FY 15-16 CHILD MEDICAID CLIENT SATISFACTION REPORT

September 2016

This report was produced by Health Services Advisory Group, Inc. for the Colorado Department of Health Care Policy & Financing.

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CONTENTS

1. Executive Summary

The State of Colorado requires annual administration of client satisfaction surveys to Medicaid clients enrolled in Fee-for-Service (FFS), Denver Health Medicaid Choice (DHMC), and Rocky Mountain Health Plans (RMHP). For FFS, surveyed clients included 1) FFS clients not enrolled in the Accountable Care Collaborative (ACC) and 2) FFS clients enrolled in one of the seven participating Regional Care Collaborative Organizations (RCCOs).[1-1] Effective June 2016, the Colorado Department of Health Care Policy & Financing (the Department) announced the new name for Medicaid in Colorado as Health First Colorado (Colorado's Medicaid Program). The Department contracts with Health Services Advisory Group, Inc. (HSAG) to administer and report the results of the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Surveys.[1-2,1-3,1-4] The goal of the CAHPS Health Plan Surveys is to provide performance feedback that is actionable and will aid in improving overall client satisfaction.

It is important to note that in state fiscal year (SFY) 2015-2016, the survey instrument selected for FFS clients was a modified version of the CAHPS 5.0 Child Medicaid Health Plan Survey with the Healthcare Effectiveness Data and Information Set (HEDIS®) supplemental item set and survey questions from the Child Clinician and Group CAHPS surveys with Patient-Centered Medical Home™ (PCMH) items (Child CAHPS PCMH Survey).[1-5,1-6] For DHMC and RMHP, the standardized survey instrument selected was the CAHPS 5.0 Child Medicaid Health Plan Survey with the HEDIS supplemental item set. The parents or caretakers of child clients enrolled in Colorado Non-ACC FFS, the seven participating RCCOs, DHMC, and RMHP completed the surveys from March to May 2016.

In SFY 2015-2016, the sampling approach utilized for the Colorado FFS child population was similar to the approach in SFY 2014-201. The sampling approach was as follows: 1) select a FFS population not enrolled in a RCCO (i.e., non-ACC clients), 2) only sample RCCO clients that were attributed to a primary care provider (PCP), and 3) select separate samples for each RCCO. A trend analysis was performed that compared the 2016 and 2015 Colorado Non-ACC FFS and RCCO CAHPS results.[1-7,1-8] Table 1-1, on the following page, lists the RCCOs for each region.

[1-1] RCCOs are regional entities of the Accountable Care Collaborative (ACC).

[1-2] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

[1-3] The DHMC CAHPS Child Medicaid Survey administration was performed by Morpace. The RMHP CAHPS Child Medicaid Survey administration was performed by the Center for the Study of Services (CSS).

[1-4] DHMC and RMHP are managed care plans that serve approximately 8 percent of Colorado's Medicaid population.

[1-5] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

[1-6] Patient-Centered Medical Home™ (PCMH) is a trademark of the National Committee for Quality Assurance (NCQA).

[1-7] The Colorado Non-ACC FFS results presented throughout this report represent the survey results for FFS child clients not enrolled in a RCCO (i.e., non-ACC clients).

[1-8] The RCCO-level and Colorado FFS ACC Program aggregate-level CAHPS results presented throughout this report represent the survey results for FFS child clients enrolled in one of the seven participating RCCOs who are also attributed to a PCP.

Table 1-1 Participating Colorado RCCOs
Region 1: Rocky Mountain Health Plans
Region 2: Colorado Access
Region 3: Colorado Access
Region 4: Integrated Community Health Partners
Region 5: Colorado Access
Region 6: Colorado Community Health Alliance
Region 7: Community Care of Central Colorado

Non-ACC FFS and RCCO Performance Highlights

The Non-ACC FFS and RCCO Results Section of this report details the CAHPS results for Colorado Non-ACC FFS, clients enrolled in one of seven participating RCCOs, and the Colorado FFS ACC Program in aggregate (i.e., seven RCCOs combined). The following is a summary of the CAHPS performance highlights. The performance highlights are categorized into three major types of analyses performed on the CAHPS survey data:

- Trend Analysis
- Non-ACC and RCCO Comparisons
- Priority Assignments

The detailed results of the CAHPS survey analysis are described in the Non-ACC FFS and RCCO Results Section beginning on page 2-1.

Trend Analysis

In order to evaluate trends in the Colorado Non-ACC FFS, the Colorado FFS ACC Program, and the seven participating RCCOs, HSAG compared the 2016 CAHPS results to the 2015 general child CAHPS results.[1-9] The detailed results of the trend analysis are described in the Non-ACC FFS and RCCO Results Section beginning on page 2-9. Table 1-2 presents the statistically significant results from this analysis.

Table 1-2
Trend Analysis Highlights

	Colorado Non-ACC FFS	Colorado FFS ACC Program	Region 1: Rocky Mountain Health Plans	Region 2: Colorado Access	Region 3: Colorado Access	Region 4: Integrated Community Health Partners	Region 5: Colorado Access	Region 6: Colorado Community Health Alliance	Region 7: Community Care of Central Colorado
Global Rating									
Rating of All Health Care	▼	—	—	—	—	—	—	—	—
Rating of Personal Doctor	▼	—	—	—	—	—	—	▲	—
Composite Measure									
Getting Needed Care	—	▼	▼	—	—	—	—	—	—
Shared Decision Making	—	▲	—	—	—	—	▲	—	—
Individual Measure									
Health Promotion and Education	—	—	—	—	—	▲	—	—	—

▲ *Indicates the 2016 score is significantly higher than the 2015 score*
▼ *Indicates the 2016 score is significantly lower than the 2015 score*

[1-9] CAHPS results for 2016 were trended to the 2015 general child CAHPS results for those measures that were captured through the 2016 customized survey instrument.

Non-ACC and RCCO Comparisons

In order to identify performance differences in client satisfaction between the non-ACC and ACC populations, case-mix adjusted results for Colorado Non-ACC FFS and the Colorado FFS ACC Program were compared to one another using standard statistical tests. In order to identify performance differences in RCCO client satisfaction, case-mix adjusted results for each RCCO were compared to the Colorado FFS ACC Program average using standard statistical tests.[1-10] These comparisons were performed on the three global ratings, four composite measures, and two individual item measures. The detailed results of the non-ACC and RCCO comparative analysis are described in the Non-ACC FFS and RCCO Results Section beginning on page 2-28.

There were no statistically significant results between the non-ACC and ACC populations in 2016.[1-11]

Table 1-3 presents the statistically significant results from the RCCO comparisons.[1-12]

Table 1-3
RCCO Comparisons Highlights

Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7
			↑ Health Promotion and Education	↑ Health Promotion and Education		↓ Health Promotion and Education

↑ Statistically better than the State Average
↓ Statistically worse than the State Average

[1-10] CAHPS results are known to vary due to differences in respondent age, respondent education level, and member health status. Therefore, the results for the non-ACC and ACC population comparisons and RCCO comparisons were case-mix adjusted for differences in these demographic variables.
[1-11] Caution should be exercised when evaluating the non-ACC and ACC population comparisons, given that population differences may impact results.
[1-12] Caution should be exercised when evaluating the RCCO comparisons, given that RCCO differences may impact results.

Priority Assignments

Based on the results of the National Committee for Quality Assurance (NCQA) comparisons and trend analysis, priority assignments were derived for each measure.[1-13] Measures were assigned into one of four main categories for quality improvement (QI): top, high, moderate, and low priority. Table 1-4 presents the top and high priorities for Colorado Non-ACC FFS and each RCCO.

Table 1-4
Top and High Priorities

Non-ACC FFS	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7
◆ Rating of All Health Care	◆ Rating of All Health Care	◆ Rating of Personal Doctor	◆ Getting Needed Care	◆ Rating of All Health Care	◆ Rating of Specialist Seen Most Often+	◆ Rating of All Health Care	◆ Rating of All Health Care
◆ Rating of Personal Doctor	◆ Rating of Specialist Seen Most Often+	◆ Getting Needed Care	◆ Getting Care Quickly	◆ Rating of Personal Doctor	◆ Getting Needed Care	◆ Rating of Specialist Seen Most Often+	◆ Rating of Personal Doctor
◆ Rating of Specialist Seen Most Often	◆ Getting Needed Care	◆ Getting Care Quickly	◆ How Well Doctors Communicate	◆ Rating of Specialist Seen Most Often+	◆ Getting Care Quickly	◆ Getting Needed Care	◆ Getting Needed Care
◆ Getting Needed Care	◆ Coordination of Care	◆ How Well Doctors Communicate	◆ Coordination of Care+	◆ Getting Needed Care	◆ Coordination of Care+	◆ Getting Care Quickly	◆ Getting Care Quickly
◆ Getting Care Quickly		◆ Coordination of Care+		◆ Getting Care Quickly		◆ Coordination of Care	◆ Coordination of Care+
◆ Coordination of Care				◆ How Well Doctors Communicate			

Please note: CAHPS scores with fewer than 100 respondents are denoted with a cross (+). If there are fewer than 100 respondents for a CAHPS measure, caution should be exercised when interpreting these results.

[1-13] NCQA does not publish benchmarks and thresholds for the Shared Decision Making composite measure, and Health Promotion and Education individual item measure; therefore, priority assignments could not be derived for these CAHPS measures.

DHMC and RMHP Performance Highlights

The DHMC and RMHP Results Section of this report details the CAHPS results for DHMC and RMHP. The following is a summary of the CAHPS performance highlights. The performance highlights are categorized into three major types of analyses performed on the CAHPS survey data:

- Trend Analysis
- NCQA Comparisons
- Priority Assignments

The detailed results of the CAHPS survey analysis are described in the DHMC and RMHP Results Section beginning on page 3-1.

Trend Analysis

In order to evaluate trends in the Colorado Medicaid managed care plan's client satisfaction for the general child population, HSAG performed a stepwise trend analysis, where applicable. The first step compared the 2016 CAHPS results to the 2015 general child CAHPS results.[1-14,1-15] If the initial 2016 and 2015 trend analysis did not yield any significant differences, then an additional trend analysis was performed between the 2016 and 2014 CAHPS results. The detailed results of the trend analysis are described in the DHMC and RMHP Results Section beginning on page 3-6. The bullets below present the statistically significant results from this analysis.

- DHMC scored significantly higher in 2016 than in 2015 on one measure, Getting Care Quickly.
- DHMC scored significantly lower in 2016 than in 2014 on one measure, Health Promotion and Education.

[1-14] CAHPS results for 2016 were trended to the 2015 general child CAHPS results, where applicable.
[1-15] RMHP discontinued their Medicaid product in which children were enrolled and implemented a new Medicaid risk product; therefore, trending was not performed for RMHP.

NCQA Comparisons

Overall client satisfaction ratings for four CAHPS global ratings (Rating of Health Plan, Rating of All Health Care, Rating of Personal Doctor, and Rating of Specialist Seen Most Often), four composite measures (Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, and Customer Service), and one individual item measure (Coordination of Care) were compared to NCQA's 2016 HEDIS Benchmarks and Thresholds for Accreditation.[1-16,1-17] This comparison resulted in ratings of one (★) to five (★★★★★) stars on these CAHPS measures, where one was the lowest possible rating and five was the highest possible rating. The detailed results of this analysis are described in the DHMC and RMHP Results Section beginning on page 3-19. Table 1-5 presents the highlights from this comparison.

Table 1-5
NCQA Comparisons Highlights

DHMC	RMHP
★ Getting Care Quickly	★+ Getting Care Quickly
★ Getting Needed Care	★+ Rating of All Health Care
★★★ Customer Service	★+ Rating of Health Plan
★★★★+ Coordination of Care	★★+ Customer Service
★★★★ How Well Doctors Communicate	★★+ Getting Needed Care
★★★★ Rating of Health Plan	★★★★+ Rating of Personal Doctor
★★★★★+ Rating of Specialist Seen Most Often	★★★★+ Rating of Specialist Seen Most Often
★★★★★ Rating of All Health Care	★★★★★+ Coordination of Care
★★★★★ Rating of Personal Doctor	★★★★★+ How Well Doctors Communicate

Please note: CAHPS scores with fewer than 100 respondents are denoted with a cross (+). If there are fewer than 100 respondents for a CAHPS measure, caution should be exercised when interpreting these results.

[1-16] National Committee for Quality Assurance. *HEDIS Benchmarks and Thresholds for Accreditation 2016*. Washington, DC: NCQA, January 21, 2016.

[1-17] NCQA does not publish benchmarks and thresholds for the Shared Decision Making composite measure, and Health Promotion and Education individual item measure; therefore, overall client satisfaction ratings could not be derived for these CAHPS measures.

Priority Assignments

Based on the results of the NCQA comparisons and trend analysis for DHMC, and the NCQA comparisons analysis for RMHP, priority assignments were derived for each measure. Measures were assigned into one of four main categories for QI: top, high, moderate, and low priority. Table 1-6 presents the top and high priorities for each plan.

Table 1-6
Top and High Priorities

DHMC	RMHP
◆ Getting Needed Care ◆ Getting Care Quickly	◆ Rating of Health Plan+ ◆ Rating of All Health Care+ ◆ Getting Needed Care+ ◆ Getting Care Quickly+ ◆ Customer Service+

2. Non-ACC FFS and RCCO Results

The following section presents the CAHPS results for Colorado Non-ACC FFS clients, Colorado FFS ACC Program, and the seven participating RCCOs.[2-1]

Survey Administration and Response Rates

Survey Administration

For the Colorado Medicaid CAHPS Survey administration, child clients eligible for sampling included those who:

- Were currently enrolled in Colorado Non-ACC FFS, or enrolled in one of the seven participating RCCOs and attributed to a PCP.
- Had been continuously enrolled for at least five of the last six months of 2015.
- Were 17 years of age or younger as of December 31, 2015.

The standard NCQA HEDIS Specifications for Survey Measures require a sample size of 1,650 clients for the CAHPS 5.0 Child Medicaid Health Plan Survey without CCC measurement set.[2-2] For Colorado Non-ACC FFS and participating RCCOs, a sample of 1,650 child clients was selected from each for the CAHPS 5.0 child sample.

[2-1] RCCOs are regional entities of the Accountable Care Collaborative (ACC).

[2-2] National Committee for Quality Assurance. *HEDIS® 2016, Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2015.

Table 2-1 presents the sample sizes for Colorado Non-ACC FFS and each of the seven participating RCCOs.

Table 2-1
Colorado Non-ACC FFS and RCCOs
Sample Sizes

Name	Total Sample Size
Colorado Non-ACC FFS	1,650
Region 1: Rocky Mountain Health Plans	1,650
Region 2: Colorado Access	1,650
Region 3: Colorado Access	1,650
Region 4: Integrated Community Health Partners	1,650
Region 5: Colorado Access	1,650
Region 6: Colorado Community Health Alliance	1,650
Region 7: Community Health Partnership	1,650

The survey administration protocol was designed to achieve a high response rate from clients, thus minimizing the potential effects of non-response bias. The survey process employed was a mixed mode methodology which allowed clients two methods by which they could complete the surveys. The first phase, or mail phase, consisted of a survey being mailed to the sampled clients. For Colorado Non-ACC FFS and the seven participating RCCOs, those clients who were identified as Spanish-speaking through administrative data were mailed a Spanish version of the survey. Clients that were not identified as Spanish-speaking received an English version of the survey. The cover letter included with the English version of the survey had a Spanish cover letter on the back side informing clients that they could call the toll-free number to request a Spanish version of the CAHPS questionnaire. The cover letter provided with the Spanish version of the CAHPS questionnaire included a text box with a toll-free number that clients could call to request a survey in another language (i.e., English). A reminder postcard was sent to all non-respondents, followed by a second survey mailing and reminder postcard. The second phase, or telephone phase, consisted of Computer Assisted Telephone Interviewing (CATI) for sampled clients who had not mailed in a completed survey. A minimum of three CATI calls was made to each non-respondent.[2-3] Additional information on the survey protocol is included in the Reader's Guide Section beginning on page 5-4.

Response Rates

The Colorado CAHPS 5.0 Child Medicaid Health Plan Survey administration was designed to achieve the highest possible response rate. The CAHPS Survey response rate is the total number of completed surveys divided by all eligible clients of the sample. A client's survey was assigned a disposition code of "completed" if at least one question was answered. Eligible clients included the entire random sample minus ineligible clients. Ineligible clients met at least one of the following criteria: they were deceased, were invalid (did not meet the eligible population criteria), or had a language barrier.

[2-3] National Committee for Quality Assurance. *Quality Assurance Plan for HEDIS 2016 Survey Measures.* Washington, DC: NCQA Publication, 2015.

A total of 3,697 completed surveys were returned on behalf of Colorado Non-ACC FFS and RCCO child clients, including 470 Non-ACC FFS and 3,227 RCCO clients. The 2016 Colorado Non-ACC FFS and FFS ACC Program aggregate response rate of 28.7 percent was 1.9 percentage points higher than the national child Medicaid response rate reported by NCQA for 2015, which was 26.8 percent.[2-4,2-5]

Table 2-2 depicts the sample distribution and response rates for the Colorado Non-ACC FFS and FFS ACC Program combined, Colorado Non-ACC FFS, and the seven participating RCCOs.

Table 2-2
Colorado Medicaid FFS and RCCO
Sample Distribution and Response Rate

Plan Name	Total Sample	Ineligible Records	Eligible Sample	Total Respondents	Response Rate
Colorado Non-ACC FFS and FFS ACC Program	13,200	337	12,863	3,697	28.74%
Colorado Non-ACC FFS	1,650	56	1,594	470	29.49%
Region 1: Rocky Mountain Health Plans	1,650	47	1,603	474	29.57%
Region 2: Colorado Access	1,650	41	1,609	455	28.28%
Region 3: Colorado Access	1,650	50	1,600	473	29.56%
Region 4: Integrated Community Health Partners	1,650	22	1,628	450	27.64%
Region 5: Colorado Access	1,650	38	1,612	475	29.47%
Region 6: Colorado Community Health Alliance	1,650	48	1,602	459	28.65%
Region 7: Community Care of Central Colorado	1,650	35	1,615	441	27.31%

[2-4] National Committee for Quality Assurance. *HEDIS 2016 Survey Vendor Update Training*. October 28, 2015.
[2-5] Please note, 2016 national response rate information was not available at the time this report was produced.

Child and Respondent Demographics

In general, the demographics of a response group influence overall client satisfaction scores. For example, older and healthier respondents tend to report higher levels of client satisfaction; therefore, caution should be exercised when comparing populations that have significantly different demographic properties.[2-6]

Table 2-3 through Table 2-7 show the demographic characteristics of children for whom a parent/caretaker completed a CAHPS 5.0 Child Medicaid Health Plan Survey for age, gender, race, ethnicity, and general health status, respectively, for Colorado Non-ACC FFS, the Colorado FFS ACC Program in aggregate, and each RCCO.

Table 2-3
Child Demographics
Age

Plan Name	Less than 1	1 to 3	4 to 7	8 to 12	13 to 18
Colorado Non-ACC FFS	**1.6%**	**14.5%**	**20.6%**	**32.1%**	**31.2%**
Colorado FFS ACC Program	**0.8%**	**18.0%**	**24.5%**	**30.5%**	**26.2%**
Region 1: Rocky Mountain Health Plans	0.9%	18.1%	23.2%	33.3%	24.6%
Region 2: Colorado Access	0.7%	18.1%	24.2%	31.8%	25.2%
Region 3: Colorado Access	0.2%	18.7%	23.2%	30.0%	27.9%
Region 4: Integrated Community Health Partners	0.7%	16.9%	26.7%	29.3%	26.4%
Region 5: Colorado Access	1.4%	16.8%	25.7%	30.8%	25.2%
Region 6: Colorado Community Health Alliance	0.9%	18.3%	22.8%	29.1%	28.9%
Region 7: Community Care of Central Colorado	1.0%	19.0%	25.8%	28.7%	25.5%

Please note: Percentages may not total 100% due to rounding. Children are eligible for inclusion in CAHPS if they are age 17 or younger as of December 31, 2015. Some children eligible for the CAHPS Survey turned age 18 between January 1, 2016, and the time of survey administration.

[2-6] Agency for Healthcare Research and Quality. *CAHPS Health Plan Survey and Reporting Kit 2008*. Rockville, MD: US Department of Health and Human Services, July 2008.

Table 2-4 Child Demographics Gender		
Plan Name	**Male**	**Female**
Colorado Non-ACC FFS	**50.3%**	**49.7%**
Colorado FFS ACC Program	**51.9%**	**48.1%**
Region 1: Rocky Mountain Health Plans	50.9%	49.1%
Region 2: Colorado Access	51.5%	48.5%
Region 3: Colorado Access	52.6%	47.4%
Region 4: Integrated Community Health Partners	53.1%	46.9%
Region 5: Colorado Access	52.2%	47.8%
Region 6: Colorado Community Health Alliance	50.9%	49.1%
Region 7: Community Care of Central Colorado	51.8%	48.2%
Please note: Percentages may not total 100% due to rounding.		

Table 2-5 Child Demographics Race					
Plan Name	**Multi-Racial**	**White**	**Black**	**Asian**	**Other**
Colorado Non-ACC FFS	**16.7%**	**66.1%**	**1.5%**	**3.3%**	**12.4%**
Colorado FFS ACC Program	**15.8%**	**58.5%**	**5.1%**	**2.4%**	**18.2%**
Region 1: Rocky Mountain Health Plans	14.8%	64.5%	0.7%	1.2%	18.8%
Region 2: Colorado Access	10.6%	65.8%	1.1%	0.8%	21.7%
Region 3: Colorado Access	17.2%	50.5%	8.2%	4.6%	19.4%
Region 4: Integrated Community Health Partners	15.2%	64.5%	1.1%	1.1%	18.2%
Region 5: Colorado Access	13.0%	44.4%	15.3%	4.0%	23.4%
Region 6: Colorado Community Health Alliance	17.7%	61.6%	1.3%	4.0%	15.3%
Region 7: Community Care of Central Colorado	22.3%	56.5%	8.9%	1.6%	10.8%
Please note: Percentages may not total 100% due to rounding.					

Table 2-6 Child Demographics Ethnicity		
Plan Name	**Hispanic**	**Non-Hispanic**
Colorado Non-ACC FFS	**44.1%**	**55.9%**
Colorado FFS ACC Program	**58.6%**	**41.4%**
Region 1: Rocky Mountain Health Plans	43.5%	56.5%
Region 2: Colorado Access	71.2%	28.8%
Region 3: Colorado Access	63.3%	36.7%
Region 4: Integrated Community Health Partners	65.2%	34.8%
Region 5: Colorado Access	71.9%	28.1%
Region 6: Colorado Community Health Alliance	52.9%	47.1%
Region 7: Community Care of Central Colorado	42.8%	57.2%
Please note: Percentages may not total 100% due to rounding.		

Table 2-7 Child Demographics General Health Status					
Plan Name	**Excellent**	**Very Good**	**Good**	**Fair**	**Poor**
Colorado Non-ACC FFS	**41.1%**	**33.7%**	**18.2%**	**5.5%**	**1.4%**
Colorado FFS ACC Program	**44.1%**	**33.9%**	**17.0%**	**4.6%**	**0.4%**
Region 1: Rocky Mountain Health Plans	47.6%	33.6%	15.3%	2.9%	0.7%
Region 2: Colorado Access	42.8%	35.2%	17.3%	4.3%	0.5%
Region 3: Colorado Access	42.9%	34.4%	18.2%	4.5%	0.0%
Region 4: Integrated Community Health Partners	42.5%	36.2%	15.6%	4.6%	1.0%
Region 5: Colorado Access	41.6%	31.4%	19.5%	7.4%	0.0%
Region 6: Colorado Community Health Alliance	45.9%	31.9%	18.7%	3.5%	0.0%
Region 7: Community Care of Central Colorado	45.4%	34.7%	13.8%	5.3%	0.7%
Please note: Percentages may not total 100% due to rounding.					

Table 2-8 through Table 2-10 show the self-reported age, level of education, and relationship to the child for the respondents who completed the CAHPS 5.0 Child Medicaid Health Plan Survey for Colorado Non-ACC FFS, the Colorado FFS ACC Program, and each RCCO.

Table 2-8
Respondent Demographics
Respondent Age

Plan Name	Under 18	18 to 24	25 to 34	35 to 44	45 to 54	55 and Older
Colorado Non-ACC FFS	**2.8%**	**3.3%**	**28.6%**	**43.8%**	**15.7%**	**5.9%**
Colorado FFS ACC Program	**3.8%**	**5.6%**	**34.3%**	**37.8%**	**12.9%**	**5.6%**
Region 1: Rocky Mountain Health Plans	3.6%	4.5%	36.7%	36.4%	14.3%	4.5%
Region 2: Colorado Access	2.9%	6.2%	35.1%	36.3%	12.4%	7.2%
Region 3: Colorado Access	4.1%	6.0%	30.0%	43.3%	12.3%	4.3%
Region 4: Integrated Community Health Partners	6.2%	7.4%	35.5%	32.3%	10.2%	8.4%
Region 5: Colorado Access	4.0%	5.0%	35.5%	41.0%	11.0%	3.6%
Region 6: Colorado Community Health Alliance	4.1%	4.3%	31.1%	38.8%	18.2%	3.6%
Region 7: Community Care of Central Colorado	2.0%	6.2%	36.1%	36.4%	11.6%	7.7%

Please note: Percentages may not total 100% due to rounding.

Table 2-9
Respondent Demographics
Respondent Education

Plan Name	8th Grade or Less	Some High School	High School Graduate	Some College	College Graduate
Colorado Non-ACC FFS	**6.4%**	**7.8%**	**21.7%**	**37.0%**	**27.1%**
Colorado FFS ACC Program	**9.7%**	**14.2%**	**30.7%**	**32.1%**	**13.2%**
Region 1: Rocky Mountain Health Plans	8.8%	10.6%	28.0%	34.5%	18.1%
Region 2: Colorado Access	14.6%	15.5%	33.7%	29.4%	6.9%
Region 3: Colorado Access	11.2%	15.3%	38.1%	24.3%	11.2%
Region 4: Integrated Community Health Partners	5.5%	13.5%	28.6%	39.3%	13.0%
Region 5: Colorado Access	12.9%	18.9%	32.1%	25.7%	10.3%
Region 6: Colorado Community Health Alliance	8.1%	14.3%	27.7%	31.5%	18.4%
Region 7: Community Care of Central Colorado	6.4%	11.6%	27.0%	40.6%	14.4%

Please note: Percentages may not total 100% due to rounding.

