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Presenting CSQ Scales® Results



CSQ Scales® 2020
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CSQ Scales® Overview

The CSQ Scales® were created in response to the need for a standard instrument to replace idiosyncratic, ad hoc, and/or untested tools. The goal was to develop a standardized measure with strong psychometric properties that could be used to assess general

satisfaction across varied health and human services. The CSQScales® (CSQ) include a series of brief instruments. The CSQ is documented to have excellent reliability and internal consistency. The CSQ is reported to have high levels of client and staff acceptability when tested in numerous studies involving diverse client samples and a wide range of health and human service programs. In summary, the major strengths of the CSQ include its utility as a standard measure, excellent reliability and internal consistency, acceptability to clients and service providers, and sensitivity to different levels of program quality, and value to service providers committed to enhancement of quality and impact of services (Attkisson & Greenfield, 1996, 2004; Attkisson & Pascoe, 1983; Attkisson & Zwick, 1982; Greenfield, 1983; Larsen, Attkisson, Hargreaves, & Nguyen, 1979; Nguyen, Attkisson, & Stegner, 1983).

Users of the CSQScales® will find that the most reliable, candid, and useful data are collected in a survey protocol that allows respondents to make their ratings anonymously in a secure setting. Respondents must be instructed to respond with candor and all private health information must be protected. Respondents must understand that their access to services and continued access to needed care and services will not in any way be impacted by participation in the survey.

Presenting CSQ Scales® Results

1. CSQ results are typically not presented at the individual consumer/patient/client level. Most CSQ data are collected in an anonymous, confidential protocol, in a fashion that is linkable (for study or evaluation purposes only) to key demographic, geographic, service use, and other data.
2. CSQ results are typically presented as aggregate data by total populations of interest; and, when possible, in sub-populations of interest (e.g., age groupings, gender, ethno-cultural group, language group, service type or level, amount of service, or phase intervals within the process of delivery of services. In presenting sub-group results, be careful that the data presented cannot be linked to any individual or very small sub-group of individuals.
3. CSQ results typically include analyses by total arithmetic score and the mean item score (average of the mean score).
4. CSQ results can also be compared across time periods by comparing data obtained at a subsequent time with data collected at a baseline occasion. The CSQ-18A and the CSQ-18B were constructed to be equivalent scales although they contain different specific items. This type of comparison is often desired for “test-retest” comparisons.
5. Investigators often calculate: (a) measures of internal consistency (Cronbach’s

alpha), (b) correlations with demographic, geographic, service use, and other data such as symptoms and functional data, (c) correlations with measures of efficiency and effectiveness of service delivery, (d) correlations with general health status ratings, (e) correlations with pain ratings and functional status, and (f) correlations with measures of general life satisfaction. Suggested rating scales for several of these latter domains are available on request for purchasers of the CSQ Scales® (info@csqscales.com).

6. CSQ results are typically presented graphically: (a) population statistical distributions of item and total scores, (b) bar graphs comparing different populations or samples, (c) bar graphs comparing results for sub-populations or level or amount of service, (d) line graphs comparing populations, samples, or sub-groups over a time series of three or more occasions, and (e) conversion of raw scores to standardized scores when sample size is sufficient to allow such conversions to be made.
7. CSQ results from a specific site are frequently compared with results from other investigations when such comparisons are of interest and can help in the interpretation of findings in a particular study setting.
8. It is possible to use a variety of data transform methods to enhance the presentation and understanding of CSQ data. One linear procedure is to compute the total score, by adding up the individual scores from the 8 items and the multiplying by 3.125 to obtain a distribution from 25 to 100. I suggested this linear transform of the raw CSQ-8 scores to a colleague as a mechanism for displaying the scores in the generally familiar zero to one hundred "school room" **format. I further suggested that my colleague might consider converting the transformed scores into percentiles and then treating each quartile as a level of relative satisfaction.** If you implement this approach, please let me know how this works out. With repeated use of the CSQ Scales over time you can use your own setting as its own control. Then recruit a sister setting to do the same and make comparisons. Please keep in touch as you proceed. You may find that your score distribution is negatively skewed with the proportion of satisfied clients being greater than the less satisfied clients. In this case, the percentile quartiles will assist in segmenting levels of relative satisfaction and dissatisfaction. Consult your local statistician additional ideas about linear and non-linear data transform possibilities.
9. *The CSQ Scales® Reprint Portfolio* contains reports and reprints from a wide range of studies that can guide establishment of appropriate comparison data. The portfolio can be purchased on the CSQ Scales® web site (www.csqscales.com).

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