methods of in-office administration include handing out paper surveys (to be completed onsite or mailed back), directing patients to survey kiosks, or offering access to the survey on office-based computers or tablets.

In several tests of in-office administration, the CAHPS Consortium has not identified a systematic method that produces results comparable to those from other modes. Consequently, in-office administration is not recommended as a mode of administration. Practices also have the perception that in-office administration is a more cost-effective method for measuring patient experience, but a recent study found the cost of this mode of administration to be equivalent or greater than that of a mail survey using a vendor once staff time, data entry, and analysis are considered.[iii]

How to Prepare Data for Public Reporting

Once collected, the resulting data must be aggregated across organizations and analyzed for public reporting. This aggregation may involve rolling up results at different levels of data collection, such as from the provider level to the site/clinic level. The collection and aggregation of clinical measures can serve as a possible model for aggregating patient experience information.

The data repository and aggregation function is best served by a neutral third party. In some cases, the Alliance can serve in this role. Another option for communities is to use the CAHPS Database to serve this purpose. The CAHPS Database is a national repository of CAHPS Survey data including CG-CAHPS data that is sponsored by the Agency for Healthcare Research and Quality through the CAHPS User Network. This free resource aggregates CAHPS survey data from voluntary submissions and offers users access to comparative data and benchmarks.

How These Decisions Play Out in Three Alliances

The leveraged approach can be and has been a feasible and effective way to achieve community-wide reporting of patient experience information. To illustrate how the issues discussed in this brief manifest in the real world, the following table highlights how three Alliances—in Minnesota, Maine, and Wisconsin—came to consensus on the key decision points outlined in this guide. All three Alliances are still in the implementation phases, so some decisions may be subject to change.

Decision Point	**Minnesota**	**Maine**	**Wisconsin**
Version of CG-CAHPS Survey	Visit	12-Month with PCMH Supplemental Items	Visit
Sampling Frequency	Point-in-time	Point-in-time	Continuous sampling
Reporting Level	Clinic site level	Clinic site level	Clinic site and system levels
Population Surveyed	Adult patients of all specialties, excluding psychiatry	Adult patients of primary care and specialty practices; parents of children served by pediatric practices	Adult patients of primary care practices
Administration Mode	All modes approved by CAHPS Consortium	All modes approved by CAHPS Consortium	All modes approved by CAHPS Consortium
Preparation for Public Reporting	To be determined	CAHPS Database	To be determined

These communities offer solid evidence that the leveraged approach gives practices a way to meet their own internal needs while contributing toward the community collaboration. Moreover, they have found that the process of engaging practices can in itself produce greater awareness of and support for the community-wide effort to assess, improve, and report on patient experience.

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[i] Shaller D, Sofaer S, Findlay S, et al. "Consumers and Quality-Driven Health Care: A Call to Action." *Health Affairs*, 2003 (22)2: 95-101, March/April.

[ii] Browne K, Roseman D, Shaller D, et al. "Measuring Patient Experience as a Strategy for Improving Primary Care." *Health Affairs*, (29)5:, 921-925, May 2010.

[iii] Edgman-Levitan S, Brown J, Fowlder FJ, et al. *Feedback Loop: Testing a Patient Experience Survey in the Safety Net*. California HealthCare Foundation, October 2011. Available at: http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/F/PDF%20FeedbackLoopTestingPatientExperienceSurvey.pdf

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