Table 2-10 Respondent Demographics Relationship to Child				
Plan Name	**Mother or Father**	**Grandparent**	**Legal Guardian**	**Other**
Colorado Non-ACC FFS	**95.3%**	**2.8%**	**0.9%**	**0.9%**
Colorado FFS ACC Program	**93.9%**	**4.3%**	**0.9%**	**1.0%**
Region 1: Rocky Mountain Health Plans	92.7%	5.0%	0.7%	1.6%
Region 2: Colorado Access	93.3%	5.0%	1.0%	0.7%
Region 3: Colorado Access	96.9%	1.7%	0.2%	1.2%
Region 4: Integrated Community Health Partners	89.7%	7.8%	1.5%	1.0%
Region 5: Colorado Access	96.7%	2.4%	0.0%	1.0%
Region 6: Colorado Community Health Alliance	96.4%	2.1%	0.7%	0.7%
Region 7: Community Care of Central Colorado	91.1%	5.9%	2.0%	1.0%
Please note: Percentages may not total 100% due to rounding.				

Trend Analysis

For purposes of calculating the Colorado Non-ACC FFS, Colorado FFS ACC Program, and seven participating RCCOs CAHPS results, presented in Figure 2-1 through Figure 2-9, question summary rates were calculated for each global rating and individual item measure, and global proportions were calculated for each composite measure. Both the question summary rates and global proportions were calculated in accordance with NCQA HEDIS Specifications for Survey Measures.[2-7] The scoring of the global ratings, composite measures, and individual item measures involved assigning top-level responses a score of one, with all other responses receiving a score of zero. After applying this scoring methodology, the percentage of top-level responses was calculated in order to determine the question summary rates and global proportions. For additional details, please refer to the *NCQA HEDIS 2016 Specifications for Survey Measures, Volume 3*.

For the Colorado FFS ACC Program, the results were weighted based on each of the RCCO's total eligible population. Additionally, for purposes of this report, CAHPS scores are reported for those measures even when NCQA's minimum reporting threshold of 100 respondents was not met; therefore, caution should be exercised when interpreting these results. CAHPS scores with less than 100 respondents are denoted with a cross (+).

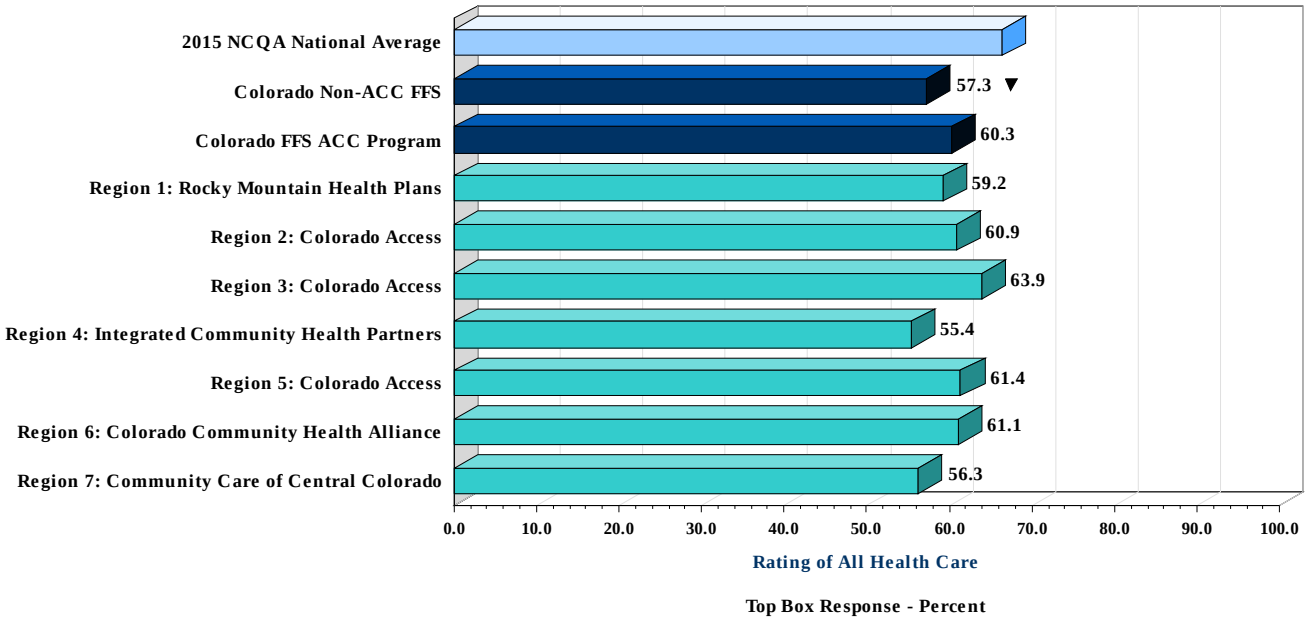
[2-7] National Committee for Quality Assurance. *HEDIS® 2016, Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA Publication, 2015.

Global Ratings

Rating of All Health Care

Parents/caretakers of child clients were asked to rate all their child's health care on a scale of 0 to 10, with 0 being the "worst health care possible" and 10 being the "best health care possible." Top-level responses were defined as those responses with a rating of 9 or 10. Figure 2-1 shows the 2015 NCQA national average and the 2016 Rating of All Health Care question summary rates for Colorado Non-ACC FFS, the Colorado FFS ACC Program, and the seven participating RCCOs.[2-8,2-9,2-10]

Figure 2-1—Rating of All Health Care



Statistical Significance Note: ▲ indicates the 2016 score is significantly higher than the 2015 score
▼ indicates the 2016 score is significantly lower than the 2015 score

2-8 Colorado FFS ACC Program scores presented in this section are derived from the combined results of the seven participating RCCOs. The scores were weighted based on the total eligible population (i.e., population of children enrolled in a RCCO and attributed to a PCP).

2-9 NCQA national averages were not available for 2016 at the time this report was prepared; therefore, 2015 NCQA national data are presented in this section.

2-10 The source for the NCQA national averages for the general child population contained in this publication is Quality Compass® 2015 data and is used with the permission of the National Committee for Quality Assurance (NCQA). Quality Compass 2015 includes certain CAHPS data. Any data display, analysis, interpretation, or conclusion based on these data is solely that of the authors, and NCQA specifically disclaims responsibility for any such display, analysis, interpretation, or conclusion. Quality Compass® is a registered trademark of NCQA. CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Table 2-11 displays the 2015 and 2016 Rating of All Health Care question summary rates, and the trend results for Colorado Non-ACC FFS, the Colorado FFS ACC Program, and the seven participating RCCOs.

Table 2-11
Trend Analysis
Rating of All Health Care

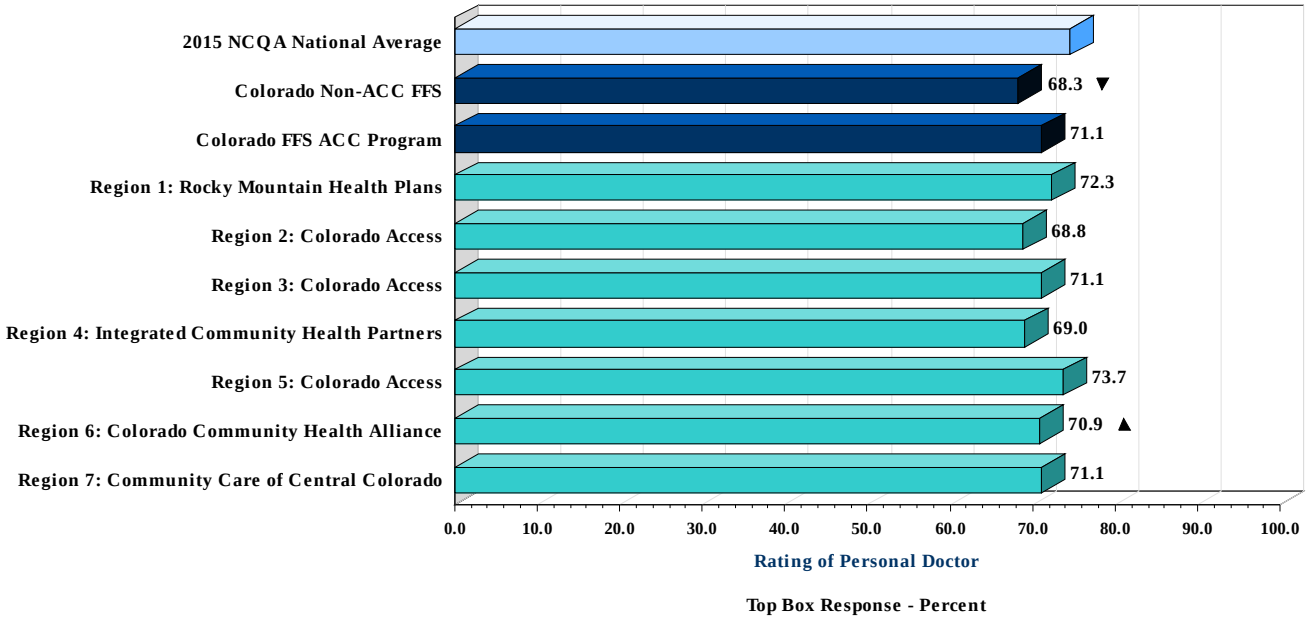
Plan Name	2015	2016	Trend Results
Colorado Non-ACC FFS	**67.5%**	**57.3%**	▼
Colorado FFS ACC Program	**62.1%**	**60.3%**	—
Region 1: Rocky Mountain Health Plans	61.6%	59.2%	—
Region 2: Colorado Access	61.6%	60.9%	—
Region 3: Colorado Access	67.8%	63.9%	—
Region 4: Integrated Community Health Partners	55.2%	55.4%	—
Region 5: Colorado Access	65.5%	61.4%	—
Region 6: Colorado Community Health Alliance	56.7%	61.1%	—
Region 7: Community Care of Central Colorado	58.8%	56.3%	—

▲ *Indicates the 2016 score is significantly higher than the 2015 score*
▼ *Indicates the 2016 score is significantly lower than the 2015 score*
\+ *Indicates fewer than 100 responses. Caution should be exercised when evaluating these results.*

Rating of Personal Doctor

Parents/caretakers of child clients were asked to rate their child's personal doctor on a scale of 0 to 10, with 0 being the "worst personal doctor possible" and 10 being the "best personal doctor possible." Top-level responses were defined as those responses with a rating of 9 or 10. Figure 2-2 shows the 2015 NCQA national average and the 2016 Rating of Personal Doctor question summary rates for Colorado Non-ACC FFS, the Colorado FFS ACC Program, and the seven participating RCCOs.

Figure 2-2—Rating of Personal Doctor



Statistical Significance Note: ▲ indicates the 2016 score is significantly higher than the 2015 score
▼ indicates the 2016 score is significantly lower than the 2015 score

Table 2-12 displays the 2015 and 2016 Rating of Personal Doctor question summary rates, and the trend results for Colorado Non-ACC FFS, the Colorado FFS ACC Program, and the seven participating RCCOs.

Table 2-12
Trend Analysis
Rating of Personal Doctor

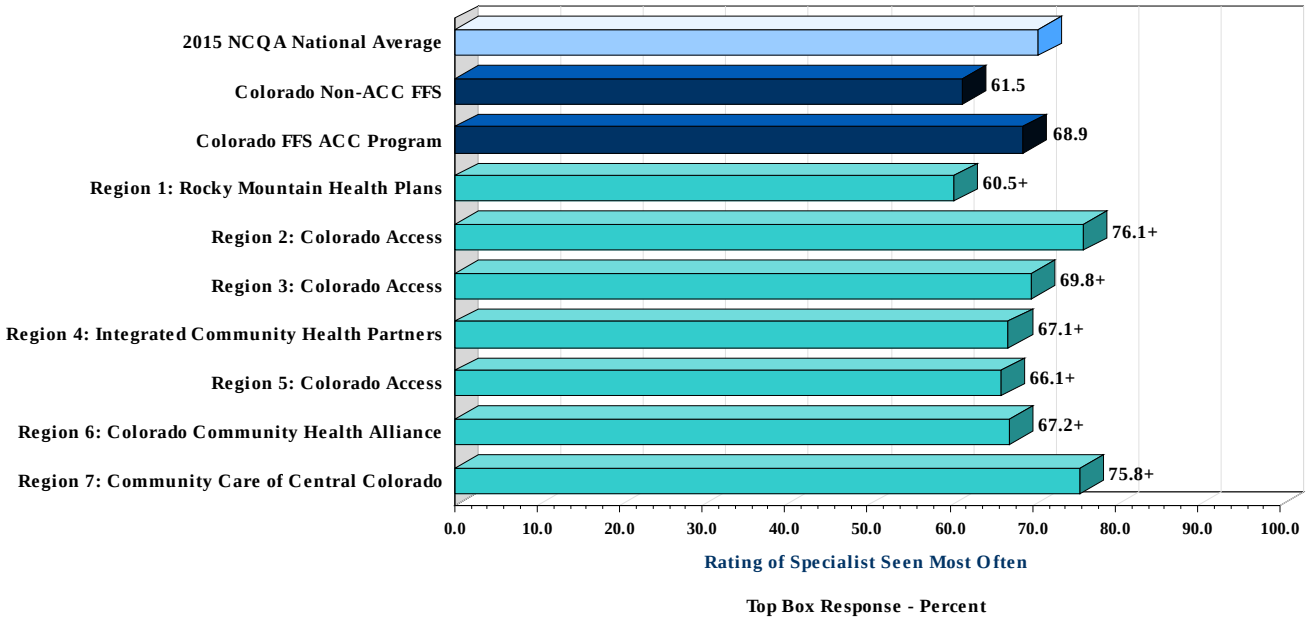
Plan Name	2015	2016	Trend Results
Colorado Non-ACC FFS	**76.1%**	**68.3%**	▼
Colorado FFS ACC Program	**68.2%**	**71.1%**	—
Region 1: Rocky Mountain Health Plans	66.3%	72.3%	—
Region 2: Colorado Access	67.3%	68.8%	—
Region 3: Colorado Access	68.7%	71.1%	—
Region 4: Integrated Community Health Partners	71.4%	69.0%	—
Region 5: Colorado Access	72.9%	73.7%	—
Region 6: Colorado Community Health Alliance	63.1%	70.9%	▲
Region 7: Community Care of Central Colorado	68.3%	71.1%	—

▲ *Indicates the 2016 score is significantly higher than the 2015 score*
▼ *Indicates the 2016 score is significantly lower than the 2015 score*
\+ *Indicates fewer than 100 responses. Caution should be exercised when evaluating these results.*

Rating of Specialist Seen Most Often

Parents/caretakers of child clients were asked to rate the specialist their child saw most often on a scale of 0 to 10, with 0 being the "worst specialist possible" and 10 being the "best specialist possible." Top-level responses were defined as those responses with a rating of 9 or 10. Figure 2-3 shows the 2015 NCQA national average and the 2016 Rating of Specialist Seen Most Often question summary rates for Colorado Non-ACC FFS, the Colorado FFS ACC Program, and the seven participating RCCOs.

Figure 2-3—Rating of Specialist Seen Most Often



+ If there were fewer than 100 respondents for a measure, caution should be exercised when interpreting these results.

Table 2-13 displays the 2015 and 2016 Rating of Specialist Seen Most Often question summary rates, and the trend results for Colorado Non-ACC FFS, the Colorado FFS ACC Program, and the seven participating RCCOs.

Table 2-13
Trend Analysis
Rating of Specialist Seen Most Often

Plan Name	2015	2016	Trend Results
Colorado Non-ACC FFS	**70.3%+**	**61.5%**	—
Colorado FFS ACC Program	**73.8%**	**68.9%**	—
Region 1: Rocky Mountain Health Plans	70.9%+	60.5%+	—
Region 2: Colorado Access	80.9%+	76.1%+	—
Region 3: Colorado Access	75.0%+	69.8%+	—
Region 4: Integrated Community Health Partners	80.4%+	67.1%+	—
Region 5: Colorado Access	71.8%+	66.1%+	—
Region 6: Colorado Community Health Alliance	67.2%+	67.2%+	—
Region 7: Community Care of Central Colorado	71.2%+	75.8%+	—

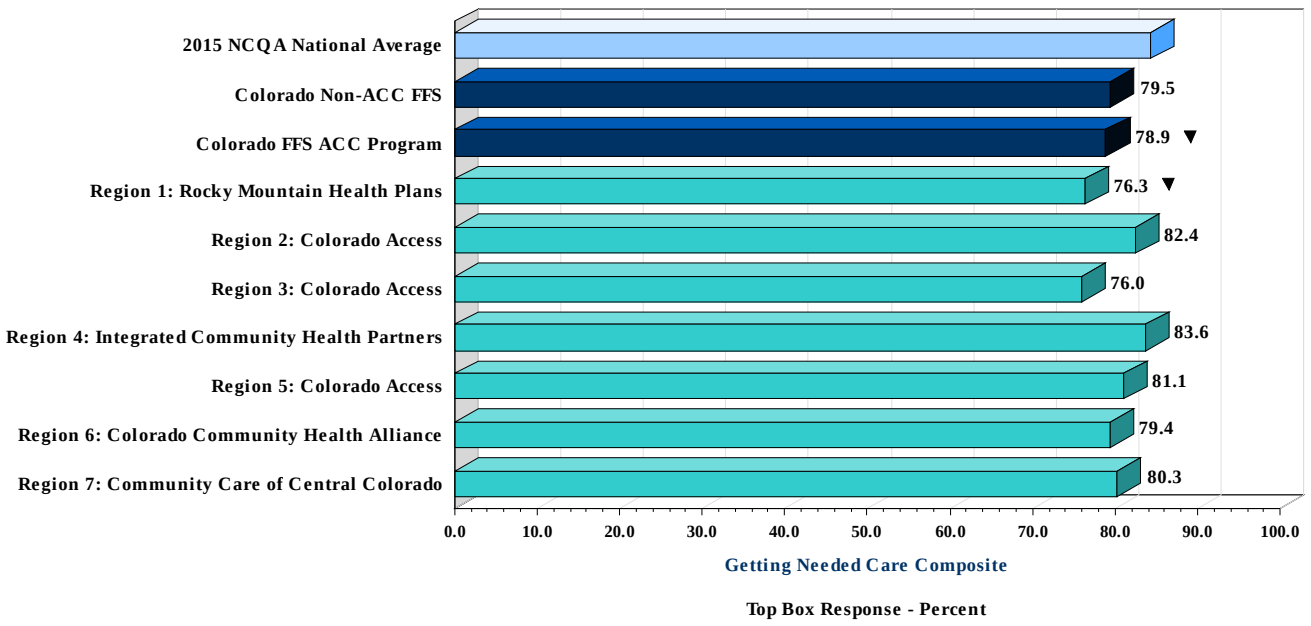
▲ *Indicates the 2016 score is significantly higher than the 2015 score*
▼ *Indicates the 2016 score is significantly lower than the 2015 score*
\+ *Indicates fewer than 100 responses. Caution should be exercised when evaluating these results.*

Composite Measures

Getting Needed Care

Parents/caretakers of child clients were asked two questions to assess how often it was easy to get needed care for their child. For each of these questions (Questions 14 and 28), a top-level response was defined as a response of "Usually" or "Always." Figure 2-4 shows the 2015 NCQA national average and the 2016 Getting Needed Care global proportions for Colorado Non-ACC FFS, the Colorado FFS ACC Program, and the seven participating RCCOs.

Figure 2-4—Getting Needed Care



Statistical Significance Note: ▲ indicates the 2016 score is significantly higher than the 2015 score
▼ indicates the 2016 score is significantly lower than the 2015 score

Table 2-14 displays the 2015 and 2016 Getting Needed Care global proportions, and the trend results for Colorado Non-ACC FFS, the Colorado FFS ACC Program, and the seven participating RCCOs.

Table 2-14
Trend Analysis
Getting Needed Care Composite

Plan Name	2015	2016	Trend Results
Colorado Non-ACC FFS	**85.0%**	**79.5%**	—
Colorado FFS ACC Program	**83.7%**	**78.9%**	▼
Region 1: Rocky Mountain Health Plans	86.0%	76.3%	▼
Region 2: Colorado Access	89.5%	82.4%	—
Region 3: Colorado Access	82.2%	76.0%	—
Region 4: Integrated Community Health Partners	89.5%	83.6%	—
Region 5: Colorado Access	81.7%	81.1%	—
Region 6: Colorado Community Health Alliance	76.3%	79.4%	—
Region 7: Community Care of Central Colorado	83.9%	80.3%	—

▲ *Indicates the 2016 score is significantly higher than the 2015 score*
▼ *Indicates the 2016 score is significantly lower than the 2015 score*
\+ *Indicates fewer than 100 responses. Caution should be exercised when evaluating these results.*

Getting Care Quickly

Parents/caretakers of child clients were asked two questions to assess how often their child received care quickly. For each of these questions (Questions 4 and 6), a top-level response was defined as a response of "Usually" or "Always." Figure 2-5 shows the 2015 NCQA national average and the 2016 Getting Care Quickly global proportions for Colorado Non-ACC FFS, the Colorado FFS ACC Program, and the seven participating RCCOs.

Figure 2-5—Getting Care Quickly

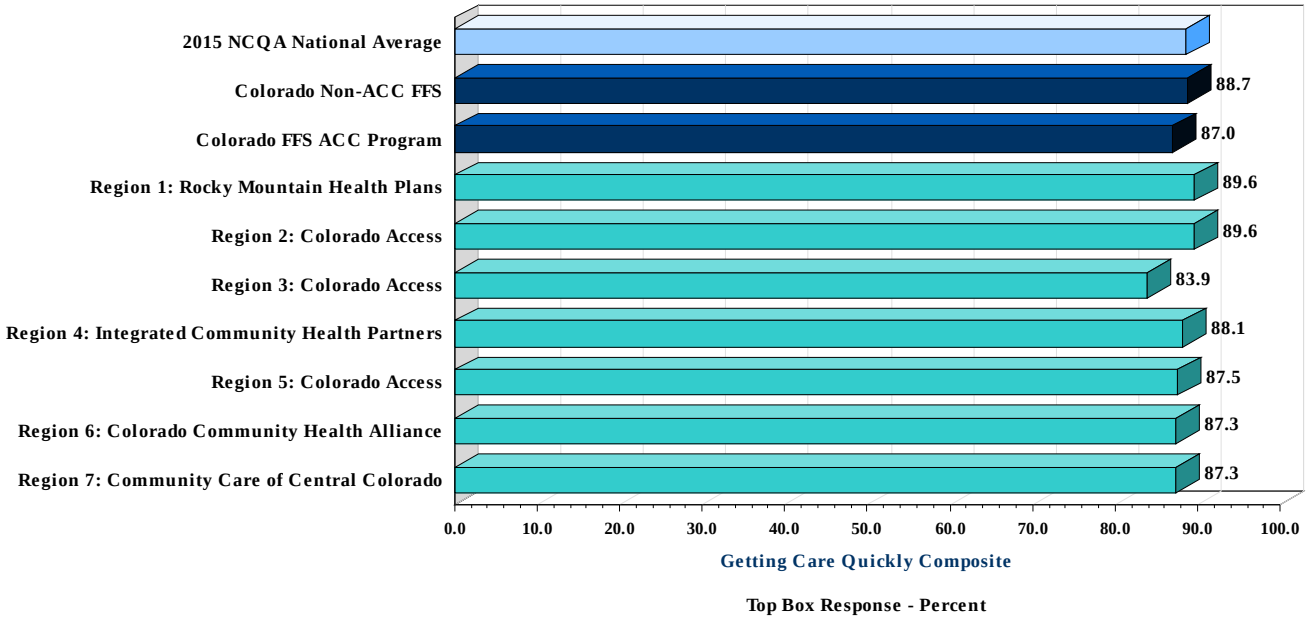


Table 2-15 displays the 2015 and 2016 Getting Care Quickly global proportions, and the trend results for Colorado Non-ACC FFS, the Colorado FFS ACC Program, and the seven participating RCCOs.

Table 2-15
Trend Analysis
Getting Care Quickly Composite

Plan Name	2015	2016	Trend Results
Colorado Non-ACC FFS	**89.0%**	**88.7%**	—
Colorado FFS ACC Program	**86.4%**	**87.0%**	—
Region 1: Rocky Mountain Health Plans	90.4%	89.6%	—
Region 2: Colorado Access	87.9%	89.6%	—
Region 3: Colorado Access	84.2%	83.9%	—
Region 4: Integrated Community Health Partners	87.2%	88.1%	—
Region 5: Colorado Access	84.4%	87.5%	—
Region 6: Colorado Community Health Alliance	85.0%	87.3%	—
Region 7: Community Care of Central Colorado	88.4%	87.3%	—

▲ *Indicates the 2016 score is significantly higher than the 2015 score*
▼ *Indicates the 2016 score is significantly lower than the 2015 score*
\+ *Indicates fewer than 100 responses. Caution should be exercised when evaluating these results.*

How Well Doctors Communicate

Parents/caretakers of child clients were asked four questions to assess how often their child's doctors communicated well. For each of these questions (Questions 17, 18, 19, and 22), a top-level response was defined as a response of "Usually" or "Always." Figure 2-6 shows the 2015 NCQA national average and the 2016 How Well Doctors Communicate global proportions for Colorado Non-ACC FFS, the Colorado FFS ACC Program, and the seven participating RCCOs.

Figure 2-6—How Well Doctors Communicate

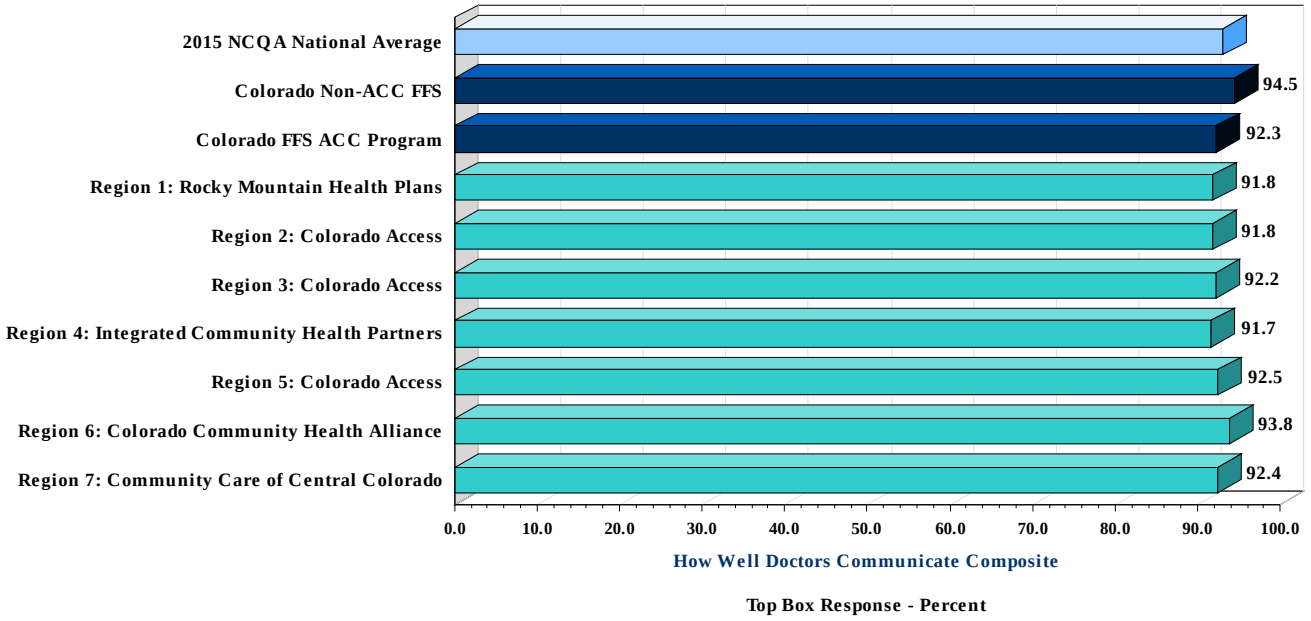


Table 2-16 displays the 2015 and 2016 How Well Doctors Communicate global proportions, and the trend results for Colorado Non-ACC FFS, the Colorado FFS ACC Program, and the seven participating RCCOs.

Table 2-16
Trend Analysis
How Well Doctors Communicate Composite

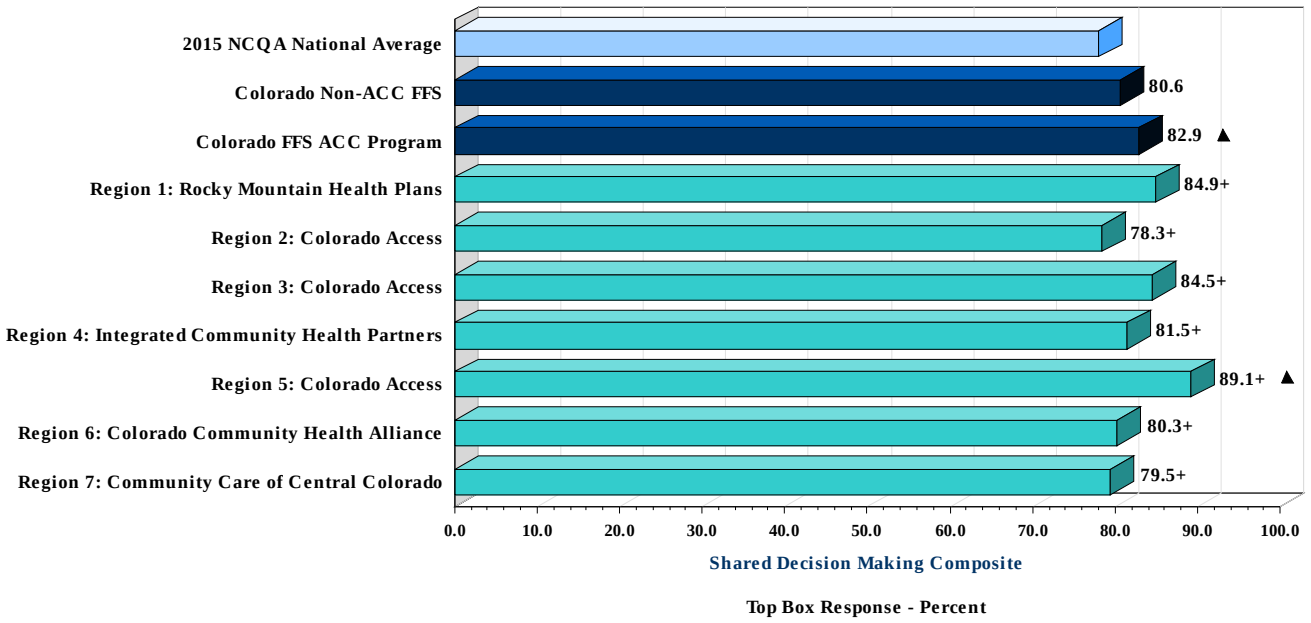
Plan Name	2015	2016	Trend Results
Colorado Non-ACC FFS	**95.1%**	**94.5%**	**—**
Colorado FFS ACC Program	**93.7%**	**92.3%**	**—**
Region 1: Rocky Mountain Health Plans	93.1%	91.8%	—
Region 2: Colorado Access	93.8%	91.8%	—
Region 3: Colorado Access	94.4%	92.2%	—
Region 4: Integrated Community Health Partners	94.8%	91.7%	—
Region 5: Colorado Access	93.6%	92.5%	—
Region 6: Colorado Community Health Alliance	94.2%	93.8%	—
Region 7: Community Care of Central Colorado	91.7%	92.4%	—

▲ *Indicates the 2016 score is significantly higher than the 2015 score*
▼ *Indicates the 2016 score is significantly lower than the 2015 score*
\+ *Indicates fewer than 100 responses. Caution should be exercised when evaluating these results.*

Shared Decision Making

Parents/caretakers of child clients were asked three questions to assess if their child's doctors discussed starting or stopping a medication with them. For each of these questions (Questions 10, 11, and 12), a top-level response was defined as a response of "Yes." Figure 2-7 shows the 2015 NCQA national average and the 2016 Shared Decision Making global proportions for Colorado Non-ACC FFS, the Colorado FFS ACC Program, and the seven participating RCCOs.

Figure 2-7—Shared Decision Making



Statistical Significance Note: ▲ indicates the 2016 score is significantly higher than the 2015 score
▼ indicates the 2016 score is significantly lower than the 2015 score

+ If there were fewer than 100 respondents for a measure, caution should be exercised when interpreting these results.

Table 2-17 displays the 2015 and 2016 Shared Decision Making global proportions, and the trend results for Colorado Non-ACC FFS, the Colorado FFS ACC Program, and the seven participating RCCOs.

Table 2-17
Trend Analysis
Shared Decision Making Composite

Plan Name	2015	2016	Trend Results
Colorado Non-ACC FFS	**78.9%**	**80.6%**	—
Colorado FFS ACC Program	**77.8%**	**82.9%**	▲
Region 1: Rocky Mountain Health Plans	84.8%+	84.9%+	—
Region 2: Colorado Access	75.4%+	78.3%+	—
Region 3: Colorado Access	76.6%+	84.5%+	—
Region 4: Integrated Community Health Partners	81.4%+	81.5%+	—
Region 5: Colorado Access	79.5%	89.1%+	▲
Region 6: Colorado Community Health Alliance	80.3%+	80.3%+	—
Region 7: Community Care of Central Colorado	71.3%+	79.5%+	—

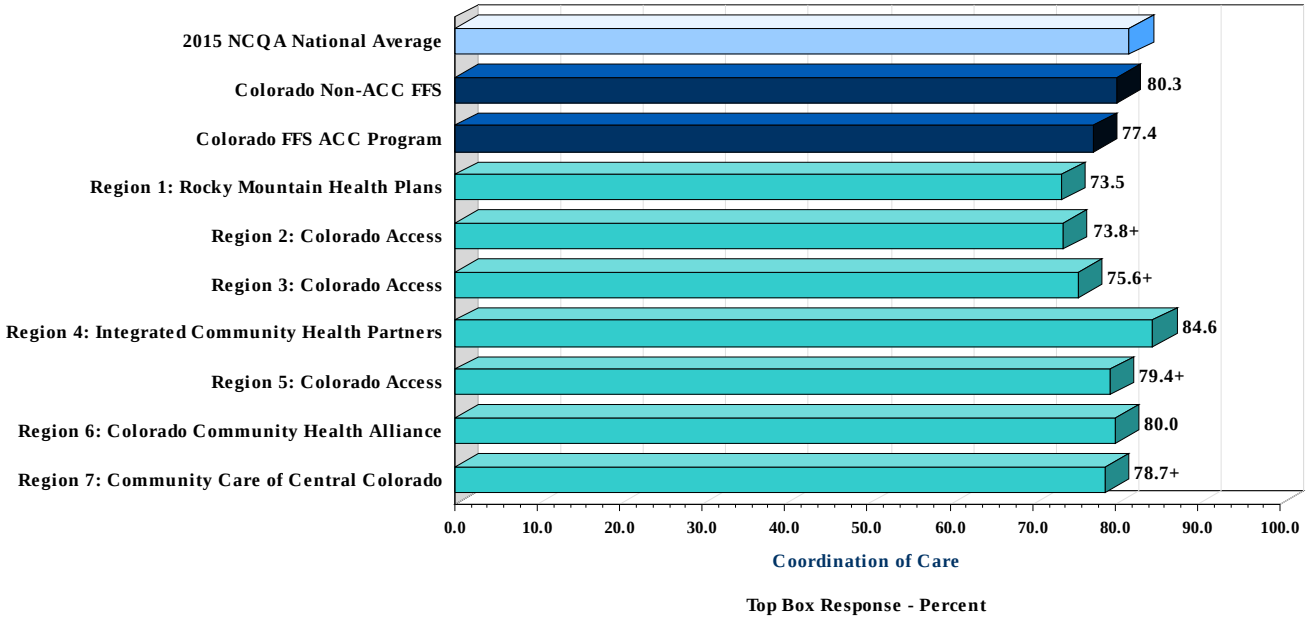
▲ *Indicates the 2016 score is significantly higher than the 2015 score*
▼ *Indicates the 2016 score is significantly lower than the 2015 score*
\+ *Indicates fewer than 100 responses. Caution should be exercised when evaluating these results.*

Individual Item Measures

Coordination of Care

Parents/caretakers of child clients were asked a question to assess how often their child's personal doctor seemed informed and up-to-date about care their child had received from another doctor. For this question (Question 25), a top-level response was defined as a response of "Usually" or "Always." Figure 2-8 shows the 2015 NCQA national average and the 2016 Coordination of Care question summary rates for Colorado Non-ACC FFS, the Colorado FFS ACC Program, and the seven participating RCCOs.

Figure 2-8—Coordination of Care



+ If there were fewer than 100 respondents for a measure, caution should be exercised when interpreting these results.

Table 2-18 displays the 2015 and 2016 Coordination of Care question summary rates, and the trend results for Colorado Non-ACC FFS, the Colorado FFS ACC Program, and the seven participating RCCOs.

Table 2-18
Trend Analysis
Coordination of Care

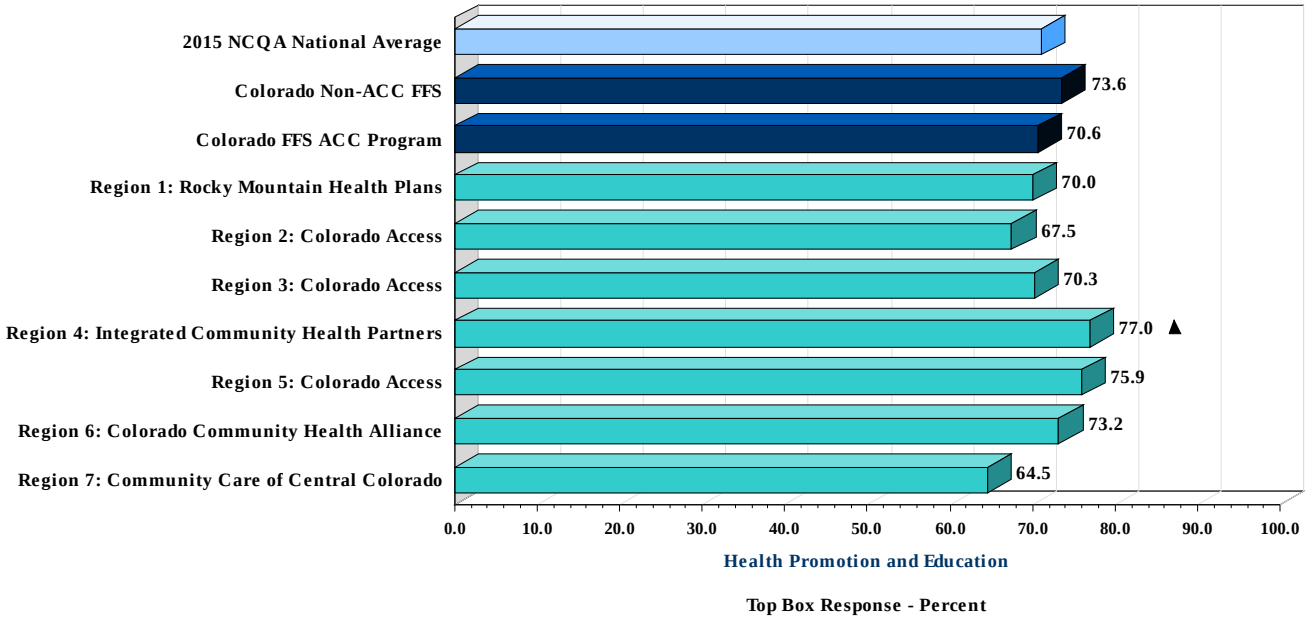
Plan Name	2015	2016	Trend Results
Colorado Non-ACC FFS	**82.0%**	**80.3%**	—
Colorado FFS ACC Program	**77.8%**	**77.4%**	—
Region 1: Rocky Mountain Health Plans	79.1%+	73.5%	—
Region 2: Colorado Access	83.5%+	73.8%+	—
Region 3: Colorado Access	75.0%+	75.6%+	—
Region 4: Integrated Community Health Partners	75.0%+	84.6%	—
Region 5: Colorado Access	81.8%+	79.4%+	—
Region 6: Colorado Community Health Alliance	81.8%+	80.0%	—
Region 7: Community Care of Central Colorado	75.5%	78.7%+	—

▲ *Indicates the 2016 score is significantly higher than the 2015 score*
▼ *Indicates the 2016 score is significantly lower than the 2015 score*
\+ *Indicates fewer than 100 responses. Caution should be exercised when evaluating these results.*

Health Promotion and Education

Parents/caretakers of child clients were asked a question to assess if their child's doctor talked with them about specific things they could do to prevent illness in their child. For this question (Question 8), a top-level response was defined as a response of "Yes." Figure 2-9 shows the 2015 NCQA national average and the 2016 Health Promotion and Education question summary rates for Colorado Non-ACC FFS, the Colorado FFS ACC Program, and the seven participating RCCOs.

Figure 2-9—Health Promotion and Education



Statistical Significance Note: ▲ indicates the 2016 score is significantly higher than the 2015 score
▼ indicates the 2016 score is significantly lower than the 2015 score

Table 2-19 displays the 2015 and 2016 Health Promotion and Education question summary rates, and the trend results for Colorado Non-ACC FFS, the Colorado FFS ACC Program, and the seven participating RCCOs.

Table 2-19
Trend Analysis
Health Promotion and Education

Plan Name	2015	2016	Trend Results
Colorado Non-ACC FFS	**74.4%**	**73.6%**	**—**
Colorado FFS ACC Program	**68.6%**	**70.6%**	**—**
Region 1: Rocky Mountain Health Plans	66.6%	70.0%	—
Region 2: Colorado Access	66.4%	67.5%	—
Region 3: Colorado Access	69.4%	70.3%	—
Region 4: Integrated Community Health Partners	66.8%	77.0%	▲
Region 5: Colorado Access	74.2%	75.9%	—
Region 6: Colorado Community Health Alliance	71.3%	73.2%	—
Region 7: Community Care of Central Colorado	66.0%	64.5%	—

▲ *Indicates the 2016 score is significantly higher than the 2015 score*
▼ *Indicates the 2016 score is significantly lower than the 2015 score*
\+ *Indicates fewer than 100 responses. Caution should be exercised when evaluating these results.*

Non-ACC and RCCO Comparisons

In order to identify performance differences in client satisfaction between the non-ACC and ACC populations, the CAHPS results for Colorado Non-ACC FFS and the Colorado FFS ACC Program average were compared to one another using standard tests for statistical significance. In order to identify performance differences in RCCO client satisfaction between the seven Colorado RCCOs, the CAHPS results for each RCCO were compared to one another using standard tests for statistical significance.[2-11]

For purposes of these comparisons, results were case-mix adjusted. Case-mix refers to the characteristics of respondents used in adjusting the results for comparability among each population/RCCO. Results for Colorado Non-ACC FFS, the Colorado FFS ACC Program, and the individual RCCOs were case-mix adjusted for client general health status, respondent educational level, and respondent age.[2-12] Given that differences in case-mix can result in differences in ratings between the Colorado Non-ACC FFS and ACC populations and the individual RCCOs that are not due to differences in quality, the data were adjusted to account for disparities in these characteristics. The case-mix adjustment was performed using standard regression techniques (i.e., covariance adjustment).

The scoring of the global ratings, composite measures, and individual item measures involved assigning top-level responses a score of one, with all other responses receiving a score of zero. After applying this scoring methodology, the percentage of top-level responses was calculated in order to determine the question summary rates and global proportions. For additional detail, please refer to the *NCQA HEDIS 2016 Specifications for Survey Measures, Volume 3*.

Statistically significant differences are noted in the tables by arrows. A population/RCCO that performed statistically better than the comparative population is denoted with an upward (↑) arrow. Conversely, a population/RCCO that performed statistically worse than the comparative population is denoted with a downward (↓) arrow. A population/RCCO that is not statistically different than the comparative population is denoted with a horizontal (↔) arrow.

For purposes of this report, CAHPS scores are reported for those measures even when NCQA's minimum reporting threshold of 100 respondents was not met; therefore, caution should be exercised when interpreting these results. CAHPS scores with less than 100 respondents are denoted with a cross (+).

[2-11] Caution should be exercised when evaluating the comparisons of the non-ACC and ACC populations, and RCCO comparisons, given that population and RCCO differences may impact CAHPS results.

[2-12] Agency for Healthcare Research and Quality. *CAHPS Health Plan Survey and Reporting Kit 2008*. Rockville, MD: US Department of Health and Human Services, July 2008.

Non-ACC and ACC Comparisons

Table 2-20 shows the results of the non-ACC and ACC comparisons analysis for each CAHPS measure. **NOTE: These results may differ from those presented in the rates and proportions figures because they have been adjusted for differences in case mix (i.e., the percentages presented have been case-mix adjusted).**

Table 2-20
ACC and Non-ACC Plan Comparisons

Measure	Colorado Non-ACC FFS	Colorado FFS ACC Program
Global Ratings		
Rating of All Health Care	58.6% ↔	58.4% ↔
Rating of Personal Doctor	69.4% ↔	69.8% ↔
Rating of Specialist Seen Most Often	63.2% ↔	66.7% ↔
Composite Measures		
Getting Needed Care	79.9% ↔	79.4% ↔
Getting Care Quickly	88.8% ↔	87.6% ↔
How Well Doctors Communicate	94.4% ↔	92.3% ↔
Shared Decision Making	80.0% ↔	83.3% ↔
Individual Measures		
Coordination of Care	82.1% ↔	76.6% ↔
Health Promotion and Education	73.4% ↔	71.5% ↔

Please note: CAHPS scores with fewer than 100 respondents are denoted with a cross (+). If there are fewer than 100 respondents for a CAHPS measure, caution should be exercised when interpreting these results.

Summary of Non-ACC and ACC Comparisons Results

- Colorado Non-ACC FFS did not score significantly lower or higher than the Colorado FFS ACC Program average on any CAHPS measures.

RCCO Comparisons

Table 2-21 through Table 2-23 show the results of the RCCO comparisons analysis for the global ratings, composite measures, and individual item measures, respectively. **NOTE: These results may differ from those presented in the rates and proportions figures because they have been adjusted for differences in case mix (i.e., the percentages presented have been case-mix adjusted).**

Table 2-21
Plan Comparisons
Global Ratings

Plan Name	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often
Region 1: Rocky Mountain Health Plans	59.1% ⇔	72.6% ⇔	60.8%+ ⇔
Region 2: Colorado Access	59.8% ⇔	68.0% ⇔	75.7%+ ⇔
Region 3: Colorado Access	63.5% ⇔	70.4% ⇔	68.8%+ ⇔
Region 4: Integrated Community Health Partners	56.0% ⇔	69.7% ⇔	67.8%+ ⇔
Region 5: Colorado Access	61.7% ⇔	73.5% ⇔	66.1%+ ⇔
Region 6: Colorado Community Health Alliance	61.5% ⇔	71.1% ⇔	67.1%+ ⇔
Region 7: Community Care of Central Colorado	56.7% ⇔	71.5% ⇔	76.3%+ ⇔

Please note: CAHPS scores with fewer than 100 respondents are denoted with a cross (+). If there are fewer than 100 respondents for a CAHPS measure, caution should be exercised when interpreting these results.

Table 2-22
Plan Comparisons
Composite Measures

Plan Name	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Shared Decision Making
Region 1: Rocky Mountain Health Plans	76.0% ⇔	89.5% ⇔	91.7% ⇔	84.7%+ ⇔
Region 2: Colorado Access	82.3% ⇔	89.6% ⇔	91.9% ⇔	79.0%+ ⇔
Region 3: Colorado Access	76.1% ⇔	83.9% ⇔	92.2% ⇔	84.9%+ ⇔
Region 4: Integrated Community Health Partners	83.9% ⇔	88.2% ⇔	91.7% ⇔	81.2%+ ⇔
Region 5: Colorado Access	81.1% ⇔	87.9% ⇔	92.7% ⇔	89.5%+ ⇔
Region 6: Colorado Community Health Alliance	79.3% ⇔	87.0% ⇔	93.8% ⇔	80.2%+ ⇔
Region 7: Community Care of Central Colorado	80.4% ⇔	87.2% ⇔	92.4% ⇔	78.8%+ ⇔

Please note: CAHPS scores with fewer than 100 respondents are denoted with a cross (+). If there are fewer than 100 respondents for a CAHPS measure, caution should be exercised when interpreting these results.

Table 2-23 Plan Comparisons Individual Measures		
Plan Name	**Coordination of Care**	**Health Promotion and Education**
Region 1: Rocky Mountain Health Plans	74.8% ⇔	69.8% ⇔
Region 2: Colorado Access	73.0%+ ⇔	67.9% ⇔
Region 3: Colorado Access	75.0%+ ⇔	70.5% ⇔
Region 4: Integrated Community Health Partners	84.6% ⇔	76.7% ↑
Region 5: Colorado Access	79.2%+ ⇔	76.0% ↑
Region 6: Colorado Community Health Alliance	79.5% ⇔	73.0% ⇔
Region 7: Community Care of Central Colorado	79.6%+ ⇔	64.3% ↓
Please note: CAHPS scores with fewer than 100 respondents are denoted with a cross (+). If there are fewer than 100 respondents for a CAHPS measure, caution should be exercised when interpreting these results.		

Summary of RCCO Comparisons Results

The comparisons of the RCCO populations revealed the following statistically significant results:

- Region 4: Integrated Community Health Partners scored significantly higher than the Colorado FFS ACC Program average on one CAHPS measure, Health Promotion and Education.
- Region 5: Colorado Access scored significantly higher than the Colorado FFS ACC Program average on one CAHPS measure, Health Promotion and Education.
- Region 7: Community Care of Central Colorado scored significantly lower than the Colorado FFS ACC Program average on one CAHPS measure, Health Promotion and Education.

NCQA Comparisons

In order to assess the overall performance of Colorado Non-ACC FFS, the Colorado FFS ACC Program, and the participating RCCOs, the CAHPS global ratings, three composite measures, and one individual item were scored on a three-point scale using the scoring methodology detailed in NCQA's HEDIS Specifications for Survey Measures.[2-13] The resulting three-point mean scores were compared to NCQA's HEDIS Benchmarks and Thresholds for Accreditation.[2-14] Based on this comparison, ratings of one (★) to five (★★★★★) stars were determined for each CAHPS measure, where one is the lowest possible rating and five is the highest possible rating.

★★★★★	indicates a score at or above the 90th percentile
★★★★	indicates a score at or between the 75th and 89th percentiles
★★★	indicates a score at or between the 50th and 74th percentiles
★★	indicates a score at or between the 25th and 49th percentiles
★	indicates a score below the 25th percentile

[2-13] National Committee for Quality Assurance. *HEDIS® 2016, Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2015.

[2-14] National Committee for Quality Assurance. *HEDIS Benchmarks and Thresholds for Accreditation 2016*. Washington, DC: NCQA, January 21, 2016.

Table 2-24 shows the three-point mean scores and overall client satisfaction ratings for the three global ratings for Colorado Non-ACC FFS, the Colorado FFS ACC Program, and the seven participating RCCOs.

Table 2-24
NCQA Comparisons
Overall Client Satisfaction for Global Ratings

Plan Name	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often
Colorado Non-ACC FFS	★ **2.466**	★★★ **2.620**	★ **2.496**
Colorado FFS ACC Program	★★ **2.494**	★★★ **2.634**	★★ **2.583**
Region 1: Rocky Mountain Health Plans	★ 2.484	★★★★ 2.656	★+ 2.474
Region 2: Colorado Access	★★★ 2.522	★★ 2.593	★★★★★+ 2.696
Region 3: Colorado Access	★★★ 2.542	★★★ 2.633	★★★★★+ 2.660
Region 4: Integrated Community Health Partners	★ 2.424	★★ 2.600	★+ 2.506
Region 5: Colorado Access	★★★ 2.553	★★★★★ 2.695	★★+ 2.581
Region 6: Colorado Community Health Alliance	★★ 2.507	★★★ 2.640	★+ 2.525
Region 7: Community Care of Central Colorado	★ 2.441	★★ 2.619	★★★★★+ 2.726

Please note: CAHPS scores with fewer than 100 respondents are denoted with a cross (+). If there are fewer than 100 respondents for a CAHPS measure, caution should be exercised when interpreting these results.

Table 2-25 shows the three-point mean scores and overall client satisfaction ratings for the three composite measures and one individual item for Colorado Non-ACC FFS, the Colorado FFS ACC Program, and the seven participating RCCOs. NCQA does not publish benchmarks and thresholds for the Shared Decision Making composite measure, and Health Promotion and Education individual item measure; therefore, overall client satisfaction ratings could not be determined.

Table 2-25
NCQA Comparisons
Overall Client Satisfaction for Composite and Individual Item Measures

Plan Name	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Coordination of Care
Colorado Non-ACC FFS	★ **2.302**	★★ **2.605**	★★★★ **2.725**	★★ **2.368**
Colorado FFS ACC Program	★ **2.311**	★★ **2.566**	★★ **2.679**	★ **2.333**
Region 1: Rocky Mountain Health Plans	★ 2.283	★★★ 2.610	★★★ 2.682	★ 2.294
Region 2: Colorado Access	★ 2.351	★★ 2.591	★★ 2.646	★+ 2.310
Region 3: Colorado Access	★ 2.232	★ 2.514	★★ 2.664	★+ 2.256
Region 4: Integrated Community Health Partners	★ 2.369	★★ 2.562	★★ 2.671	★★★ 2.447
Region 5: Colorado Access	★ 2.317	★★ 2.555	★★★ 2.691	★+ 2.320
Region 6: Colorado Community Health Alliance	★ 2.323	★★ 2.571	★★★ 2.708	★ 2.320
Region 7: Community Care of Central Colorado	★ 2.300	★★ 2.552	★★★ 2.686	★+ 2.340

Please note: CAHPS scores with fewer than 100 respondents are denoted with a cross (+). If there are fewer than 100 respondents for a CAHPS measure, caution should be exercised when interpreting these results.

Summary of NCQA Comparisons Results

The NCQA comparisons revealed the following summary highlights.

- Colorado Non-ACC FFS scored at or between the 75th and 89th percentiles on one CAHPS measure, How Well Doctors Communicate. Colorado Non-ACC FFS scored below the 25th percentile on three CAHPS measures: Rating of All Health Care, Rating of Specialist Seen Most Often, and Getting Needed Care.
- Colorado FFS ACC scored at or between the 50th and 74th percentiles on one CAHPS measure, Rating of Personal Doctor. Colorado FFS ACC Program scored below the 25th percentile on two CAHPS measures: Getting Needed Care and Coordination of Care.
- Region 1: Rocky Mountain Health Plans scored at or between the 75th and 89th percentiles on one CAHPS measure, Rating of Personal Doctor. Region 1 scored below the 25th percentile on four CAHPS measures: Rating of All Health Care, Rating of Specialist Seen Most Often, Getting Needed Care, and Coordination of Care.
- Region 2: Colorado Access scored at or above the 90th percentile on one CAHPS measure, Rating of Specialist Seen Most Often. Region 2 scored below the 25th percentile on two CAHPS measures: Getting Needed Care and Coordination of Care.
- Region 3: Colorado Access scored at or above the 90th percentile on one CAHPS measure, Rating of Specialist Seen Most Often. Region 3 scored below the 25th percentile on three CAHPS measures: Getting Needed Care, Getting Care Quickly, and Coordination of Care.
- Region 4: Integrated Community Health Partners scored at or between the 50th and 74th percentiles on one CAHPS measure, Coordination of Care. Region 4 scored below the 25th percentile on three CAHPS measures: Rating of All Health Care, Rating of Specialist Seen Most Often, and Getting Needed Care.
- Region 5: Colorado Access scored at or above the 90th percentile on one CAHPS measure, Rating of Personal Doctor. Region 5 scored below the 25th percentile on two CAHPS measures: Getting Needed Care and Coordination of Care.
- Region 6: Colorado Community Health Alliance scored at or between the 50th and 74th percentiles on two CAHPS measures: Rating of Personal Doctor and How Well Doctors Communicate. Region 6 scored below the 25th percentile on three CAHPS measures: Rating of Specialist Seen Most Often, Getting Needed Care, and Coordination of Care.
- Region 7: Community Care of Central Colorado scored at or above the 90th percentile on one CAHPS measure, Rating of Specialist Seen Most Often. Region 7 scored below the 25th percentile on three CAHPS measures: Rating of All Health Care, Getting Needed Care, and Coordination of Care.

3. DHMC and RMHP Results

The following section presents the CAHPS results for DHMC and RMHP. In December 2014, RMHP discontinued their existing Medicaid product in which children were enrolled. The children were transitioned to their ACC program (i.e., RCCO Region 1). RMHP implemented a new Medicaid risk product in September 2014, and children who qualify on the basis of disability were enrolled into this Medicaid product. In general, low income children are not eligible for the new Medicaid risk product. Due to RMHP's child Medicaid population change, a trend analysis was not performed for RMHP, as RMHP's 2016 results are not comparable to prior year's CAHPS results. In addition, RMHP's and DHMC's results were not compared or combined to create an aggregate since the results represent different populations.

Survey Administration and Response Rates

Survey Administration

For the Colorado Medicaid CAHPS Survey administration, child clients eligible for sampling included those who:

- Were currently enrolled in DHMC or RMHP.
- Had been continuously enrolled for at least five of the last six months of 2015.
- Were 17 years of age or younger as of December 31, 2015.

The standard NCQA HEDIS Specifications for Survey Measures require a sample size of 1,650 clients for the CAHPS 5.0 Child Medicaid Health Plan Survey without CCC measurement set.[3-1] For DHMC, a stratified sample of at least 1,650 child clients was selected. RMHP was unable to identify 1,650 eligible child clients for inclusion in the survey; therefore, the sample size for RMHP was 382.[3-2] NCQA protocol does not place any restrictions on oversampling rates. No oversampling was performed for RMHP. DHMC conducted a 37 percent oversample of its population.

[3-1] National Committee for Quality Assurance. *HEDIS® 2016, Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2015.

[3-2] RMHP sample size was extremely low due to the transition of children into RCCO Region 1.

Table 3-1 presents the sample sizes for DHMC and RMHP.

Table 3-1
Colorado Medicaid Plans
Sample Sizes

Name	Total Sample Size
DHMC	2,255
RMHP	382

The survey administration protocol was designed to achieve a high response rate from clients, thus minimizing the potential effects of non-response bias. The survey process employed by DHMC was a mixed mode methodology which allows clients two methods by which they could complete the surveys. The first phase, or mail phase, consisted of a survey being mailed to the sampled clients. DHMC provided English and Spanish versions of the mail survey and allowed clients the option to complete a CATI survey in English or Spanish.[3-3] The cover letter included with the English version of the survey had a Spanish cover letter on the back side informing clients that they could call the toll-free number to request a Spanish version of the CAHPS questionnaire. The cover letter provided with the Spanish version of the CAHPS questionnaire included a text box with a toll-free number that clients could call to request a survey in another language (i.e., English). A reminder postcard was sent to all non-respondents, followed by a second survey mailing and reminder postcard. The second phase, or telephone phase, consisted of CATI for sampled clients who had not mailed in a completed survey. A minimum of three CATI calls was made to each non-respondent.[3-4] The survey administration protocol employed by RMHP was a standard Internet mixed-mode methodology, which allowed sample members the option to complete the survey via the mail option or on the Internet. Additional information on the survey protocol is included in the Reader's Guide Section beginning on page 5-4.

[3-3] DMHC utilized an enhanced mixed-mode survey methodology pre-approved by NCQA.
[3-4] National Committee for Quality Assurance. *Quality Assurance Plan for HEDIS 2016 Survey Measures.* Washington, DC: NCQA Publication, 2015.

Response Rates

The Colorado CAHPS 5.0 Child Medicaid Health Plan Survey administration was designed to achieve the highest possible response rate. The CAHPS Survey response rate is the total number of completed surveys divided by all eligible clients of the sample. A client's survey was assigned a disposition code of "completed" if clients answered at least three of the following five questions: 3, 15, 27, 31, and 36. Eligible clients included the entire random sample (including any oversample) minus ineligible clients. Ineligible clients met at least one of the following criteria: they were deceased, were invalid (did not meet the eligible population criteria), were removed from the sample during deduplication, or had a language barrier.

A total of 421 and 86 completed surveys were returned on behalf of child clients enrolled in the DHMC and RMHP, respectively. DHMC's response rate of 20.8 percent and RMHP's response rate of 25.8 percent were 6 percentage points lower and 1 percentage point lower, respectively, than the national child Medicaid response rate reported by NCQA for 2015, which was 26.8 percent.[3-5,3-6]

Table 3-2 depicts the sample distribution and response rates for DHMC and RMHP.

Table 3-2
Colorado Medicaid Managed Care Program
Sample Distribution and Response Rate

Plan Name	Total Sample	Ineligible Records	Eligible Sample	Total Respondents	Response Rate
DHMC	2,255	232	2,023	421	20.81%
RMHP	382	49	333	86	25.83%

[3-5] National Committee for Quality Assurance. *HEDIS 2016 Survey Vendor Update Training*. October 28, 2015.
[3-6] Please note, 2016 national response rate information was not available at the time this report was produced.

Child and Respondent Demographics

In general, the demographics of a response group influence overall client satisfaction scores. For example, older and healthier respondents tend to report higher levels of client satisfaction; therefore, caution should be exercised when comparing populations that have significantly different demographic properties.[3-7]

Table 3-3 shows the demographic characteristics of children for whom a parent/caretaker completed a CAHPS 5.0 Child Medicaid Health Plan Survey for age, gender, race, ethnicity, and general health status for DHMC and RMHP.

Table 3-3
Child Demographics
Age, Gender, Race, Ethnicity, and General Health Status

	DHMC	RMHP
Age		
Less than 1	0.7%	0.0%
1 to 3	14.2%	3.6%
4 to 7	27.9%	21.4%
8 to 12	32.0%	29.8%
13 to 18	25.2%	45.2%
Gender		
Male	54.7%	62.4%
Female	45.3%	37.6%
Race		
Multi-Racial	8.1%	14.5%
White	34.3%	69.9%
Black	9.2%	3.6%
Asian	3.1%	0.0%
Other	45.3%	12.0%
Ethnicity		
Hispanic	80.5%	32.1%
Non-Hispanic	19.5%	67.9%
General Health Status		
Excellent	41.1%	14.3%
Very Good	35.2%	33.3%
Good	18.7%	33.3%
Fair	4.8%	16.7%
Poor	0.2%	2.4%

Please note: Percentages may not total 100% due to rounding. Children are eligible for inclusion in CAHPS if they are age 17 or younger as of December 31, 2015. Some children eligible for the CAHPS Survey turned age 18 between January 1, 2016, and the time of survey administration.

[3-7] Agency for Healthcare Research and Quality. *CAHPS Health Plan Survey and Reporting Kit 2008*. Rockville, MD: US Department of Health and Human Services, July 2008.

Table 3-4 shows the self-reported age, level of education, and relationship to the child for the respondents who completed the CAHPS 5.0 Child Medicaid Health Plan Survey for DHMC and RMHP.

Table 3-4
Respondent Demographics
Respondent Age, Education, and Relationship to Child

	DHMC	RMHP
Respondent Age		
Under 18	2.6%	8.3%
18 to 24	4.8%	3.6%
25 to 34	32.7%	21.4%
35 to 44	37.7%	36.9%
45 to 54	14.9%	16.7%
55 or Older	7.2%	13.1%
Respondent Education		
8th Grade or Less	22.5%	2.4%
Some High School	29.1%	14.6%
High School Graduate	24.5%	34.1%
Some College	16.5%	28.0%
College Graduate	7.5%	20.7%
Relationship to Child		
Mother or Father	94.2%	97.5%
Grandparent	4.3%	2.5%
Legal Guardian	0.5%	0.0%
Other	1.0%	0.0%

Please note: Percentages may not total 100% due to rounding.

Trend Analysis

In 2014, DHMC had 412 completed CAHPS Surveys. In 2015, DHMC had 537 completed general child CAHPS Surveys.[3-8] In 2016, DHMC had 421 completed CAHPS Surveys. These completed surveys were used to calculate the 2016, 2015, and 2014 CAHPS results presented in this section for trending purposes. In 2016, RMHP had 86 completed CAHPS Surveys. As noted previously, a trend analysis was not performed for RMHP due to changes in the plan's population; however, the 2016 results are presented in the graphs.

For purposes of the trend analysis, question summary rates were calculated for each global rating and individual item measure, and global proportions were calculated for each composite measure. Both the question summary rates and global proportions were calculated in accordance with NCQA HEDIS Specifications for Survey Measures.[3-9] The scoring of the global ratings, composite measures, and individual item measures involved assigning top-level responses a score of one, with all other responses receiving a score of zero. After applying this scoring methodology, the percentage of top-level responses was calculated in order to determine the question summary rates and global proportions. For additional details, please refer to the *NCQA HEDIS 2016 Specifications for Survey Measures, Volume 3*.

In order to evaluate trends in Colorado Medicaid client satisfaction, HSAG performed a stepwise three-year trend analysis, where applicable. The first step compared the 2016 DMHC CAHPS scores to the corresponding 2015 DMHC general child scores. If the initial 2016 and 2015 trend analysis did not yield any statistically significant differences, then an additional trend analysis was performed between 2016 and 2014 results. Figure 3-1 through Figure 3-11 show the results of this trend analysis. Statistically significant differences are noted with directional triangles. Scores that were statistically higher in 2016 than in 2015 are noted with black upward (▲) triangles. Scores that were statistically lower in 2016 than in 2015 are noted with black downward (▼) triangles. Scores that were statistically higher in 2016 than in 2014 are noted with red upward (▲) triangles. Scores that were statistically lower in 2016 than in 2014 are noted with red downward (▼) triangles. Scores in 2016 that were not statistically different from scores in 2015 or in 2014 are not noted with triangles.

CAHPS scores with fewer than 100 respondents are denoted with a cross (+). Caution should be exercised when interpreting results for those measures with fewer than 100 respondents.

[3-8] In 2015, DMHC administered the CAHPS 5.0 Child Medicaid Health Plan Survey with the CCC measurement set. Therefore, the completed surveys represent the general child population that was surveyed.

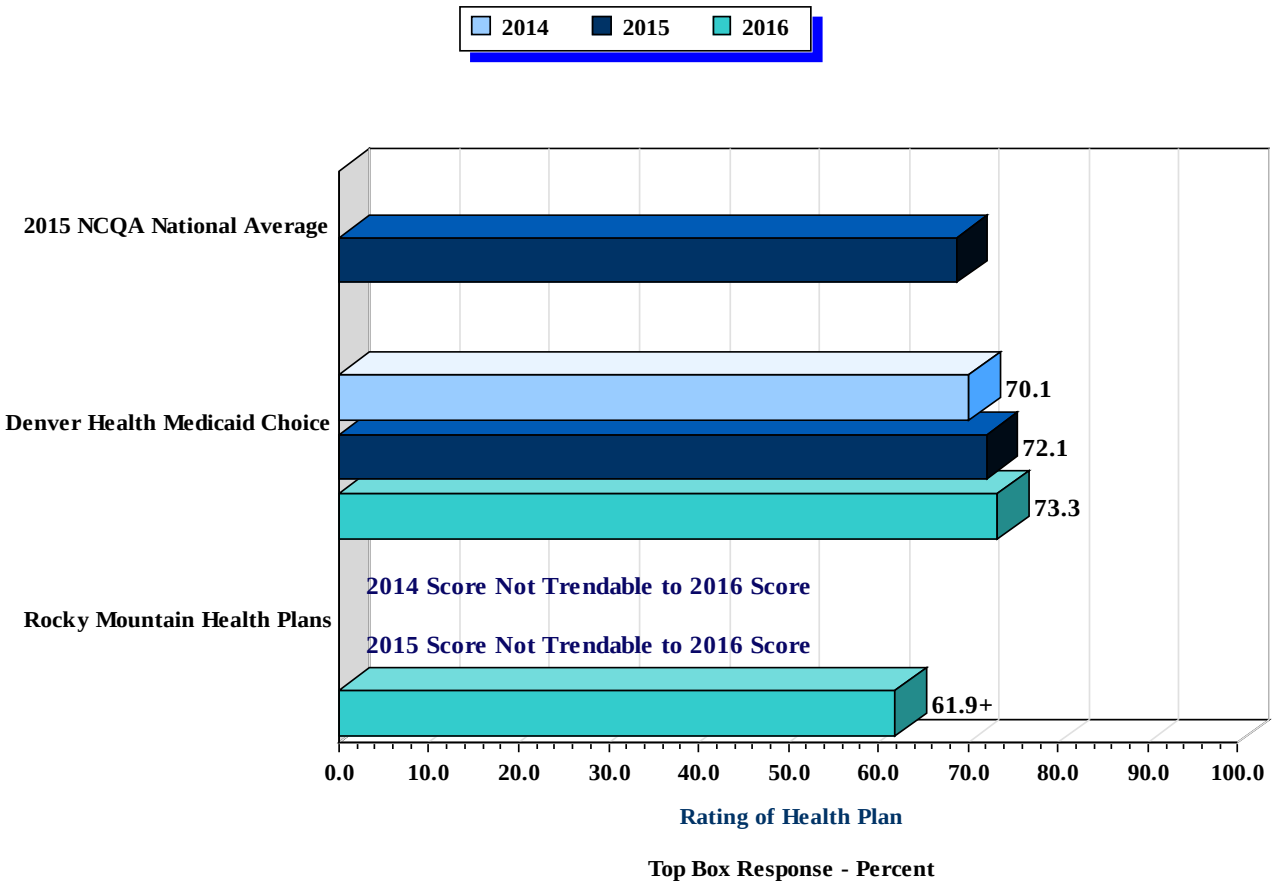
[3-9] National Committee for Quality Assurance. *HEDIS® 2016, Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA Publication, 2015.

Global Ratings

Rating of Health Plan

Colorado Medicaid parents/caretakers of child clients were asked to rate their child's health plan on a scale of 0 to 10, with 0 being the "worst health plan possible" and 10 being the "best health plan possible." Top-level responses were defined as those responses with a rating of 9 or 10. Figure 3-1 shows the 2015 NCQA national average, and the 2014, 2015, and 2016 Rating of Health Plan question summary rates for DHMC and RMHP (only the 2016 question summary rate).[3-10,3-11]

Figure 3-1—Rating of Health Plan



+ If the plan had fewer than 100 respondents for a measure, caution should be exercised when interpreting these results.

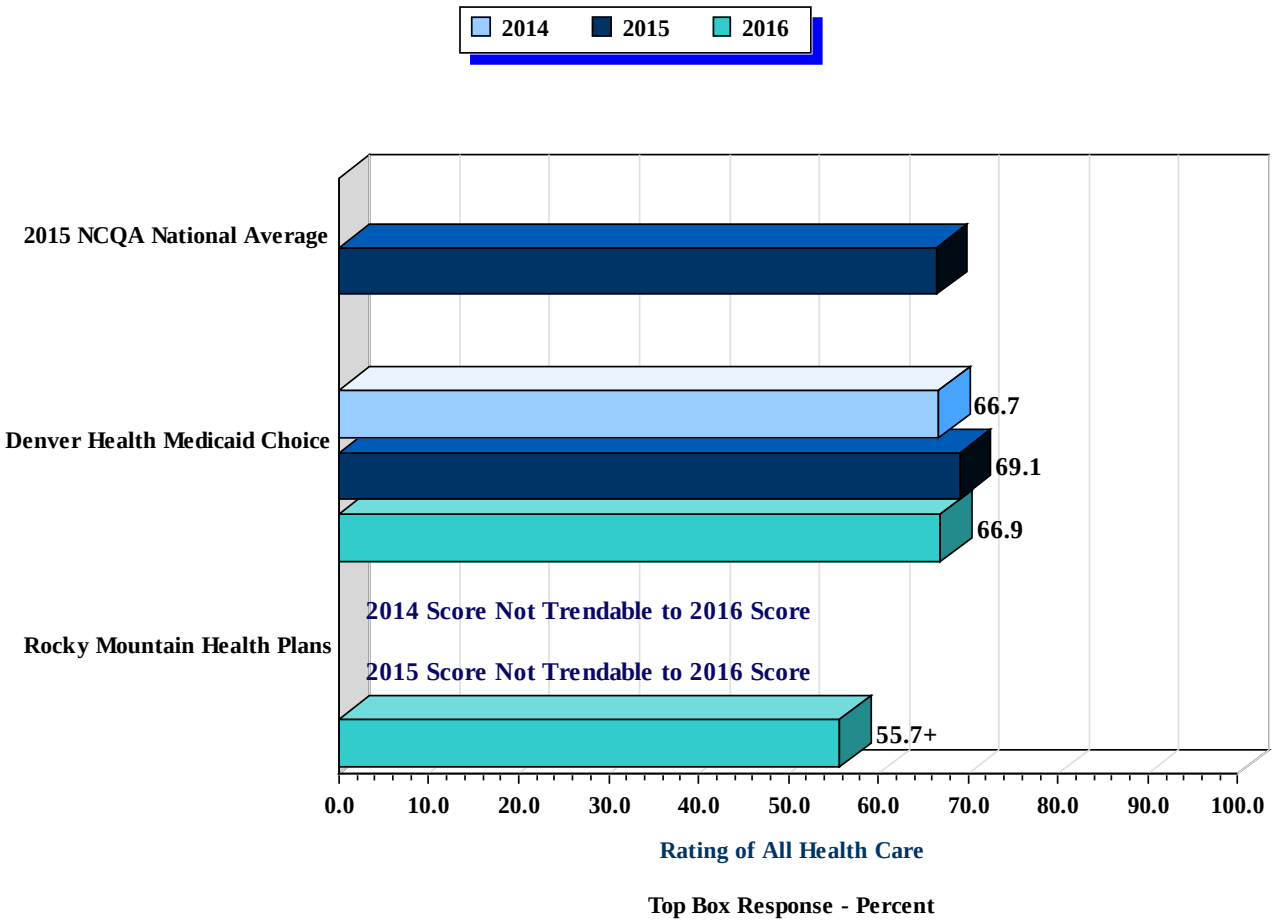
[3-10] NCQA national averages were not available for 2016 at the time this report was prepared; therefore, 2015 NCQA national data are presented in this section.

[3-11] The source for the NCQA national averages for the general child population contained in this publication is Quality Compass® 2015 data and is used with the permission of the National Committee for Quality Assurance (NCQA). Quality Compass 2015 includes certain CAHPS data. Any data display, analysis, interpretation, or conclusion based on these data is solely that of the authors, and NCQA specifically disclaims responsibility for any such display, analysis, interpretation, or conclusion. Quality Compass® is a registered trademark of NCQA. CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Rating of All Health Care

Colorado Medicaid parents/caretakers of child clients were asked to rate all their child's health care on a scale of 0 to 10, with 0 being the "worst health care possible" and 10 being the "best health care possible." Top-level responses were defined as those responses with a rating of 9 or 10. Figure 3-2 shows the 2015 NCQA national average, and the 2014, 2015, and 2016 Rating of All Health Care question summary rates for DHMC and RMHP (only the 2016 question summary rate).

Figure 3-2—Rating of All Health Care

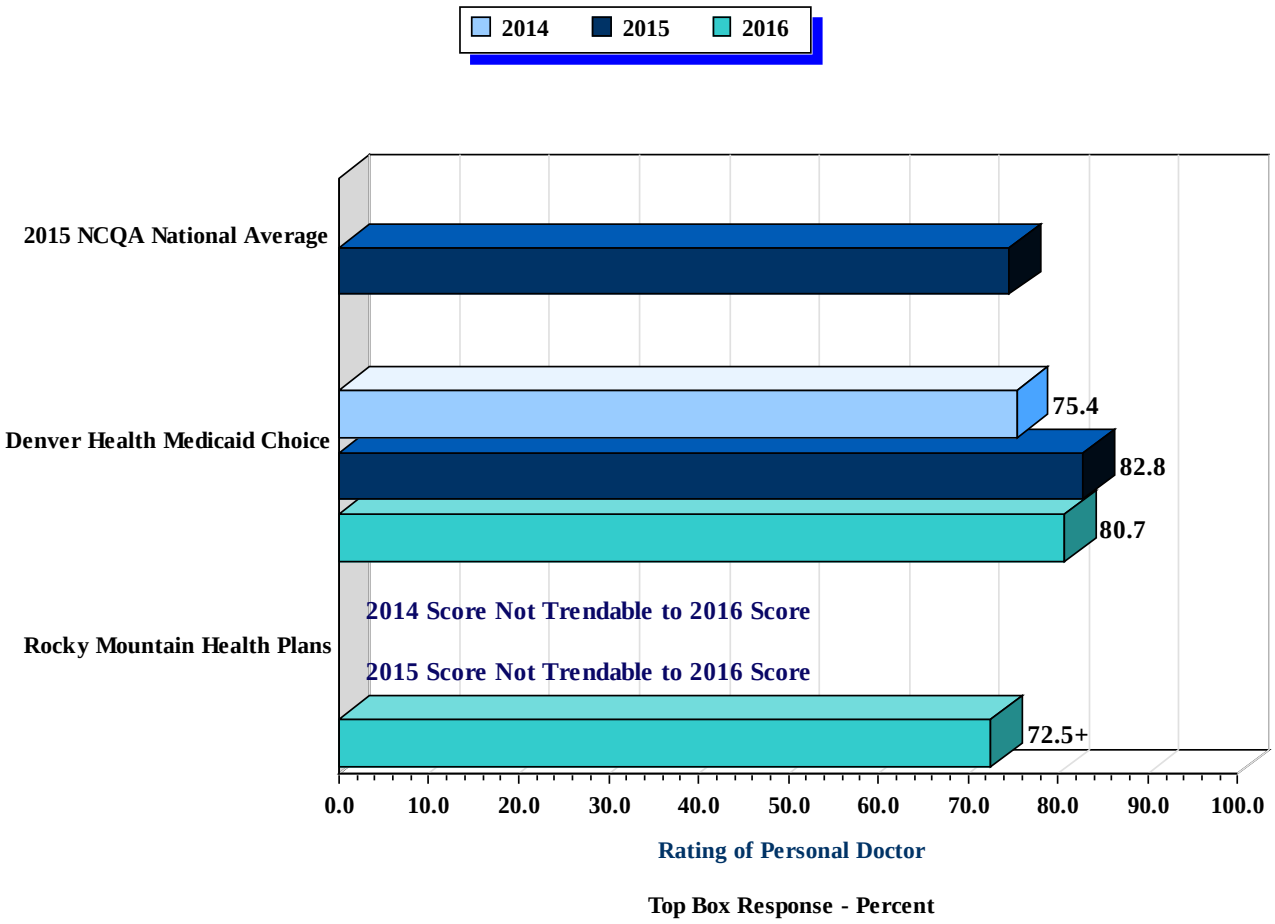


+ If the plan had fewer than 100 respondents for a measure, caution should be exercised when interpreting these results.

Rating of Personal Doctor

Colorado Medicaid parents/caretakers of child clients were asked to rate their child's personal doctor on a scale of 0 to 10, with 0 being the "worst personal doctor possible" and 10 being the "best personal doctor possible." Top-level responses were defined as those responses with a rating of 9 or 10. Figure 3-3 shows the 2015 NCQA national average, and the 2014, 2015, and 2016 Rating of Personal Doctor question summary rates for DHMC and RMHP (only the 2016 question summary rate).

Figure 3-3—Rating of Personal Doctor

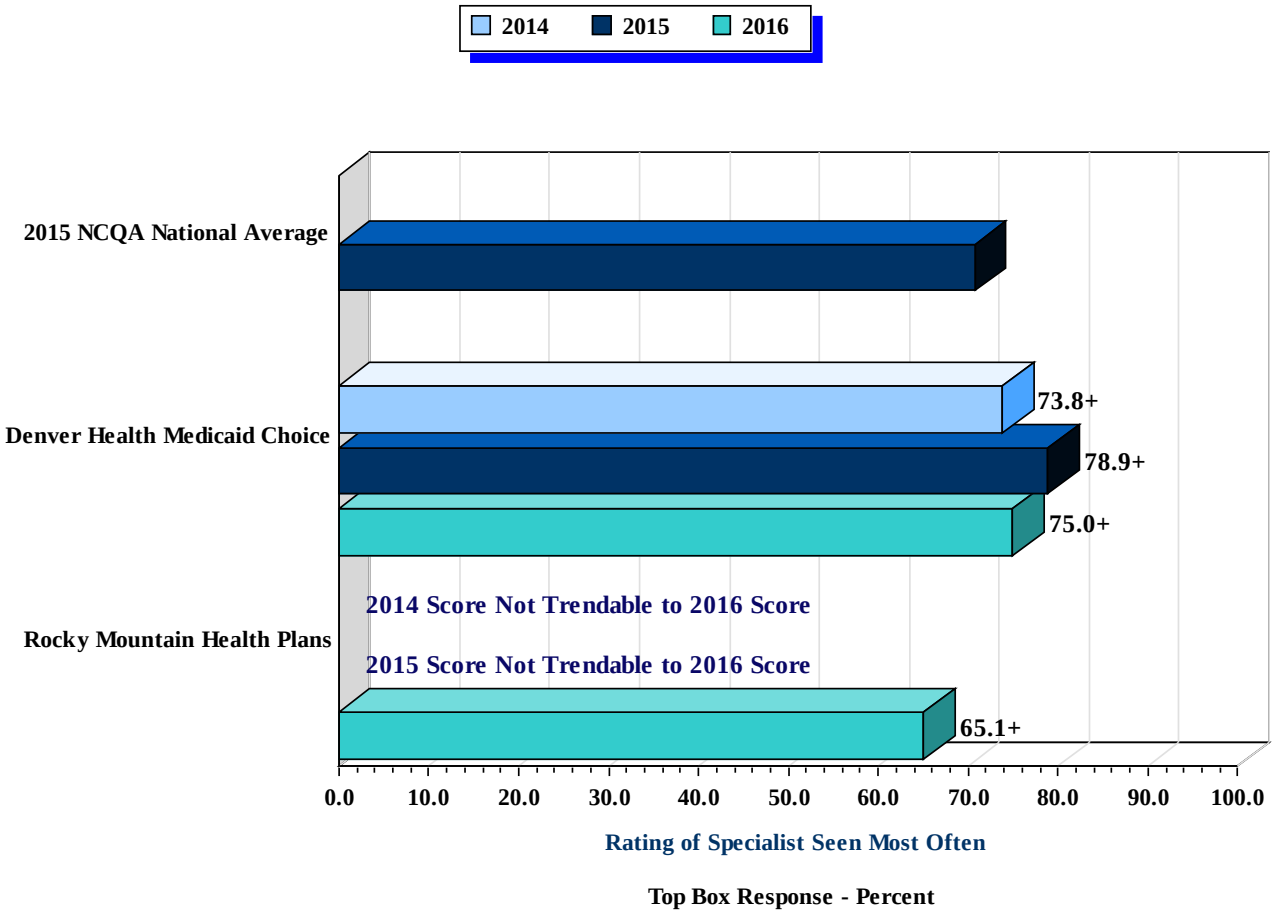


+ If the plan had fewer than 100 respondents for a measure, caution should be exercised when interpreting these results.

Rating of Specialist Seen Most Often

Colorado Medicaid parents/caretakers of child clients were asked to rate the specialist their child saw most often on a scale of 0 to 10, with 0 being the "worst specialist possible" and 10 being the "best specialist possible." Top-level responses were defined as those responses with a rating of 9 or 10. Figure 3-4 shows the 2015 NCQA national average, and the 2014, 2015, and 2016 Rating of Specialist Seen Most Often question summary rates for DHMC and RMHP (only the 2016 question summary rate).

Figure 3-4—Rating of Specialist Seen Most Often



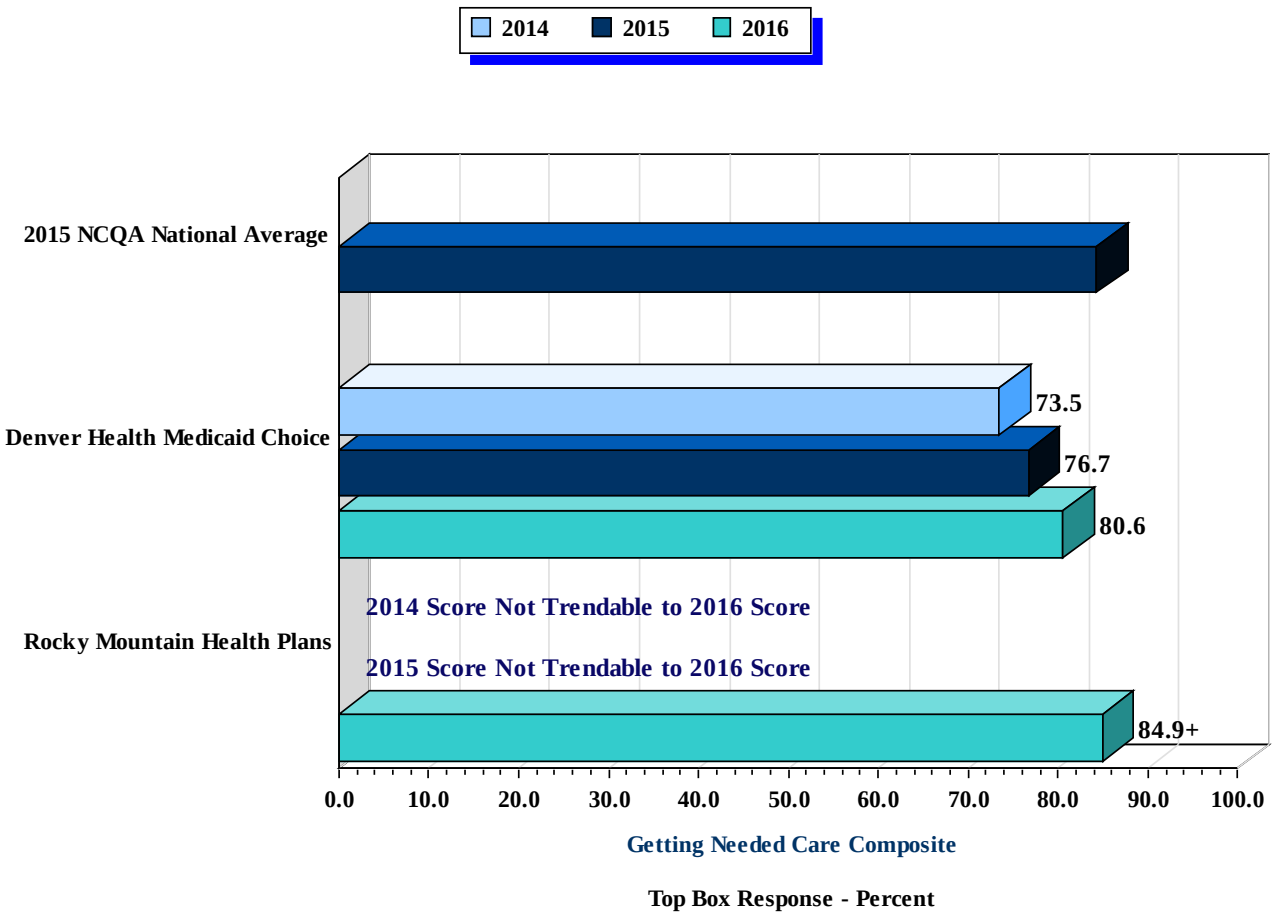
+ If the plan had fewer than 100 respondents for a measure, caution should be exercised when interpreting these results.

Composite Measures

Getting Needed Care

Colorado Medicaid parents/caretakers of child clients were asked two questions to assess how often it was easy to get needed care for their child. For each of these questions (Questions 14 and 28), a top-level response was defined as a response of "Usually" or "Always." Figure 3-5 shows the 2015 NCQA national average, and the 2014, 2015, and 2016 Getting Needed Care global proportions for DHMC and RMHP (only the 2016 global proportion).

Figure 3-5—Getting Needed Care

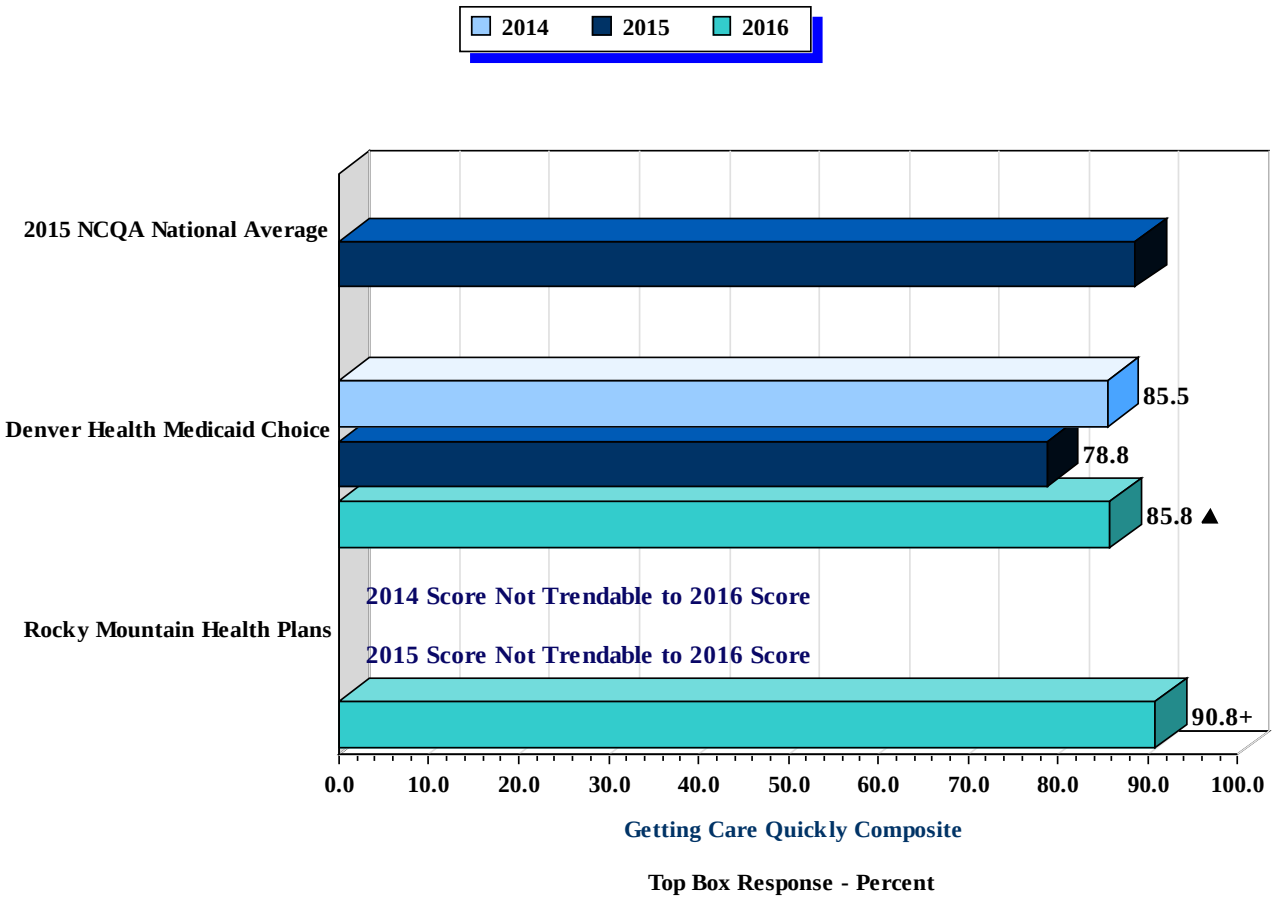


+ If the plan had fewer than 100 respondents for a measure, caution should be exercised when interpreting these results.

Getting Care Quickly

Colorado Medicaid parents/caretakers of child clients were asked two questions to assess how often their child received care quickly. For each of these questions (Questions 4 and 6), a top-level response was defined as a response of "Usually" or "Always." Figure 3-6 shows the 2015 NCQA national average, and the 2014, 2015, and 2016 Getting Care Quickly global proportions for DHMC and RMHP (only the 2016 global proportion).

Figure 3-6—Getting Care Quickly



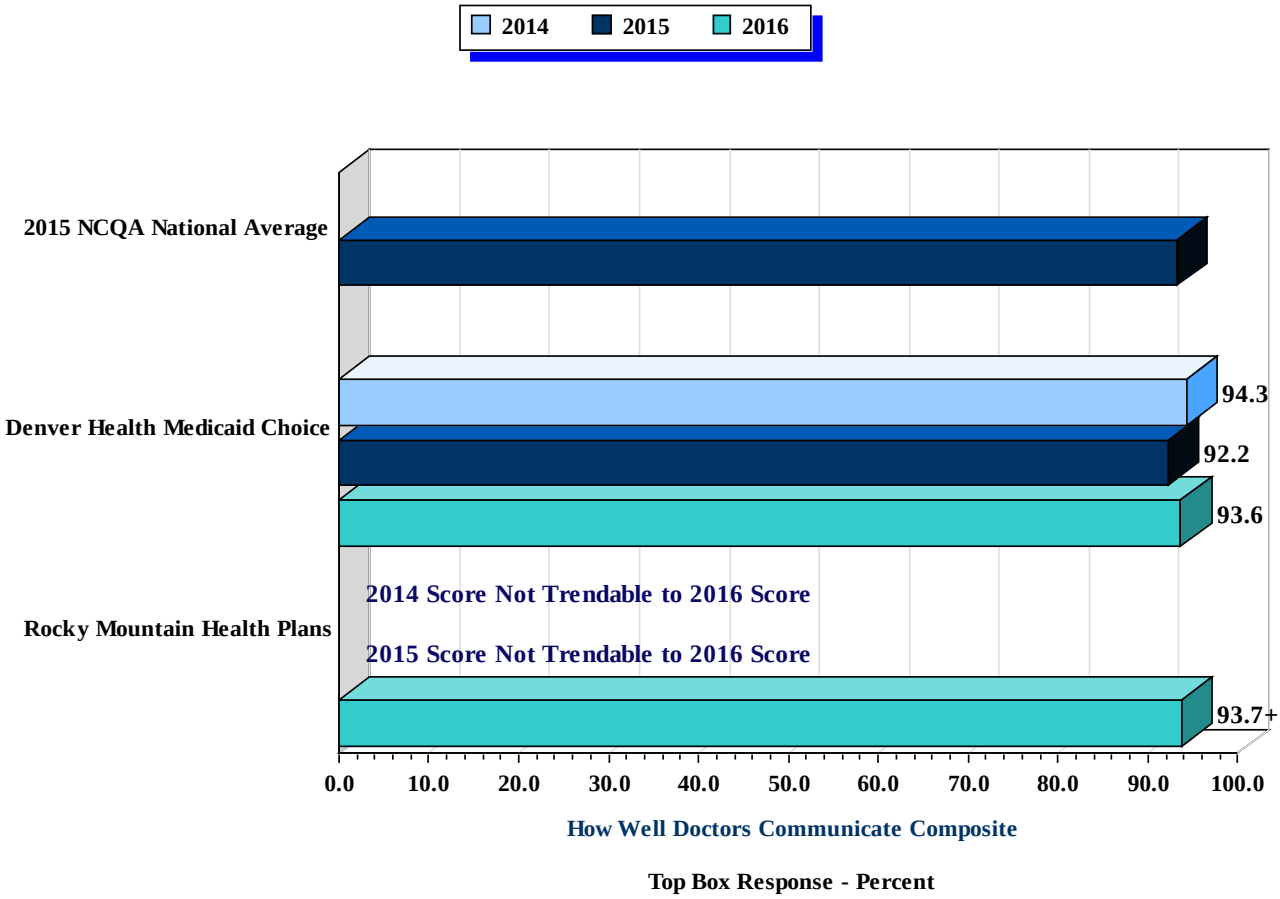
Statistical Significance Note: ▲ indicates the 2016 score is significantly higher than the 2015 score
▼ indicates the 2016 score is significantly lower than the 2015 score

+ If there were fewer than 100 respondents for a measure, caution should be exercised when interpreting these results.

How Well Doctors Communicate

Colorado Medicaid parents/caretakers of child clients were asked four questions to assess how often their child's doctors communicated well. For each of these questions (Questions 17, 18, 19, and 22), a top-level response was defined as a response of "Usually" or "Always." Figure 3-7 shows the 2015 NCQA national average, and the 2014, 2015, and 2016 How Well Doctors Communicate global proportions for DHMC and RMHP (only the 2016 global proportion).

Figure 3-7—How Well Doctors Communicate

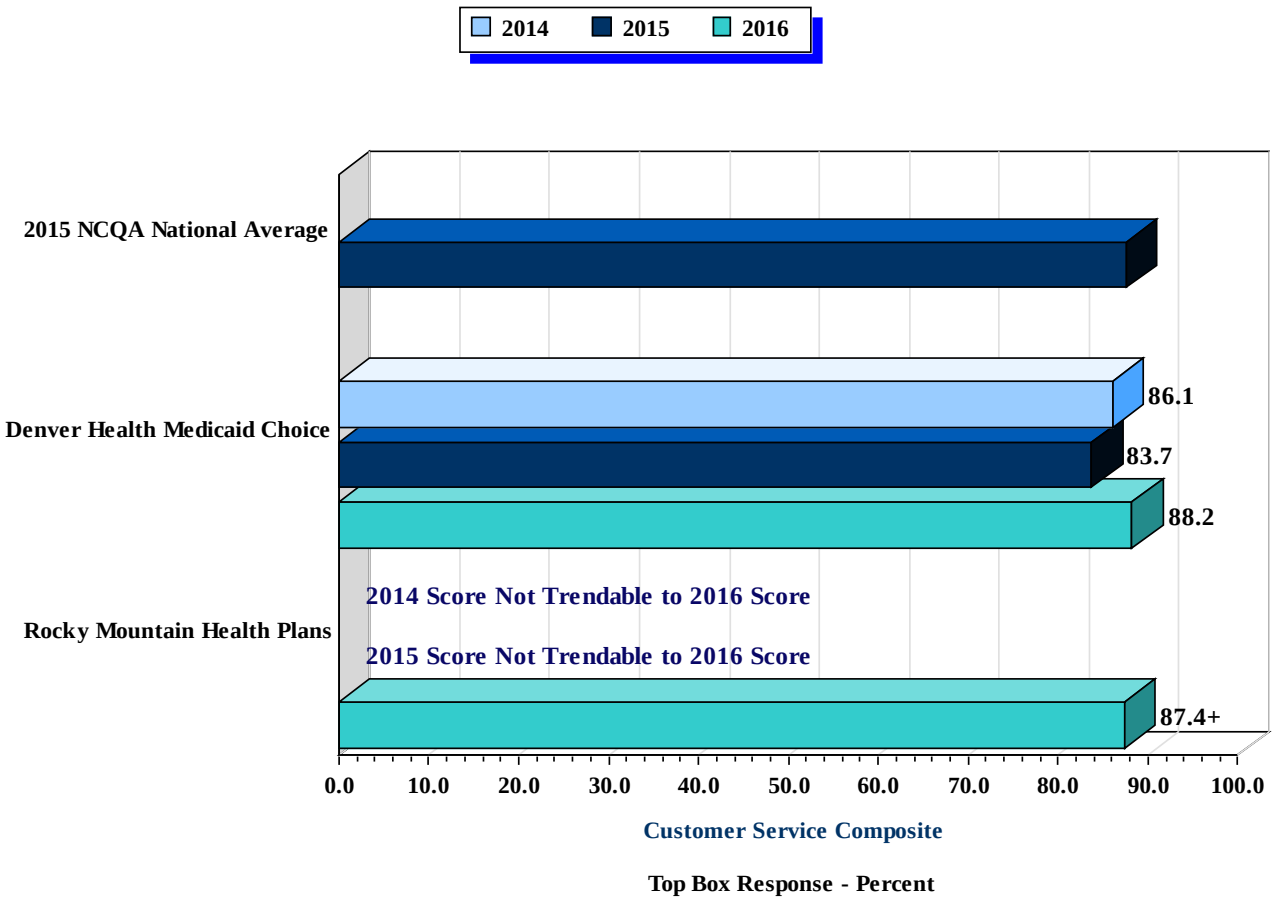


+ If the plan had fewer than 100 respondents for a measure, caution should be exercised when interpreting these results.

Customer Service

Colorado Medicaid parents/caretakers of child clients were asked two questions to assess how often they obtained needed help/information from customer service. For each of these questions (Questions 32 and 33), a top-level response was defined as a response of "Usually" or "Always." Figure 3-8 shows the 2015 NCQA national average, and the 2014, 2015, and 2016 Customer Service global proportions for DHMC and RMHP (only the 2016 global proportion).

Figure 3-8—Customer Service

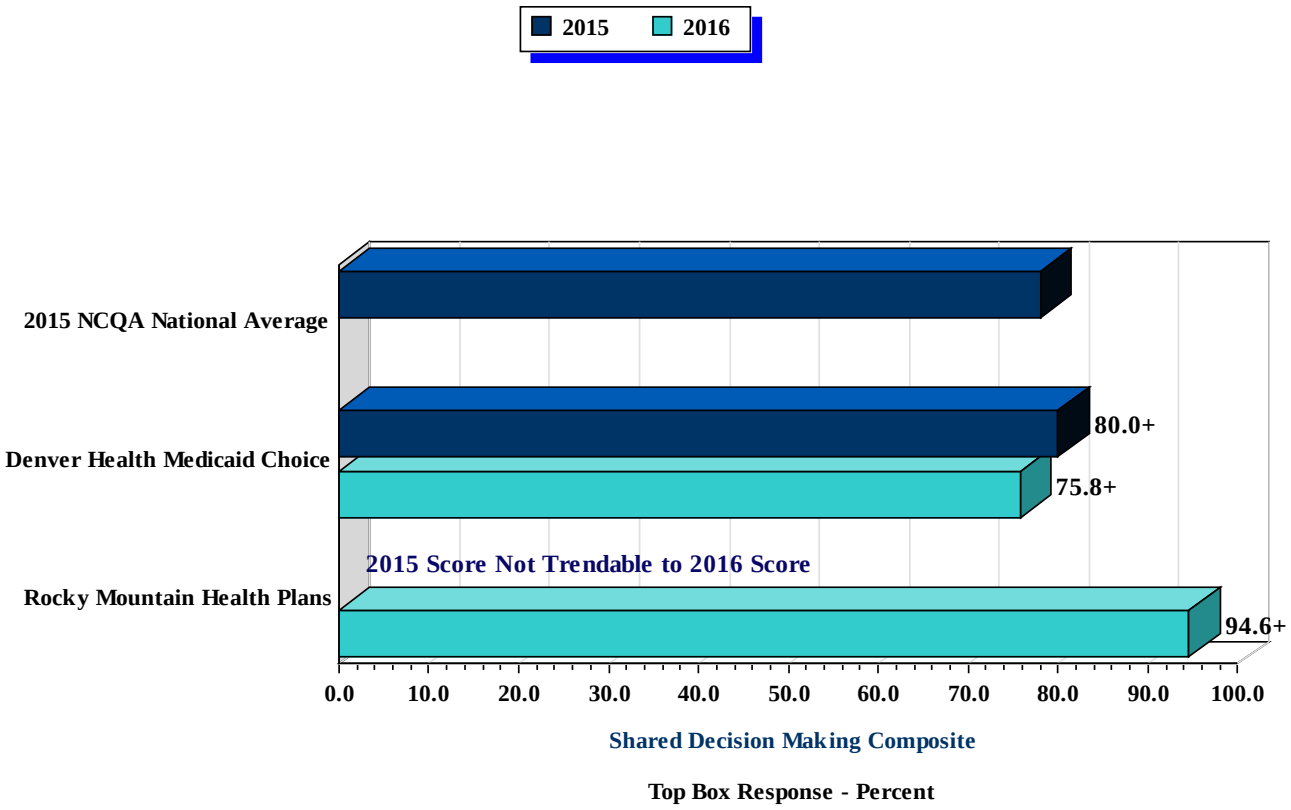


+ If the plan had fewer than 100 respondents for a measure, caution should be exercised when interpreting these results.

Shared Decision Making

Colorado Medicaid parents/caretakers of child clients were asked three questions to assess if their child's doctors discussed starting or stopping a medication with them. For each of these questions (Questions 10, 11, and 12), a top-level response was defined as a response of "Yes." Figure 3-9 shows the 2015 NCQA national average, and the 2015 and 2016 Shared Decision Making global proportions for DHMC and RMHP (only the 2016 global proportion).[3-12]

Figure 3-9—Shared Decision Making



+ If the plan had fewer than 100 respondents for a measure, caution should be exercised when interpreting these results.

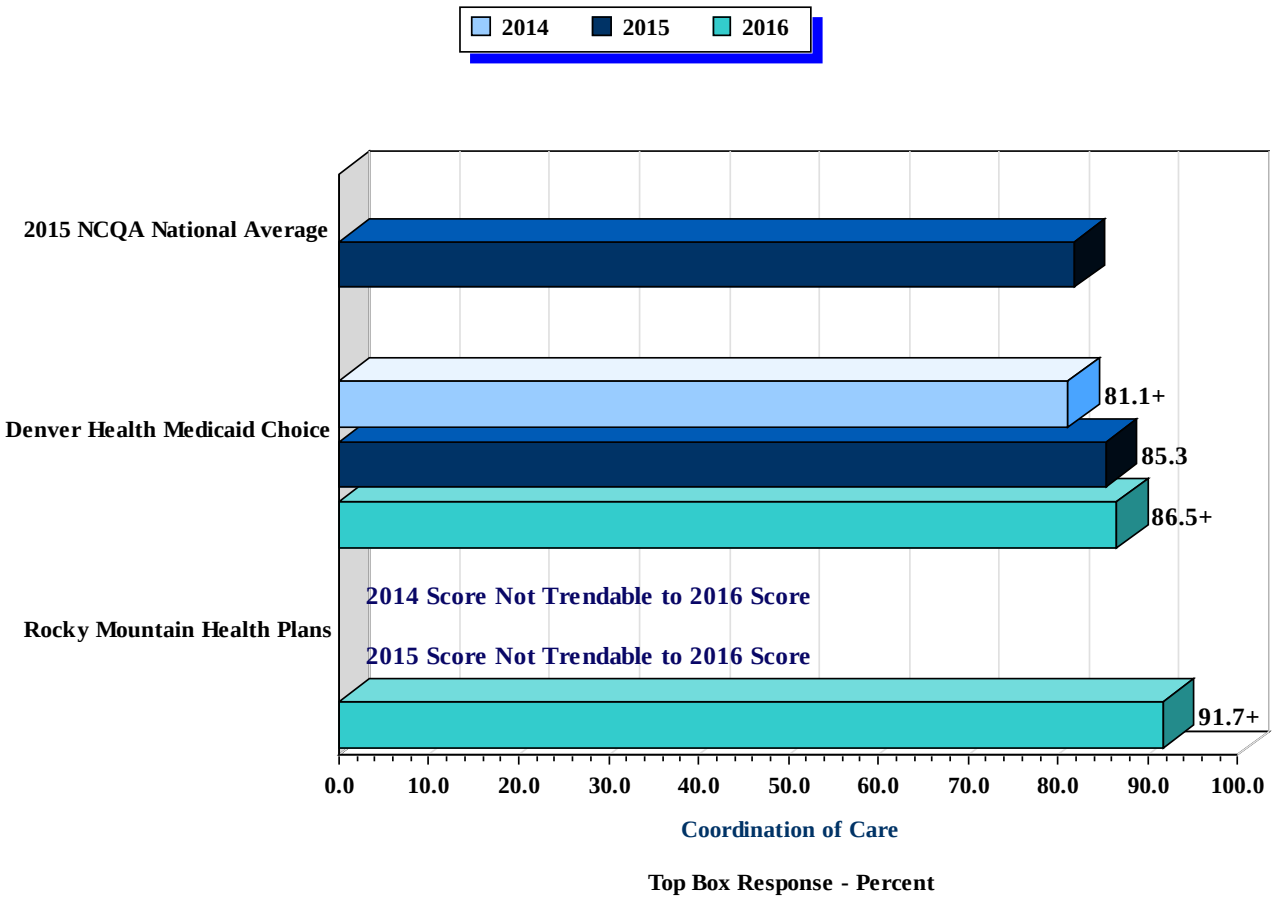
[3-12] As a result of the changes to the Shared Decision Making composite measure, trending to the 2014 scores could not be performed for this CAHPS measure for 2016.

Individual Item Measures

Coordination of Care

Colorado Medicaid parents/caretakers of child clients were asked a question to assess how often their child's personal doctor seemed informed and up-to-date about care their child had received from another doctor. For this question (Question 25), a top-level response was defined as a response of "Usually" or "Always." Figure 3-10 shows the 2015 NCQA national average, and the 2014, 2015, and 2016 Coordination of Care question summary rates for DHMC and RMHP (only the 2016 question summary rate).

Figure 3-10—Coordination of Care

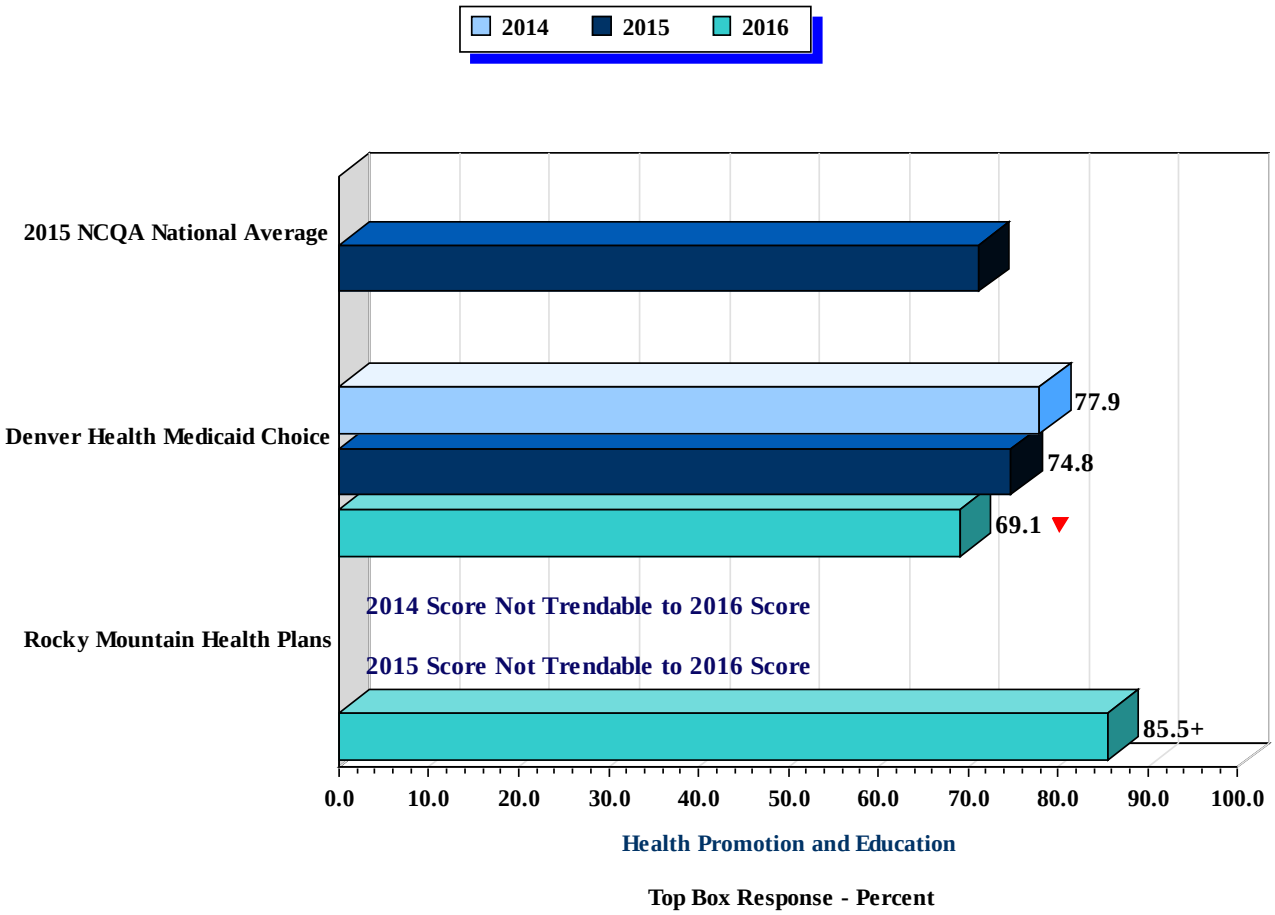


+ If the plan had fewer than 100 respondents for a measure, caution should be exercised when interpreting these results.

Health Promotion and Education

Colorado Medicaid parents/caretakers of child clients were asked a question to assess if their child's doctor talked with them about specific things they could do to prevent illness in their child. For this question (Question 8), a top-level response was defined as a response of "Yes." Figure 3-11 shows the 2015 NCQA national average, and the 2014, 2015, and 2016 Health Promotion and Education question summary rates for DHMC and RMHP (only the 2016 question summary rate).

Figure 3-11—Health Promotion and Education



Statistical Significance Note: ▲ indicates the 2016 score is significantly higher than the 2014 score
▼ indicates the 2016 score is significantly lower than the 2014 score

+ If the plan had fewer than 100 respondents for a measure, caution should be exercised when interpreting these results.

Summary of Trend Analysis Results

The following bullets summarizes the statistically significant differences from the trend analysis for DHMC.

- DHMC scored significantly higher in 2016 than in 2015 on one measure, Getting Care Quickly.
- DHMC scored significantly lower in 2016 than in 2014 on one measure, Health Promotion and Education.

NCQA Comparisons

In order to assess the overall performance of the Colorado Medicaid plans, the four global ratings, four composite measures, and one individual item were scored on a three-point scale using the scoring methodology detailed in NCQA's HEDIS Specifications for Survey Measures.[3-13] The resulting three-point mean scores were compared to NCQA's HEDIS Benchmarks and Thresholds for Accreditation.[3-14] Based on this comparison, plan ratings of one (★) to five (★★★★★) stars were determined for each CAHPS measure, where one is the lowest possible rating and five is the highest possible rating.

★★★★★	indicates a score at or above the 90th percentile
★★★★	indicates a score at or between the 75th and 89th percentiles
★★★	indicates a score at or between the 50th and 74th percentiles
★★	indicates a score at or between the 25th and 49th percentiles
★	indicates a score below the 25th percentile

[3-13] National Committee for Quality Assurance. *HEDIS® 2016, Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2015.

[3-14] National Committee for Quality Assurance. *HEDIS Benchmarks and Thresholds for Accreditation 2016*. Washington, DC: NCQA, January 21, 2016.

Table 3-5 shows the three-point mean scores and overall client satisfaction ratings on the four global ratings, four composite measures, and one individual item measure. NCQA does not provide benchmarks for the Shared Decision Making composite measure, and Health Promotion and Education individual item measure; therefore, overall client satisfaction ratings could not be determined. In addition, caution should be taken when evaluating RMHP's client satisfaction ratings results given that RMHP's population is not comparable to NCQA's benchmark data.

Table 3-5
NCQA Comparisons
Overall Client Satisfaction Ratings

	Denver Health Medicaid Choice	Rocky Mountain Health Plans
Global Rating		
Rating of Health Plan	★★★★ 2.658	★+ 2.452
Rating of All Health Care	★★★★★ 2.609	★+ 2.486
Rating of Personal Doctor	★★★★★ 2.774	★★★★+ 2.675
Rating of Specialist Seen Most Often	★★★★★+ 2.683	★★★★+ 2.628
Composite Measure		
Getting Needed Care	★ 2.355	★★+ 2.413
Getting Care Quickly	★ 2.526	★+ 2.532
How Well Doctors Communicate	★★★★ 2.729	★★★★★+ 2.752
Customer Service	★★★ 2.549	★★+ 2.517
Individual Measure		
Coordination of Care	★★★★+ 2.469	★★★★★+ 2.542

Please note: CAHPS scores with fewer than 100 respondents are denoted with a cross (+). If there are fewer than 100 respondents for a CAHPS measure, caution should be exercised when interpreting these results.

Summary of NCQA Comparisons Results

The following table summarizes the NCQA comparisons results for DHMC and RMHP.

Table 3-6
NCQA Comparisons Highlights

Denver Health Medicaid Choice	Rocky Mountain Health Plans
★ Getting Care Quickly	★+ Getting Care Quickly
★ Getting Needed Care	★+ Rating of All Health Care
★★★ Customer Service	★+ Rating of Health Plan
★★★★+ Coordination of Care	★★+ Customer Service
★★★★ How Well Doctors Communicate	★★+ Getting Needed Care
★★★★ Rating of Health Plan	★★★★+ Rating of Personal Doctor
★★★★★+ Rating of Specialist Seen Most Often	★★★★+ Rating of Specialist Seen Most Often
★★★★★ Rating of All Health Care	★★★★★+ Coordination of Care
★★★★★ Rating of Personal Doctor	★★★★★+ How Well Doctors Communicate

Please note: CAHPS scores with fewer than 100 respondents are denoted with a cross (+). If there are fewer than 100 respondents for a CAHPS measure, caution should be exercised when interpreting these results.

4. Recommendations

General Recommendations

HSAG recommends the continued administration of the CAHPS 5.0 Child Medicaid Health Plan Survey in SFY 2016-2017. HSAG will continue performing complete benchmarking and trend evaluation on the child Medicaid data. HSAG also recommends the continued use of administrative data in identifying the Spanish-speaking population. The number of completed surveys in Spanish for the SFY 2014-2015 survey administration is comparable to the completed surveys in Spanish for the SFY 2015-2016 survey administration due to the identification of these clients prior to the start of the survey.

Priority Assignments

This section presents the results of the priority assignments for Colorado Non-ACC FFS, the seven RCCOs, DHMC, and RMHP. The priority assignments of each CAHPS measure are grouped into four main categories for QI: top, high, moderate, and low priority.[4-1] For Colorado Non-ACC FFS, the RCCOs and DHMC, the priority of the CAHPS measure is based on the combined results of the NCQA comparisons and trend analysis. For RMHP, the priority of the CAHPS measure is based on the results of the NCQA comparisons.

The priorities presented in this section should be viewed as potential suggestions for QI. Additional sources of QI information, such as other HEDIS results, should be incorporated into a comprehensive QI plan. A number of resources are available to assist state Medicaid agencies and plans with the implementation of CAHPS-based QI initiatives. A comprehensive list of these resources is included in the Reader's Guide Section, beginning on page 5-12.

[4-1] NCQA does not provide benchmarks for the Shared Decision Making composite measure, and Health Promotion and Education individual item measure; therefore, priority assignments cannot be derived for these measures.

Priority Assignments

Table 4-1 shows how the priority assignments are determined for Colorado Non-ACC FFS, RCCOs, and DHMC on each CAHPS measure.

Table 4-1—Derivation of Priority Assignments Based on NCQA Comparisons and Trend Analysis

NCQA Comparisons (Star Ratings)	Trend Analysis	Priority Assignment
★	▼	Top
★	—	Top
★	▲	Top
★★	▼	Top
★★	—	High
★★	▲	High
★★★	▼	High
★★★	—	Moderate
★★★	▲	Moderate
★★★★	▼	Moderate
★★★★	—	Moderate
★★★★★	▼	Moderate
★★★★	▲	Low
★★★★★	—	Low
★★★★★	▲	Low

Please note: Trend analysis results reflect those between either the 2016 and 2015 results or the 2016 and 2014 results.[4-2] *If statistically significant differences were not identified during the trend analysis, this lack of statistical significance is denoted with a hyphen (—) in the table above.*

Table 4-2 shows how the priority assignments are determined for RMHP on each CAHPS measure.

Table 4-2—Derivation of Priority Assignments Based on NCQA Comparisons

NCQA Comparisons (Star Ratings)	Priority Assignment
★	Top
★★	High
★★★	Moderate
★★★★	Moderate
★★★★★	Low

[4-2] For more detailed information on the trend analysis results, please see the Non-ACC FFS and RCCO Results and DHMC and RMHP Results sections of this report.

Global Ratings

Rating of Health Plan

Table 4-3 shows the priority assignment for the Rating of Health Plan measure for DHMC and RMHP.

Table 4-3
Priority Assignments
Rating of Health Plan

Plan	NCQA Comparisons (Star Ratings)	Trend Analysis	Priority Assignment
Denver Health Medicaid Choice	★★★★	—	Moderate
Rocky Mountain Health Plans	★+	N/A	Top+

In order to improve the overall Rating of Health Plan, QI activities should target alternatives to one-on-one visits, health plan operations, enhancing online patient portals, promoting QI initiatives, and coordination of health services.

Alternatives to One-on-One Visits

To achieve improved quality, timeliness, and access to care, health plans should engage in efforts that assist providers in examining and improving their systems' abilities' to manage patient demand. As an example, health plans can test alternatives to traditional one-on-one visits, such as telephone consultations, telemedicine, or group visits for certain types of health care services and appointments to increase physician availability. Additionally, for patients who need a follow-up appointment, a system could be developed and tested where a nurse or physician assistant contacts the patient by phone two weeks prior to when the follow-up visit would have occurred to determine whether the patient's current status and condition warrants an in-person visit, and if so, schedule the appointment at that time. Otherwise, an additional status follow-up contact could be made by phone in lieu of an in-person office visit. By finding alternatives to traditional one-on-one, in-office visits, health plans can assist in improving physician availability and ensuring patients receive immediate medical care and services.

Health Plan Operations

It is important for health plans to view their organization as a collection of microsystems (such as providers, administrators, and other staff that provide services to members) that provide the health plan's health care "products." Health care microsystems include: a team of health providers, patient/population to whom care is provided, environment that provides information to providers and patients, support staff, equipment, and office environment. The goal of the microsystems approach is to focus on small, replicable, functional service systems that enable health plan staff to provide high-quality, patient-centered care. The first step to this approach is to define a measurable collection of activities. Once the microsystems are identified, new processes that improve care should be tested and implemented. Effective processes can then be rolled out throughout the health plan.

Online Patient Portal

To help increase members' satisfaction with their health plan, health plans should consider enhancing their current online patient portal or Web-based systems to integrate online tools and services that focus on patient-centered care. In addition to benefits and coverage forms, online health information and services that can be made available to members include: online medical records, electronic communication with providers, and educational health information and resources on various medical conditions. Access to online interactive tools, such as health discussion boards allow questions to be answered by trained clinicians. Online health risk assessments can provide members instant feedback and education on the medical condition(s) specific to their health care needs. An online patient portal can also be an effective means of promoting health awareness and education. Health plans should periodically review health information content for accuracy and request member and/or physician feedback to ensure relevancy of online services and tools provided.

Promote QI Initiatives

Implementation of organization-wide QI initiatives are most successful when health plan staff at every level are involved; therefore, creating an environment that promotes QI in all aspects of care can encourage organization-wide participation in QI efforts. Methods for achieving this can include aligning QI goals to the mission and goals of the health plan organization, establishing plan-level performance measures, clearly defining and communicating collected measures to providers and staff, and offering provider-level support and assistance in implementing QI initiatives. Furthermore, by monitoring and reporting the progress of QI efforts internally, health plans can assess whether QI initiatives have been effective in improving the quality of care delivered to members.

Specific QI initiatives aimed at engaging employees can include quarterly employee forums, an annual all-staff assembly, topic-specific improvement teams, leadership development courses, and employee awards. As an example, improvement teams can be implemented to focus on specific topics such as service quality; rewards and recognition; and patient, physician, and employee satisfaction.

Coordination of Health Services

Health plans should develop a structured approach to coordinating care for children with complex needs. This includes developing strategies for meeting the behavioral health, learning, and/or attention needs of children. Research has identified a planning approach that can be used to provide a coordinated care system that addresses the medical, behavioral, and social needs of children with chronic conditions.

The planning approach focuses on the developing aspect of providing care management services to children and their families. Some of the key elements involved in the planning process include a patient- and family-centered system of care that focuses on community-based services that are built on a system of care values (e.g., team-based, individualized, outcomes-based). Research has shown that efforts that focus on moving the child towards community-based services (i.e., informal support) like home-based therapy, mentoring services, and community support groups can promote better outcomes. However, in order for informal support to be effective, families or caretakers must be actively involved in the planning, decision making, and care of the child.

Rating of All Health Care

Table 4-4 shows the priority assignments for the Rating of All Health Care measure for Colorado Non-ACC FFS and the seven participating RCCOs.

Table 4-4
Priority Assignments
Rating of All Health Care

Plan	NCQA Comparisons (Star Ratings)	Trend Analysis	Priority Assignment
Colorado Non-ACC FFS	★	▼	Top
Region 1: Rocky Mountain Health Plans	★	—	Top
Region 2: Colorado Access	★★★	—	Moderate
Region 3: Colorado Access	★★★	—	Moderate
Region 4: Integrated Community Health Partners	★	—	Top
Region 5: Colorado Access	★★★	—	Moderate
Region 6: Colorado Community Health Alliance	★★	—	High
Region 7: Community Care of Central Colorado	★	—	Top

Table 4-5 shows the priority assignment for the Rating of All Health Care measure for DHMC and RMHP.

Table 4-5
Priority Assignments
Rating of All Health Care

Plan	NCQA Comparisons (Star Ratings)	Trend Analysis	Priority Assignment
Denver Health Medicaid Choice	★★★★★	—	Low
Rocky Mountain Health Plans	★$^{+}$	N/A	Top^{+}

In order to improve the Rating of All Health Care measure, QI activities should target client perception of access to care, patient and family engagement advisory councils, patient- and family-centered care, and involving families in care coordination.

Access to Care

RCCOs/health plans should identify potential barriers for patients receiving appropriate access to care. Access to care issues include obtaining the care that the patient and/or physician deemed necessary, obtaining timely urgent care, locating a personal doctor, or receiving adequate assistance when calling a physician office. The RCCO/health plan should attempt to reduce any hindrances a patient might encounter while seeking care. Standard practices and established protocols can assist in this process by ensuring access to care issues are handled consistently across all practices. For example, RCCOs/health plans can develop standardized protocols and scripts for common occurrences within the provider office setting, such as late patients. With proactive polices and scripts

in place, the late patient can be notified the provider has moved onto the next patient and will work the late patient into the rotation as time permits. This type of structure allows the late patient to still receive care without causing delay in the appointments of other patients. Additionally, having a well-written script prepared in the event of an uncommon but expected situation allows staff to work quickly in providing timely access to care while following protocol.

Patient and Family Engagement Advisory Councils

Since both patients and families have the direct experience of an illness or health care system, their perspectives can provide significant insight when performing an evaluation of health care processes. Therefore, RCCOs/health plans should consider creating opportunities and functional roles that include the patients and families who represent the populations they serve. Patient and family members could serve as advisory council members providing new perspectives and serving as a resource to health care processes. Patient interviews on services received and family inclusion in care planning can be an effective strategy for involving members in the design of care and obtaining their input and feedback on how to improve the delivery of care. Further, involvement in advisory councils can provide a structure and process for ongoing dialogue and creative problem-solving between the health plan and its members. The councils' roles within a RCCO/health plan organization can vary and responsibilities may include input into or involvement in: program development, implementation, and evaluation; marketing of health care services; and design of new materials or tools that support the provider-patient relationship.

Patient- and Family-Centered Care

Building on actively engaging patients and families to serve as advisory council members to aid in improving health care processes, RCCOs/health plans can also utilize patient- and family-centered care as an approach to the planning, delivery, and evaluation of healthcare that is grounded in mutually beneficial partnerships among healthcare providers, patients, and families. It is founded on the understanding that the family plays a vital role in ensuring the health and well-bring of patients of all ages. Research has shown that patient- and family-centered care results in improved care, and more efficient use of resources (e.g., reduced non-urgent emergency department visits in children), ultimately leading to improved healthcare for children and their families. By incorporating the strategies listed below, RCCOs/plans and programs can provide patient- and family-centered care management services to children with chronic conditions and their families.

Involving Families in Care Coordination

RCCOs/health plans should ensure care plans for children with chronic conditions include the desired outcomes for both the child and family. The family's role in the coordination of care process should be taken into account when developing a child member's care plan. According to the American Academy of Pediatrics' policy statement regarding "Family-Centered Care and the Pediatrician's Role," improved health outcomes of children with chronic conditions are linked to the concept of the family as a primary partner in care coordination. RCCOs/health plans should encourage family member participation in coordination of care as the family is most knowledgeable about the child's health care needs. Collaboration between family members and medical team professionals can lead to improved health for child members. To assist in family involvement, RCCOs/health plans should ensure that parents and caretakers of child members are informed about their child's health condition(s), available health care services, and how to access those services.

Rating of Personal Doctor

Table 4-6 shows the priority assignments for the Rating of Personal Doctor measure for Colorado Non-ACC FFS and the seven participating RCCOs.

Table 4-6
Priority Assignments
Rating of Personal Doctor

Plan	NCQA Comparisons (Star Ratings)	Trend Analysis	Priority Assignment
Colorado Non-ACC FFS	★★★	▼	High
Region 1: Rocky Mountain Health Plans	★★★★	—	Moderate
Region 2: Colorado Access	★★	—	High
Region 3: Colorado Access	★★★	—	Moderate
Region 4: Integrated Community Health Partners	★★	—	High
Region 5: Colorado Access	★★★★★	—	Low
Region 6: Colorado Community Health Alliance	★★★	▲	Moderate
Region 7: Community Care of Central Colorado	★★	—	High

Table 4-7 shows the priority assignment for the Rating of Personal Doctor measure for DHMC and RMHP.

Table 4-7
Priority Assignments
Rating of Personal Doctor

Plan	NCQA Comparisons (Star Ratings)	Trend Analysis	Priority Assignment
Denver Health Medicaid Choice	★★★★★	—	Low
Rocky Mountain Health Plans	★★★★+	N/A	Moderate+

In order improve the Rating of Personal Doctor measure, QI activities should target maintaining truth in scheduling, patient-direct feedback, physician-patient communication, improving shared decision making, and care manager training.

Maintain Truth in Scheduling

RCCOs/health plans can request that all providers monitor appointment scheduling to ensure that scheduling templates accurately reflect the amount of time it takes to provide patient care during a scheduled office visit. RCCOs/health plans could provide assistance or instructions to those physicians unfamiliar with this type of assessment. Patient dissatisfaction can often be the result of prolonged wait times and delays in receiving care at the scheduled appointment time. One method for evaluating appropriate scheduling of various appointment types is to measure the amount of time it

takes to complete the scheduled visit. This type of monitoring will allow providers to identify if adequate time is being scheduled for each appointment type and if appropriate changes can be made to scheduling templates to ensure patients are receiving prompt, adequate care. Patient wait times for routine appointments should also be recorded and monitored to ensure that scheduling can be optimized to minimize these wait times. Additionally, by measuring the amount of time it takes to provide care, both RCCOs/health plans and physician offices' can identify where streamlining opportunities exist. If providers are finding bottlenecks within their patient flow processes, they may consider implementing daily staff huddles to improve communication or working in teams with cross-functionalities to increase staff responsibility and availability.

Patient-Direct Feedback

RCCOs/health plans can explore additional methods for obtaining direct patient feedback to improve patient satisfaction, such as comment cards. Comment cards have been utilized and found to be a simple method for engaging patients and obtaining rapid feedback on their recent physician office visit experiences. RCCOs/health plans can assist in this process by developing comment cards that physician office staff can provide to patients following their visit. Comment cards can be provided to patients with their office visit discharge paperwork or via postal mail or e-mail. Asking patients to describe what they liked most about the care they received during their recent office visit, what they liked least, and one thing they would like to see changed can be an effective means for gathering feedback (both positive and negative). Comment card questions may also prompt feedback regarding other topics, such as providers' listening skills, wait time to obtaining an appointment, customer service, and other items of interest. Research suggests the addition of the question, "Would you recommend this physician's office to a friend?" greatly predicts overall patient satisfaction. This direct feedback can be helpful in gaining a better understanding of the specific areas that are working well and areas which can be targeted for improvement.

Physician-Patient Communication

RCCOs/health plans should encourage physician-patient communication to improve patient satisfaction and outcomes. Indicators of good physician-patient communication include providing clear explanations, listening carefully, and being understanding of patients' perspectives. RCCOs/health plans can also create specialized workshops focused on enhancing physicians' communication skills, relationship building, and the importance of physician-patient communication. Training sessions can include topics such as improving listening techniques, patient-centered interviewing skills, collaborative communication which involves allowing the patient to discuss and share in the decision making process, as well as effectively communicating expectations and goals of health care treatment. In addition, workshops can include training on the use of tools that improve physician-patient communication. Examples of effective tools include visual medication schedules and the "Teach Back" method, which has patients communicate back the information the physician has provided.

Improving Shared Decision Making

RCCOs/health plans should encourage skills training in shared decision making for all physicians. Implementing an environment of shared decision making and physician-patient collaboration requires physician recognition that patients have the ability to make choices that affect their health care. Therefore, one key to a successful shared decision making model is ensuring that physicians are

properly trained. Training should focus on providing physicians with the skills necessary to facilitate the shared decision making process; ensuring that physicians understand the importance of taking each patient's values into consideration; and understanding patients' preferences and needs. Effective and efficient training methods include seminars and workshops.

Care Manager Training

A parent or caretaker's negative perception of their child's health can have detrimental impacts on the child and family. For example, as a family's stress increases, the likelihood of treatment compliance for the child's chronic condition decreases. Research has shown that parents or caretakers of children with chronic conditions face two main issues: learning to manage their child's health, and coping with the stress caused by their child's health.

In order to relieve family tension and improve the health care of the child, RCCOs/health plans should contemplate training their personal doctors to consider the medical and emotional needs of both the child and the family. Doctors should be evaluated on several core competencies, such as caring and compassion, communication and listening, job skills and functional knowledge, customer service, leadership, outcome orientation, team orientation, and talent assessment and development.

Rating of Specialist Seen Most Often

Table 4-8 shows the priority assignments for the Rating of Specialist Seen Most Often measure for Colorado Non-ACC FFS and the seven participating RCCOs.

Table 4-8
Priority Assignments
Rating of Specialist Seen Most Often

Plan	NCQA Comparisons (Star Ratings)	Trend Analysis	Priority Assignment
Colorado Non-ACC FFS	★	—	Top
Region 1: Rocky Mountain Health Plans	★+	—	Top+
Region 2: Colorado Access	★★★★★+	—	Low+
Region 3: Colorado Access	★★★★★+	—	Low+
Region 4: Integrated Community Health Partners	★+	—	Top+
Region 5: Colorado Access	★★+	—	High+
Region 6: Colorado Community Health Alliance	★+	—	Top+
Region 7: Community Care of Central Colorado	★★★★★+	—	Low+

Table 4-9 shows the priority assignment for the Rating of Specialist Seen Most Often measure for DHMC and RMHP.

Table 4-9
Priority Assignments
Rating of Specialist Seen Most Often

Plan	NCQA Comparisons (Star Ratings)	Trend Analysis	Priority Assignment
Denver Health Medicaid Choice	★★★★★+	—	Low+
Rocky Mountain Health Plans	★★★★+	N/A	Moderate+

In order to improve the overall performance on the Rating of Specialist Seen Most Often global rating, QI activities should target planned visit management, skills training, telemedicine, and developing care coordination teams.

Planned Visit Management

RCCOs/health plans should work with providers to encourage the implementation of systems that enhance the efficiency and effectiveness of specialist care. For example, by identifying patients with chronic conditions that have routine appointments, a reminder system could be implemented to ensure that these patients are receiving the appropriate attention at the appropriate time. This triggering system could be used by staff to prompt general follow-up contact or specific interaction with patients to ensure they have necessary tests completed before an appointment or various other prescribed reasons. For example, after a planned visit, follow-up contact with patients could be scheduled within

the reminder system to ensure patients understood all information provided to them and/or to address any questions they may have.

Skills Training for Specialists

RCCOs/health plans can create specialized workshops or seminars that focus on training specialists in the skills they need to effectively communicate with patients to improve physician-patient communication. Training seminars can include sessions for improving communication skills with different cultures and handling challenging patient encounters. In addition, workshops can use case studies to illustrate the importance of communicating with patients and offer insight into specialists' roles as both managers of care and educators of patients. According to a 2009 review of more than 100 studies published in the journal *Medical Care*, patients' adherence to recommended treatments and management of chronic conditions is 12 percent higher when providers receive training in communication skills. By establishing skills training for specialists, RCCOs/health plans can not only improve the quality of care delivered to its members but also their potential health outcomes.

Telemedicine

RCCOs/health plans may want to explore the option of telemedicine with their provider networks to address issues with provider access in certain geographic areas. Telemedicine models allow for the use of electronic communication and information technologies to provide specialty services to patients in varying locations. Telemedicine such as live, interactive videoconferencing allows providers to offer care from a remote location. Physician specialists located in urban settings can diagnose and treat patients in communities where there is a shortage of specialists. Telemedicine consultation models allow for the local provider to both present the patient at the beginning of the consult and to participate in a case conference with the specialist at the end of the teleconference visit. Furthermore, the local provider is more involved in the consultation process and more informed about the care the patient is receiving.

Care Coordination Team

RCCOs/health plans should consider developing care coordination teams that consist of specialists, registered nurses, medical social workers, and health care coordinators that work in collaboration with the child member's PCP. Each member of the team could have specific responsibilities in relation to the care of the child patient. Collectively, the care coordination team could serve as an intermediary between the patient and the physician for care plan development and health concerns. In addition to communication with a PCP, the team could also serve as a resource for any additional assistance parent and caretakers may need. The team structure facilitates and streamlines communication to the physician while also providing needed care to the patient. The care team's ultimate goals are grounded in the needs of the child member and the concerns and priorities of the family.

Composite Measures

Getting Needed Care

Table 4-10 shows the priority assignments for the Getting Needed Care measure for Colorado Non-ACC FFS and the seven participating RCCOs.

Table 4-10
Priority Assignments
Getting Needed Care Composite

Plan	NCQA Comparisons (Star Ratings)	Trend Analysis	Priority Assignment
Colorado Non-ACC FFS	★	—	Top
Region 1: Rocky Mountain Health Plans	★	▼	Top
Region 2: Colorado Access	★	—	Top
Region 3: Colorado Access	★	—	Top
Region 4: Integrated Community Health Partners	★	—	Top
Region 5: Colorado Access	★	—	Top
Region 6: Colorado Community Health Alliance	★	—	Top
Region 7: Community Care of Central Colorado	★	—	Top

Table 4-11 shows the priority assignment for the Getting Needed Care measure for DHMC and RMHP.

Table 4-11
Priority Assignments
Getting Needed Care Composite

Plan	NCQA Comparisons (Star Ratings)	Trend Analysis	Priority Assignment
Denver Health Medicaid Choice	★	—	Top
Rocky Mountain Health Plans	★★+	N/A	High+

In order to improve clients' satisfaction under the Getting Needed Care measure, QI activities should target appropriate health care providers, providing interactive workshops, "max-packing," language concordance programs, and facilitating coordinated care.

Appropriate Health Care Providers

RCCOs/health plans should ensure that patients are receiving care from physicians most appropriate to treat their condition. Tracking patients to ascertain they are receiving effective, necessary care from those appropriate health care providers is imperative to assessing quality of care. RCCOs/health plans

should actively attempt to match patients with appropriate health care providers and engage providers in their efforts to ensure appointments are scheduled for patients to receive care in a timely manner. These efforts can lead to improvements in quality, timeliness, and patients' overall access to care.

Interactive Workshops

RCCOs/health plans should engage in promoting health education, health literacy, and preventive health care amongst their membership. Increasing patients' health literacy and general understanding of their health care needs can result in improved health. RCCOs/health plans can develop community-based interactive workshops and educational materials to provide information on general health or specific needs. Free workshops can vary by topic (e.g., women's health, specific chronic conditions) to address and inform the needs of different populations. Access to free health assessments also can assist RCCOs/health plans in promoting patient health awareness and preventive health care efforts.

"Max-Packing"

RCCOs/health plans can assist providers in implementing strategies within their system that allow for as many of the patient's needs to be met during one office visit when feasible; a process called "max-packing." "Max-packing" is a model designed to maximize each patient's office visit, which in many cases eliminates the need for extra appointments. Max-packing strategies could include using a checklist of preventive care services to anticipate the patient's future medical needs and guide the process of taking care of those needs a scheduled visit, whenever possible. Processes could also be implemented wherein staff review the current day's appointment schedule for any future appointments a patient may have. For example, if a patient is scheduled for their annual physical in the fall and a subsequent appointment for a flu vaccination, the current office visit could be used to accomplish both eliminating the need for a future appointment. RCCOs/health plans should encourage the care of a patient's future needs during a visit and determine if, and when, future follow-up is necessary.

Language Concordance Programs

RCCOs/health plans should make an effort to match patients with physicians who speak their preferred language. Offering incentives for physicians to become fluent in another language, in addition to recruiting bilingual physicians, is important because typically such physicians are not readily available. Matching patients to physicians who speak their language can significantly improve the health care experience and quality of care for patients. Patients who can communicate with their physician are more informed about their health issues and are able to make deliberate choices about an appropriate course of action. By increasing the availability of language-concordant physicians, patients with limited English proficiency can schedule more frequent visits with their physicians and are better able to manage health conditions.

Facilitate Coordinated Care

RCCOs/health plans should assist in facilitating the process of coordinated care between providers and care coordinators to ensure child members are receiving the care and services most appropriate for their health care needs. Coordinated care is most effective when care coordinators and providers organize their efforts to deliver the same message to parents and caretakers of child members. Members are more likely to play an active role in the management of their child's health care and

benefit from care coordination efforts if they are receiving the same information from both care coordinator and providers. Improving the system-level coordination between providers and care coordinators will enhance the service and care received by members. Additionally, providing patient registries or clinical information systems that allow providers and care coordinators to enter information on patients (e.g., notes from a telephone call or a physician visit) can help reduce duplication of services and facilitate care coordination.

Getting Care Quickly

Table 4-12 shows the priority assignments for the Getting Care Quickly measure for Colorado Non-ACC FFS and the seven participating RCCOs.

Table 4-12
Priority Assignments
Getting Care Quickly Composite

Plan	NCQA Comparisons (Star Ratings)	Trend Analysis	Priority Assignment
Colorado Non-ACC FFS	★★	—	High
Region 1: Rocky Mountain Health Plans	★★★	—	Moderate
Region 2: Colorado Access	★★	—	High
Region 3: Colorado Access	★	—	Top
Region 4: Integrated Community Health Partners	★★	—	High
Region 5: Colorado Access	★★	—	High
Region 6: Colorado Community Health Alliance	★★	—	High
Region 7: Community Care of Central Colorado	★★	—	High

Table 4-13 shows the priority assignment for the Getting Care Quickly measure for DHMC and RMHP.

Table 4-13
Priority Assignments
Getting Care Quickly Composite

Plan	NCQA Comparisons (Star Ratings)	Trend Analysis	Priority Assignment
Denver Health Medicaid Choice	★	▲	Top
Rocky Mountain Health Plans	★+	N/A	Top+

In order to improve clients' satisfaction under the Getting Care Quickly measure, QI activities should target open access scheduling, monitoring patient flow, decreasing no-show appointments, and electronic communication.

Open Access Scheduling

RCCOs/health plans should encourage providers to explore open access scheduling. An open access scheduling model can be used to match the demand for appointments with physician supply. This type of scheduling model allows for appointment flexibility and for patients to receive same-day appointments. Instead of booking appointments weeks or months in advance, an open access scheduling model includes leaving part of a physician's schedule open for same-day appointments.

Open access scheduling has been shown to have the following benefits: 1) reduces delays in patient care; 2) increases continuity of care; and 3) decreases wait times and number of no-shows resulting in cost savings.

Patient Flow Analysis

RCCOs/health plans should request that all providers monitor patient flow. The RCCOs/health plans could provide instructions and/or assistance to those providers that are unfamiliar with this type of evaluation. Dissatisfaction with timely care is often a result of bottlenecks and redundancies in the administrative and clinical patient flow processes (e.g., diagnostic tests, test results, treatments, hospital admission, and specialty services). To address these problems, it is necessary to identify these issues and determine the optimal resolution. One method that can be used to identify these problems is to conduct a patient flow analysis. A patient flow analysis involves tracking a patient's experience throughout a visit or clinical service (i.e., the time it takes to complete various parts of the visit/service). Examples of steps that are tracked include wait time at check-in, time to complete check-in, wait time in waiting room, wait time in exam room, and time with provider. This type of analysis can help providers identify "problem" areas, including steps that can be eliminated or steps that can be performed more efficiently.

Decrease No-Show Appointments

Studies have indicated that reducing the demand for unnecessary appointments and increasing availability of physicians can result in decreased no-shows and improve members' perceptions of timely access to care. RCCOs/health plans can assist providers in examining patterns related to no-show appointments in order to determine the factors contributing to patient no-shows. For example, it might be determined that only a small percentage of the physicians' patient population accounts for no-shows. Thus, further analysis could be conducted on this targeted patient population to determine if there are specific contributing factors (e.g., lack of transportation). Additionally, an analysis of the specific types of appointments that are resulting in no-shows could be conducted. Some findings have shown that follow-up visits account for a large percentage of no-shows. Thus, the RCCO/health plan can assist providers in re-examining their return visit patterns and eliminate unnecessary follow-up appointments or find alternative methods to conduct follow-up care (e.g., telephone and/or e-mail follow-up). Additionally, follow-up appointments could be conducted by another health care professional such as nurse practitioners or physician assistants.

Electronic Communication

RCCOs/health plans should encourage the use of electronic communication where appropriate. Electronic forms of communication between patients and providers can help alleviate the demand for in-person visits and provide prompt care to patients that may not require an appointment with a physician. Electronic communication can also be used when scheduling appointments, requesting referrals, providing prescription refills, answering patient questions, educating patients on health topics, and disseminating lab results. An online patient portal can aid in the use of electronic communication and provide a safe, secure location where patients and providers can communicate. It should be noted that Health Insurance Portability and Accountability Act (HIPAA) regulations must be carefully reviewed when implementing this form of communication.

How Well Doctors Communicate

Table 4-14 shows the priority assignments for the How Well Doctors Communicate measure for Colorado Non-ACC FFS and the seven participating RCCOs.

Table 4-14
Priority Assignments
How Well Doctors Communicate Composite

Plan	NCQA Comparisons (Star Ratings)	Trend Analysis	Priority Assignment
Colorado Non-ACC FFS	★★★★	—	Moderate
Region 1: Rocky Mountain Health Plans	★★★	—	Moderate
Region 2: Colorado Access	★★	—	High
Region 3: Colorado Access	★★	—	High
Region 4: Integrated Community Health Partners	★★	—	High
Region 5: Colorado Access	★★★	—	Moderate
Region 6: Colorado Community Health Alliance	★★★	—	Moderate
Region 7: Community Care of Central Colorado	★★★	—	Moderate

Table 4-15 shows the priority assignment for the How Well Doctors Communicate measure for DHMC and RMHP.

Table 4-15
Priority Assignments
How Well Doctors Communicate Composite

Plan	NCQA Comparisons (Star Ratings)	Trend Analysis	Priority Assignment
Denver Health Medicaid Choice	★★★★	—	Moderate
Rocky Mountain Health Plans	★★★★★+	N/A	Low+

In order to improve clients' satisfaction under the How Well Doctors Communicate measure, QI activities should focus on communication tools, improving health literacy, and language barriers.

Communication Tools for Patients

RCCOs/health plans can encourage patients to take a more active role in the management of their health care by providing them with the necessary tools to effectively communicate with physicians. This can include items such as "visit preparation" handouts, sample symptom logs, and health care goals and action planning forms that facilitate physician-patient communication. Furthermore, educational literature and information on medical conditions specific to their needs can encourage

patients to communicate with their physicians any questions, concerns, or expectations they may have regarding their health care and/or treatment options.

Improve Health Literacy

Often health information is presented to patients in a manner that is too complex and technical, which can result in patient non-adherence and poor health outcomes. To address this issue, RCCOs/health plans should consider revising existing and creating new print materials that are easy to understand based on patients' needs and preferences. Materials such as patient consent forms and disease education materials on various conditions can be revised and developed in new formats to aid patients' understanding of the health information that is being presented. Further, providing training for health care workers on how to use these materials with their patients and ask questions to gauge patient understanding can help improve patients' level of satisfaction with provider communication.

Additionally, health literacy coaching can be implemented to ease the inclusion of health literacy into physician practice. RCCOs/health plans can offer a full-day workshop where physicians have the opportunity to participate in simulation training resembling the clinical setting. Workshops also provide an opportunity for RCCOs/health plans to introduce physicians to the *AHRQ Health Literacy Universal Precautions Toolkit*, which can serve as a reference for devising health literacy plans.

Language Barriers

RCCOs/health plans can consider hiring interpreters that serve as full-time time staff members at provider offices with a high volume of non-English speaking patients to ensure accurate communication amongst patients and physicians. Offering an in-office, interpretation service promotes the development of relationships between the patient and family members with their physician. With an interpreter present to translate, the physician will have a clearer understanding of how to best address the appropriate health issues and the patient will feel more at ease. Having an interpreter on site is also more time efficient for both the patient and physician, allowing the physician to stay on schedule.

Customer Service

Table 4-16 shows the priority assignment for the Customer Service measure for DHMC and RMHP.

Table 4-16
Priority Assignments
Customer Service Composite

Plan	NCQA Comparisons (Star Ratings)	Trend Analysis	Priority Assignment
Denver Health Medicaid Choice	★★★	—	Moderate
Rocky Mountain Health Plans	★★+	N/A	High+

In order to improve clients' satisfaction under the Customer Service measure, QI activities should focus on customer service training programs, evaluating call centers, and establishing performance measures.

Creating an Effective Customer Service Training Program

Health plan efforts to improve customer service should include implementing a training program to meet the needs of their unique work environment. Direct patient feedback should be disclosed to employees to emphasize why certain changes need to be made. Additional recommendations from employees, managers, and business administrators should be provided to serve as guidance when constructing the training program. It is important that employees receive direction and feel comfortable putting new skills to use before applying them within the work place.

The customer service training should be geared toward teaching the fundamentals of effective communication. By reiterating basic communication techniques, employees will have the skills to communicate in a professional and friendly manner. How to appropriately deal with difficult patient interactions is another crucial concern to address. Employees should feel competent in resolving conflicts and service recovery.

The key to ensuring that employees carry out the skills they learned in training is to not only provide motivation, but implement a support structure when they are back on the job so that they are held responsible. It is advised that all employees sign a commitment statement to affirm the course of action agreed upon. Health plans should ensure leadership is involved in the training process to help establish camaraderie between managers and employees and to help employees realize the impact of their role in making change.

Call Centers

An evaluation of current call center hours and practices can be conducted to determine if the hours and resources meet members' needs. If it is determined that the call center is not meeting members' needs, an after-hours customer service center can be implemented to assist members after normal business hours and/or on weekends. Additionally, asking members to complete a short survey at the end of each call can assist in determining if members are getting the help they need and identify potential areas for customer service improvement.

Customer Service Performance Measures

Setting plan-level customer service standards can assist in addressing areas of concern and serve as domains for which health plan can evaluate and modify internal customer service performance measures, such as call center representatives' call abandonment rates (i.e., average rate of disconnects), the amount of time it takes to resolve a member's inquiry about prior authorizations, and the number of member complaints. Collected measures should be communicated with providers and staff members. Additionally, by tracking and reporting progress internally and modifying measures as needed, customer service performance is more likely to improve.

Coordination of Care

Table 4-17 shows the priority assignments for the Coordination of Care measure for Colorado Non-ACC FFS and the seven participating RCCOs.

Table 4-17
Priority Assignments
Coordination of Care

Plan	NCQA Comparisons (Star Ratings)	Trend Analysis	Priority Assignment
Colorado Non-ACC FFS	★★	—	High
Region 1: Rocky Mountain Health Plans	★	—	Top
Region 2: Colorado Access	★+	—	Top+
Region 3: Colorado Access	★+	—	Top+
Region 4: Integrated Community Health Partners	★★★	—	Moderate
Region 5: Colorado Access	★+	—	Top+
Region 6: Colorado Community Health Alliance	★	—	Top
Region 7: Community Care of Central Colorado	★+	—	Top+

Table 4-18 shows the priority assignment for the Coordination of Care measure for DHMC and RMHP.

Table 4-18
Priority Assignments
Coordination of Care

Plan	NCQA Comparisons (Star Ratings)	Trend Analysis	Priority Assignment
Denver Health Medicaid Choice	★★★★+	—	Moderate+
Rocky Mountain Health Plans	★★★★★+	N/A	Low+

In order to improve clients' satisfaction under the Coordination of Care measure, QI activities should focus on enhancing the program structure of accountable care organizations, which involves sharing data electronically and family-centered medical homes.

Enhancing RCCO/Health Plan Structure

RCCOs/health plans can integrate medical, behavioral health, and social services for children. Care coordinators ensure that children receive appropriate services based on his/her medical, behavioral, and social needs. Care coordinators perform an assessment for each child, assign the child to a primary care provider, assign the child to an appropriate risk tier to guide his/her level of care management.

The risk tier a child is placed in directs the amount of care coordination, management, and monitoring the child should receive.

Data Sharing

Interoperable health information technology and electronic medical record systems are one key to successful RCCOs/health plans. Pediatricians and hospitals operating within each organization should have effective communication processes in place to ensure information is shared on a timely basis. Systems should be designed to enable effective and efficient coordination of care and reporting on various aspects of quality improvement.

RCCOs/health plans can enable providers to share data electronically on each client and store data in a central data warehouse so all entities can easily access information. RCCOs/health plans could organize clients' health and utilization information into summary reports that track clients' interventions and outstanding needs. RCCOs/health plans should pursue joint activities that facility coordinated, effective care, such as urgent care option in the emergency department and combine medical and behavioral health services in primary care clinics.

Family-Centered Medical Home

RCCOs/health plans should ensure there are sufficient pediatric primary and specialty care pediatricians to managed and provide services to children. RCCOs/health plans should understand and support family-centered care, since the parents and/or caretakers are responsible for their child's health. It would be beneficial for RCCOs/health plans to integrate oral and mental health care into the delivery system, as some of the most common chronic care conditions children experience are oral and mental health problems. RCCOs/health plans should have systems in place to provide support to primary care practitioners committed to transforming into a family-centered medical home, such as resources for clinical and non-clinical care, technical assistance, and management support.

Developing Physician Communication Skills for Patient-Centered Care

Communication skills are an important component of the patient-centered care approach. Patient-centered communication can have a positive impact on patient satisfaction, adherence to treatments, and self-management of conditions. RCCOs/health plans should teach communications skills to their physicians to effectively communicate and interact with parents and/or caretakers of child clients. Physicians should ask questions about parents'/caretakers' concerns, priorities, and values and listen to their answers. RCCOs/health plans can train physicians in the following fundamental functions of physician-patient communication: fostering healing relationships, exchanging information, responding to patients' emotions, managing uncertainty, making informed decisions, and enabling patient self-management. Training physicians in the communication skills they need can be done through in-house programs or through communications programs offered by outside organizations.

Accountability and Improvement of Care

Although the administration of the CAHPS survey takes place at the FFS, RCCO, and plan levels, the accountability for the performance lies at both the RCCO/plan and provider network level. Table 4-19 provides a summary of the responsible parties for various aspects of care.[4-3]

Table 4-19—Accountability for Areas of Care

Domain	Composite	Who Is Accountable?	
		RCCO/Plan	Provider Network
Access	Getting Needed Care	✓	✓
	Getting Care Quickly		✓
Interpersonal Care	How Well Doctors Communicate		✓
	Shared Decision Making		✓
Plan Administrative Services	Customer Service	✓	
Personal Doctor			✓
Specialist			✓
All Health Care		✓	✓
Health Plan		✓	

Although performance on some of the global ratings and composite measures may be driven by the actions of the provider network, the health plan can still play a major role in influencing the performance of provider groups through intervention and incentive programs.

Those measures identified for Colorado Non-ACC FFS, the seven participating RCCOs, DHMC, and RMHP that exhibited low performance suggest that additional analysis may be required to identify what is truly causing low performance in these areas. Methods that could be used include:

- Conducting a correlation analysis to assess if specific issues are related to overall ratings (i.e., those question items or composites that are predictors of rating scores).
- Drawing on the analysis of population sub-groups (e.g., health status, race, age) to determine if there are client groups that tend to have lower levels of satisfaction (see Tab and Banner Book).
- Using other indicators to supplement CAHPS data such as client complaints/grievances, feedback from staff, and other survey data.
- Conducting focus groups and interviews to determine what specific issues are causing low satisfaction ratings.

After identification of the specific problem(s), then necessary QI activities could be developed. However, the methodology for QI activity development should follow a cyclical process (e.g., Plan-Do-Study-Act [PDSA]) that allows for testing and analysis of interventions in order to assure that the desired results are achieved.

[4-3] Edgman-Levitan S, Shaller D, McInnes K, et al. *The CAHPS® Improvement Guide: Practical Strategies for Improving the Patient Care Experience.* Department of Health Care Policy Harvard Medical School, October 2003.

5. Reader's Guide

This section provides a comprehensive overview of CAHPS, including the CAHPS Survey administration protocol and analytic methodology. It is designed to provide supplemental information to the reader that may aid in the interpretation and use of the CAHPS results presented in this report.

Survey Administration

Survey Overview

The survey instrument selected for FFS clients was a modified version of the CAHPS 5.0 Child Medicaid Health Plan Survey with the HEDIS supplemental item set and survey questions from the Child CAHPS PCMH Survey. For DHMC and RMHP, the standardized survey instrument selected was the CAHPS 5.0 Child Medicaid Health Plan Survey with the HEDIS supplemental item set. The CAHPS 5.0 Health Plan Surveys are a set of standardized surveys that assess patient perspectives on care. Originally, CAHPS was a five-year collaborative project sponsored by the Agency for Healthcare Research and Quality (AHRQ). The CAHPS questionnaires and consumer reports were developed under cooperative agreements among AHRQ, Harvard Medical School, RAND, and the Research Triangle Institute (RTI). In 1997, NCQA, in conjunction with AHRQ, created the CAHPS 2.0H Survey measure as part of NCQA's HEDIS.[5-1] In 2002, AHRQ convened the CAHPS Instrument Panel to re-evaluate and update the CAHPS Health Plan Surveys and to improve the state-of-the-art methods for assessing clients' experiences with care.[5-2] The result of this re-evaluation and update process was the development of the CAHPS 3.0H Health Plan Surveys. The goal of the CAHPS 3.0H Health Plan Surveys was to effectively and efficiently obtain information from the person receiving care. In 2006, AHRQ released the CAHPS 4.0 Health Plan Surveys. Based on the CAHPS 4.0 versions, NCQA introduced new HEDIS versions of the Adult Health Plan Survey in 2007 and the Child Health Plan Survey in 2009, which are referred to as the CAHPS 4.0H Health Plan Surveys.[5-3,5-4] In 2012, AHRQ released the CAHPS 5.0 Health Plan Surveys. Based on the CAHPS 5.0 versions, NCQA introduced new HEDIS versions of the Adult and Child Health Plan Surveys in August 2012, which are referred to as the CAHPS 5.0H Health Plan Surveys.[5-5]

The sampling and data collection procedures for the CAHPS 5.0 Health Plan Survey were designed to capture accurate and complete information about consumer-reported experiences with health care.

5-1 National Committee for Quality Assurance. *HEDIS® 2002, Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2001.

5-2 National Committee for Quality Assurance. *HEDIS® 2003, Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2002.

5-3 National Committee for Quality Assurance. *HEDIS® 2007, Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2006.

5-4 National Committee for Quality Assurance. *HEDIS® 2009, Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2008.

5-5 National Committee for Quality Assurance. *HEDIS® 2013, Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2012.

The sampling and data collection procedures promote both the standardized administration of survey instruments and the comparability of the resulting health plan data.

The standard CAHPS 5.0 Child Medicaid Health Plan Survey with the HEDIS supplemental item set includes 48 core questions that yield 11 measures of satisfaction. These measures include four global rating questions, five composite measures, and two individual item measures. The global measures (also referred to as global ratings) reflect overall satisfaction with the health plan, health care, personal doctors, and specialists. The composite measures are sets of questions grouped together to address different aspects of care (e.g., "Getting Needed Care" or "Getting Care Quickly"). The individual item measures are individual questions that look at a specific area of care (i.e., "Coordination of Care" and "Health Promotion and Education").

For Colorado Non-ACC FFS and the participating RCCOs, the Department elected to use a modified version of the CAHPS Survey instrument; therefore, the CAHPS survey results for the Rating of Health Plan global rating question and the Customer Service composite measure were not collected. However, for DHMC and RMHP, CAHPS survey results for all measures evaluated through the CAHPS 5.0 Child Medicaid Health Plan Survey with HEDIS supplemental item set were reported. Table 5-1 lists the global ratings, composite measures, and individual item measures included in the CAHPS 5.0 Child Medicaid Health Plan Survey with the HEDIS supplemental item set.

Table 5-1—CAHPS Measures

Global Ratings	Composite Measures	Individual Item Measures
Rating of Health Plan	Getting Needed Care	Coordination of Care
Rating of All Health Care	Getting Care Quickly	Health Promotion and Education
Rating of Personal Doctor	How Well Doctors Communicate	
Rating of Specialist Seen Most Often	Customer Service	
	Shared Decision Making	

Sampling Procedures

For the Colorado CAHPS 5.0 Child Medicaid Health Plan Surveys, child clients eligible for sampling included those who:

- Were age 17 or younger as of December 31, 2015.
- Were currently enrolled in Colorado Non-ACC FFS, one of the seven participating RCCOs and attributed to a PCP, DHMC, or RMHP.
- Had been continuously enrolled for at least five of the last six months (July through December) of 2015.
- Had Medicaid as a payer.

The standard NCQA HEDIS Specifications for Survey Measures require a sample size of 1,650 for the CAHPS 5.0 Child Medicaid Health Plan Survey with HEDIS supplemental item set.[5-6] The NCQA protocol does not place any restrictions on oversampling rates. For Colorado Non-ACC FFS, the participating RCCOs, and RMHP, oversampling was not performed on the child population. However, DHMC conducted a 37 percent oversample on its child population. This oversampling was performed to ensure a greater number of respondents to each CAHPS measure. Colorado Non-ACC FFS, the seven participating RCCOs, and DHMC met the sample size requirement of 1,650 clients; however, RMHP did not. Table 5-2 and Table 5-3 provides a summary of the sample sizes for Colorado Non-ACC FFS, the seven participating RCCOs, DHMC, and RMHP.[5-7]

Table 5-2—Colorado Non-ACC FFS and RCCOs Sample Sizes

Name	Total Sample Size
Colorado Non-ACC FFS	1,650
Region 1: Rocky Mountain Health Plans	1,650
Region 2: Colorado Access	1,650
Region 3: Colorado Access	1,650
Region 4: Integrated Community Health Partners	1,650
Region 5: Colorado Access	1,650
Region 6: Colorado Community Health Alliance	1,650
Region 7: Community Care of Central Colorado	1,650

Table 5-3—Colorado Medicaid Plans Sample Sizes

Name	Total Sample Size
DHMC	2,255
RMHP	382

[5-6] National Committee for Quality Assurance. *HEDIS® 2016, Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2015.

[5-7] The sampling for DHMC and RMHP was performed by Morpace and CSS, respectively.

Survey Protocol

Table 5-4 shows the standard mixed mode (i.e., mail followed by telephone follow-up) CAHPS timeline used in the administration of the Colorado CAHPS 5.0 Child Medicaid Health Plan Surveys for Colorado Non-ACC FFS, RCCOs, and DHMC. The mixed-mode timeline is based on NCQA HEDIS Specifications for Survey Measures.[5-8] The survey administration protocol employed by RMHP was a standard Internet mixed-mode methodology; therefore, the survey administration timeline for RMHP may have varied.

Table 5-4—CAHPS 5.0 Mixed-Mode Methodology Survey Timeline

Task	Timeline
Send first questionnaire with cover letter to the parent/caretaker of child member.	0 days
Send a postcard reminder to non-respondents four to 10 days after mailing the first questionnaire.	4 – 10 days
Send a second questionnaire (and letter) to non-respondents approximately 35 days after mailing the first questionnaire.	35 days
Send a second postcard reminder to non-respondents four to 10 days after mailing the second questionnaire.	39 – 45 days
Initiate CATI interviews for non-respondents approximately 21 days after mailing the second questionnaire.	56 days
Initiate systematic contact for all non-respondents such that at least three telephone calls are attempted at different times of the day, on different days of the week, and in different weeks.	56 – 70 days
Telephone follow-up sequence completed (i.e., completed interviews obtained or maximum calls reached for all non-respondents) approximately 14 days after initiation.	70 days

The survey administration for DHMC and RMHP was performed by Morpace and CSS, respectively. The survey process employed by RMHP was a standard Internet mixed-mode methodology, which allowed sample members the option to complete the survey via the mail option or on the Internet. The survey process employed by Colorado Non-ACC FFS, the RCCOs, and DHMC allowed clients two methods by which they could complete a survey. The first phase, or mail phase, consisted of a survey being mailed to all sampled clients. For Colorado Non-ACC FFS and the seven RCCOs, those clients who were identified as Spanish-speaking through administrative data were mailed a Spanish version of the survey. Clients that were not identified as Spanish-speaking received an English version of the survey. The English and Spanish versions of the survey included a toll-free number that clients could call to request a survey in another language (i.e., English or Spanish). A reminder postcard was sent to all non-respondents, followed by a second survey mailing and reminder postcard. The second phase, or telephone phase, consisted of CATI of sampled clients who had not mailed in a completed survey. DHMC provided English and Spanish versions of the mail survey and allowed clients the option to complete a CATI survey in English or Spanish. A series of at least three CATI calls was made to each non-respondent.[5-9] It has been shown that the addition of the telephone phase aids in the

[5-8] National Committee for Quality Assurance. *HEDIS® 2016, Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2015.

[5-9] National Committee for Quality Assurance. *Quality Assurance Plan for HEDIS 2016 Survey Measures.* Washington, DC: NCQA Publication, 2015.

reduction of non-response bias by increasing the number of respondents who are more demographically representative of a plan's population.[5-10]

All eligible child clients were provided for sampling for Colorado Non-ACC FFS and the seven RCCOs. HSAG inspected a sample of the file records to check for any apparent problems with the files, such as missing address elements. A random sample of records from each population was passed through the United States Postal Service's National Change of Address (NCOA) system to obtain new addresses for clients who had moved (if they had given the Postal Service a new address). Prior to initiating CATI, HSAG employed the Telematch telephone number verification service to locate and/or update telephone numbers for all non-respondents. The survey samples were samples with no more than one client being selected per household.

The specifications also require that the name of the plan appear in the questionnaires and cover letters; that the letters bear the signature of a high-ranking plan or state official; and that the questionnaire packages include a postage-paid reply envelope addressed to the organization conducting the surveys. HSAG followed these specifications.[5-11]

[5-10] Fowler FJ Jr., Gallagher PM, Stringfellow VL, et al. "Using Telephone Interviews to Reduce Nonresponse Bias to Mail Surveys of Health Plan Members." *Medical Care*. 2002; 40(3): 190-200.

[5-11] Please note, HSAG performed the CAHPS survey administration for Colorado Non-ACC FFS and the seven participating RCCOs only. The survey administration for DHMC and RMHP was performed by Morpace and CSS, respectively.

Methodology

HSAG used the CAHPS scoring approach recommended by NCQA in Volume 3 of HEDIS Specifications for Survey Measures. Based on NCQA's recommendations and HSAG's extensive experience evaluating CAHPS data, a number of analyses were performed to comprehensively assess client satisfaction. This section provides an overview of each analysis.

Response Rates

The administration of the CAHPS 5.0 Child Medicaid Health Plan Survey is comprehensive and is designed to achieve the highest possible response rate. NCQA defines the response rate as the total number of completed surveys divided by all eligible clients of the sample.[5-12] For Colorado Non-ACC FFS and the seven RCCOs, a client's survey was assigned a disposition code of "completed" if at least one question was answered within the survey. For DHMC and RMHP, a client's survey was assigned a disposition code of "completed" if clients answered at least three of the following five questions: 3, 15, 27, 31, and 36. Eligible clients include the entire sample (including any oversample) minus ineligible clients. Ineligible clients of the sample met one or more of the following criteria: were deceased, were invalid (did not meet criteria described on page 5-2), were removed from sample during deduplication (only applied to DHMC and RMHP), or had a language barrier.

$$\text{Response Rate} = \frac{\text{Number of Completed Surveys}}{\text{Sample - Ineligibles}}$$

Child and Respondent Demographics

The demographic analysis evaluated child and self-reported demographic information from survey respondents. Given that the demographics of a response group can influence overall client satisfaction scores, it is important to evaluate all CAHPS results in the context of the actual respondent population. If the respondent population differs significantly from the actual population of the plan or RCCO, then caution must be exercised when extrapolating the CAHPS results to the entire population.

For purposes of calculating the results for Colorado Non-ACC FFS, the seven RCCOs, DHMC, and RMHP, question summary rates were calculated for each global rating and individual item measure, and global proportions were calculated for each composite measure. Both the question summary rates and global proportions were calculated in accordance with NCQA HEDIS Specifications for Survey Measures.[5-13] The scoring of the global ratings, composite measures, and individual item measures involved assigning top-level responses a score of one, with all other responses receiving a score of zero. After applying this scoring methodology, the percentage of top-level responses was calculated in order to determine the question summary rates and global proportions. For additional details, please refer to the *NCQA HEDIS 2016 Specifications for Survey Measures, Volume 3*.

[5-12] National Committee for Quality Assurance. *HEDIS® 2016, Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2015.
[5-13] Ibid.

For purposes of this report, results are reported for a CAHPS measure even when the NCQA minimum reporting threshold of 100 respondents was not met. Therefore, caution should be exercised when interpreting results for those measures with fewer than 100 respondents.

Trend Analysis

In order to evaluate trends in client satisfaction, HSAG performed a trend analysis for Colorado Non-ACC FFS, participating RCCOs, and DHMC, where applicable.[5-14] A trend analysis was not performed for RHMP since RHMP's 2016 population was not comparable to its 2015 population. For DHMC, HSAG performed a stepwise three-year trend analysis. The first step compared the 2016 CAHPS results to the 2015 general child CAHPS results. If the initial 2016 and 2015 trend analysis did not yield any significant differences, then an additional trend analysis was performed between 2016 and 2014 results. For the Colorado Non-ACC FFS and participating RCCOs results, trending was performed between 2016 and 2015. Due to changes in survey methodology after 2014, the 2014 Colorado Non-ACC FFS and RCCO results could not be compared to the 2016 results.

The 2016 CAHPS scores were compared to their corresponding 2015 scores (or in the case of DHMC, 2015 or 2014) to determine whether there were statistically significant differences. A difference is considered significant if the two-sided *p*-value of the *t*-test is less than 0.05. Scores that were statistically higher in 2016 than in 2015 are noted with black upward (▲) triangles. Scores that were statistically lower in 2016 than in 2015 are noted with black downward (▼) triangles. Scores that were statistically higher in 2016 than in 2014 are noted with red upward (▲) triangles. Scores that were statistically lower in 2016 than in 2014 are noted with red downward (▼) triangles. Scores in 2016 that were not statistically different from scores in 2015 or in 2014 are not noted with triangles.

Weighting

For purposes of the Colorado Non-ACC FFS and RCCO results, HSAG calculated a weighted score for the Colorado FFS ACC Program. The 2016 CAHPS scores for Colorado FFS ACC Program were weighted based on each of the RCCO's total eligible population.

The weighted score was:

$$\hat{\mu} = \left(\sum_p \hat{\mu}_p / \hat{V}_p\right) / \left(\sum_p 1 / \hat{V}_p\right)$$

Non-ACC and RCCO Comparisons

Non-ACC and RCCO comparisons were performed to identify client satisfaction differences that were statistically different between the non-ACC and ACC populations, and the seven RCCOs. Given that differences in case-mix can result in differences in ratings between populations and RCCOs that are not due to differences in quality, the data were adjusted to account for disparities in these characteristics. Case-mix refers to the characteristics of clients and respondents used in adjusting the results for comparability among the comparative population or RCCO. Results for the non-ACC and

[5-14] As a result of the changes to the Shared Decision Making composite measure, trending to the 2014 scores could not be performed for this CAHPS measure for 2016.

ACC populations and the seven RCCOs were case-mix adjusted for client general health status, respondent education level, and respondent age.

For the comparisons of the non-ACC and ACC populations, one type of hypothesis test was applied to the population-level comparative results. The *t*-test determined whether there were statistically significant differences between the two populations.

For the RCCO comparisons, two types of hypothesis tests were applied to the RCCO comparative results. First, a global *F* test was calculated, which determined whether the difference between the RCCOs' scores was significant.

The *F* statistic was determined using the formula below:

$$F = \left(1/\left(P-1\right)\right)\sum_{p}\left(\hat{\mu}_{p}-\hat{\mu}\right)^{2}/\hat{V}_{p}$$

The *F* statistic, as calculated above, had an *F* distribution with ($P-1$, q) degrees of freedom, where *q* was equal to *n*-*P* (i.e., the average number of respondents in a RCCO). Due to these qualities, this *F* test produced *p* values that were slightly larger than they should have been; therefore, finding significant differences between RCCOs was less likely. An alpha-level of 0.05 was used. If the *F* test demonstrated RCCO-level differences (i.e., $p < 0.05$), then a *t* test was performed for each RCCO.

The *t*-test determined whether each RCCO's score was significantly different from the overall results of the other RCCOs. The equation for the differences was as follows:

$$\Delta_{p} = \hat{\mu}_{p} - \left(1/P\right)\sum_{p'}\hat{\mu}_{p'} = \left(\left(P-1\right)/P\right)\hat{\mu}_{p} - \sum_{p'}^{*}\left(1/P\right)\hat{\mu}_{p'}$$

In this equation, Σ^{*} was the sum of all RCCOs except RCCO *p*.

The variance of Δ_{p} was:

$$\hat{V}\left(\Delta_{p}\right) = \left[\left(P-1\right)/P\right]^{2}\hat{V}_{p} + 1/P^{2}\sum_{p'}\hat{V}_{p}$$

The *t* statistic was $\Delta_{p}/\hat{V}\left(\Delta_{p}\right)^{1/2}$ and had a *t* distribution with $(n_{p}-1)$ degrees of freedom. This statistic also produced *p* values that were slightly larger than they should have been; therefore, finding significant differences between a RCCO *p* and the combined results of all Colorado RCCOs was less likely.

NCQA Comparisons

An analysis to compare the Colorado results to the NCQA benchmarks was conducted using NCQA HEDIS Specifications for Survey Measures.[5-15] Per these specifications, no weighting or case-mix adjustment is performed on the results. NCQA also requires a minimum of 100 responses on each item in order to report the item as a valid CAHPS Survey result. However, for purposes of this report, results are reported for a CAHPS measure even when the NCQA minimum reporting threshold of 100 respondents was not met. Therefore, caution should be exercised when interpreting results for those measures with fewer than 100 respondents.

In order to perform the NCQA comparisons analysis, a three-point mean score was determined for the CAHPS global ratings, composite measures, and individual item measure.[5-16] The resulting three-point mean scores were compared to published NCQA Benchmarks and Thresholds for Accreditation to derive the overall client satisfaction ratings (i.e., star ratings). NCQA does not publish benchmarks and thresholds for the Shared Decision Making composite measure and Health Promotion and Education individual item measure; therefore, star ratings could not be assigned for these measures. For detailed information on the derivation of three-point mean scores, please refer to *NCQA HEDIS 2016 Specifications for Survey Measures, Volume 3*.

Ratings of one (★) to five (★★★★★) stars were determined for the global ratings, composite measures, and individual item measure using the following percentile distributions:

★★★★★	indicates a score at or above the 90th percentile
★★★★	indicates a score at or between the 75th and 89th percentiles
★★★	indicates a score at or between the 50th and 74th percentiles
★★	indicates a score at or between the 25th and 49th percentiles
★	indicates a score below the 25th percentile

Table 5-5 shows the benchmarks and thresholds used to derive the overall client satisfaction ratings on each CAHPS measure.[5-17]

[5-15] National Committee for Quality Assurance. *HEDIS® 2016, Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2015.
[5-16] Ibid.
[5-17] National Committee for Quality Assurance. *HEDIS Benchmarks and Thresholds for Accreditation 2016*. Washington, DC: NCQA, January 21, 2016.

Table 5-5—Overall Child Medicaid Client Satisfaction Ratings Crosswalk				
Measure	**90th Percentile**	**75th Percentile**	**50th Percentile**	**25th Percentile**
Rating of Health Plan	2.67	2.62	2.57	2.51
Rating of All Health Care	2.59	2.57	2.52	2.49
Rating of Personal Doctor	2.69	2.65	2.62	2.58
Rating of Specialist Seen Most Often	2.66	2.62	2.59	2.53
Getting Needed Care	2.58	2.53	2.47	2.39
Getting Care Quickly	2.69	2.66	2.61	2.54
How Well Doctors Communicate	2.75	2.72	2.68	2.63
Customer Service	2.63	2.58	2.53	2.50
Coordination of Care	2.51	2.46	2.41	2.36

Limitations and Cautions

The findings presented in the 2016 Colorado Child Medicaid CAHPS report are subject to some limitations in the survey design, analysis, and interpretation. These limitations should be considered carefully when interpreting or generalizing the findings. These limitations are discussed below.

Case-Mix Adjustment

While data for the non-ACC and ACC population-level, and RCCO-level comparisons have been adjusted for differences in survey-reported client general health status, respondent age, and respondent education, it was not possible to adjust for differences in client and respondent characteristics that were not measured. These characteristics include income, employment, or any other characteristics that may not be under the RCCOs' or program's control.

Non-Response Bias

The experiences of the survey respondent population may be different than that of non-respondents with respect to their health care services and may vary by RCCO/plan. Therefore, the potential for non-response bias should be considered when interpreting CAHPS results.

Causal Inferences

Although this report examines whether the parents or caretakers of clients of the Colorado Medicaid program report differences in satisfaction with various aspects of their child's health care experiences, these differences may not be completely attributable to the RCCO/plan. These analyses identify whether parents or caretakers of clients in various types of RCCOs/plans give different ratings of satisfaction. The survey by itself does not necessarily reveal the exact cause of these differences.

Survey Vendor Effects

The CAHPS 5.0 Child Medicaid Health Plan Survey administration was administered by multiple survey vendors. NCQA developed its Survey Vendor Certification Program to ensure standardization of data collection and the comparability of results across health plans. However, due to the different processes employed by the survey vendors, there is still the small potential for vendor effects. Therefore, survey vendor effects should be considered when interpreting the CAHPS results.

RMHP Results

In December 2014, RMHP discontinued their existing Medicaid product in which children were enrolled. The children were transitioned to their Accountable Care Collaborative program (i.e., RCCO Region 1), and are still enrolled in FFS Medicaid. RMHP implemented a new Medicaid risk product in September 2014. A small number of children who qualify on the basis of disability are enrolled in this Medicaid product. In general, low income children are not eligible for this new RMHP Medicaid risk product. Due to this population shift from a general Medicaid population to an exclusively disabled child population, RMHP's total sample frame size consisted of only 382 child members in 2016 compared to 16,785 child members in 2015, and RMHP's results were not comparable to DHMC's child Medicaid population.

Quality Improvement References

The CAHPS surveys were originally developed to meet the need of consumers for usable, relevant information on quality of care from the members' perspectives. However, they also play an important role as a QI tool for health care organizations, which can use the standardized data and results to identify relative strengths and weaknesses in their performance, determine where they need to improve, and track their progress over time. The following references offer guidance on possible approaches to CAHPS-related QI activities.

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6. Survey Instrument

The survey instrument selected for the 2016 Colorado Child Medicaid Client Satisfaction Survey was the CAHPS 5.0 Child Medicaid Health Plan Survey with the HEDIS supplemental item set. This section provides a copy of the survey instrument.

COLORADO
Department of Health Care Policy & Financing

DataStat

Your privacy is protected. The research staff will not share your personal information with anyone without your OK. Personally identifiable information will not be made public and will only be released in accordance with federal laws and regulations.

You may choose to answer this survey or not. If you choose not to, this will not affect the benefits your child gets. You may notice a number on the cover of this survey. This number is ONLY used to let us know if you returned your survey so we don't have to send you reminders.

If you want to know more about this study, please call 1-877-455-3391.

SURVEY INSTRUCTIONS

- **Please be sure to fill the response circle completely. Use only black or blue ink or dark pencil to complete the survey.**

Correct Mark ●

Incorrect Marks 

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

● **Yes** ➔ ***Go to Question 1***
○ **No**

START HERE

Please answer the questions for the child listed on the envelope. Please do not answer for any other children.

1. **Our records show that your child is now in [HEALTH PLAN NAME]. Is that right?**

○ Yes ➔ ***Go to Question 3***
○ No

2. **What is the name of your child's health plan? (Please print)**

_____

YOUR CHILD'S HEALTH CARE IN THE LAST 6 MONTHS

These questions ask about your child's health care. Do not include care your child got when he or she stayed overnight in a hospital. Do not include the times your child went for dental care visits.

3. In the last 6 months, did your child have an illness, injury, or condition that needed care right away in a clinic, emergency room, or doctor's office?

- ○ Yes
- ○ No ➔ ***Go to Question 5***

4. In the last 6 months, when your child needed care right away, how often did your child get care as soon as he or she needed?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

5. In the last 6 months, did you make any appointments for a check-up or routine care for your child at a doctor's office or clinic?

- ○ Yes
- ○ No ➔ ***Go to Question 7***

6. In the last 6 months, when you made an appointment for a check-up or routine care for your child at a doctor's office or clinic, how often did you get an appointment as soon as your child needed?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

7. In the last 6 months, not counting the times your child went to an emergency room, how many times did he or she go to a doctor's office or clinic to get health care?

- ○ None ➔ ***Go to Question 23***
- ○ 1 time
- ○ 2
- ○ 3
- ○ 4
- ○ 5 to 9
- ○ 10 or more times

8. In the last 6 months, not counting the times your child needed health care right away, how many days did you usually have to wait between making an appointment and your child actually seeing a health provider?

- ○ Same day
- ○ 1 day
- ○ 2 to 3 days
- ○ 4 to 7 days
- ○ 8 to 14 days
- ○ 15 to 30 days
- ○ 31 to 60 days
- ○ 61 to 90 days
- ○ 91 days or longer
- ○ My child did not see a health provider in the last 6 months

9. In the last 6 months, did you and your child's doctor or other health provider talk about specific things you could do to prevent illness in your child?

- ○ Yes
- ○ No

10. In the last 6 months, did you and your child's doctor or other health provider talk about starting or stopping a prescription medicine for your child?

- ○ Yes
- ○ No ➔ ***Go to Question 14***

11. Did you and a doctor or other health provider talk about the reasons you might want your child to take a medicine?

- ○ Yes
- ○ No

12. Did you and a doctor or other health provider talk about the reasons you might <u>not</u> want your child to take a medicine?

- ○ Yes
- ○ No

13. When you talked about your child starting or stopping a prescription medicine, did a doctor or other health provider ask you what you thought was best for your child?

- ○ Yes
- ○ No

14. In the last 6 months, how often was it easy to get the care, tests, or treatment your child needed?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

15. In the last 6 months, did your child's doctor or other health provider order a blood test, x-ray, or other test for your child?

- ○ Yes
- ○ No ➔ ***Go to Question 17***

16. In the last 6 months, when your child's doctor or other health provider ordered a blood test, x-ray or other test for your child, how often did someone follow up to give you those results?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

17. In the last 6 months, did your child's doctor or other health provider talk with you about specific goals for your child's health?

- ○ Yes
- ○ No

18. In the last 6 months, did your child's doctor or other health provider ask you if there are things that make it hard for you to take care of your child's health?

- ○ Yes
- ○ No

19. In the last 6 months, did you and your child's doctor or other health provider talk about your child's learning ability?

- ○ Yes
- ○ No

20. In the last 6 months, did you and your child's doctor or other health provider talk about the kinds of behaviors that are normal for your child at this age?

- ○ Yes
- ○ No

21. In the last 6 months, did you and your child's doctor or other health provider talk about your child's moods and emotions?

- ○ Yes
- ○ No

22. Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your child's health care in the last 6 months?

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

Worst Health Care Possible — Best Health Care Possible

23. What is your preferred method of contact regarding your child's health care?

- ○ Mail
- ○ Email
- ○ Text message
- ○ Phone
- ○ I do not have a preferred method of contact regarding my child's health care

YOUR CHILD'S PERSONAL DOCTOR

24. A personal doctor is the one your child would see if he or she needs a checkup, has a health problem or gets sick or hurt. Does your child have a personal doctor?

- ○ Yes
- ○ No ➔ ***Go to Question 45***

25. In the last 6 months, how many times did your child visit his or her personal doctor for care?

- ○ None ➔ ***Go to Question 43***
- ○ 1 time
- ○ 2
- ○ 3
- ○ 4
- ○ 5 to 9
- ○ 10 or more times

26. In the last 6 months, how often did your child's personal doctor explain things about your child's health in a way that was easy to understand?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

27. In the last 6 months, how often did your child's personal doctor listen carefully to you?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

28. In the last 6 months, how often did your child's personal doctor show respect for what you had to say?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

29. Is your child able to talk with doctors about his or her health care?

- ○ Yes
- ○ No ➔ ***Go to Question 31***

30. In the last 6 months, how often did your child's personal doctor explain things in a way that was easy for <u>your child</u> to understand?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

31. In the last 6 months, how often did your child's personal doctor spend enough time with your child?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

32. In the last 6 months, did your child's personal doctor talk with you about how your child is feeling, growing, or behaving?

- ○ Yes
- ○ No

33. Thinking about the care your child received in the last 6 months, how often do you think your child's personal doctor understood the things that really matter to you about your child's health care?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

34. In the past 6 months, did you ever leave your child's personal doctor's office confused about what to do next to manage your child's health?

- ○ Yes
- ○ No

35. In the last 6 months, did your child get care from a doctor or other health provider besides his or her personal doctor?

- ○ Yes
- ○ No ➔ ***Go to Question 37***

36. In the last 6 months, how often did your child's personal doctor seem informed and up-to-date about the care your child got from these doctors or other health providers?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

37. Some doctor's offices remind patients between visits about tests, treatment, or appointments. In the last 6 months, did you get any reminders about your child's care between visits with your child's personal doctor?

- ○ Yes
- ○ No

38. In the last 6 months, did your child take any prescription medicine?

- ○ Yes
- ○ No ➔ ***Go to Question 40***

39. In the last 6 months, did you and your child's personal doctor talk at each visit about all the prescription medicines your child was taking?

- ○ Yes
- ○ No

40. In the last 6 months, did your child's personal doctor's office give you information about what to do if your child needed care during evenings, weekends, or holidays?

- ○ Yes
- ○ No

41. In the last 6 months, did your child need care from his or her personal doctor during evenings, weekends, or holidays?

- ○ Yes
- ○ No ➔ ***Go to Question 43***

42. In the last 6 months, how often were you able to get the care your child needed from his or her personal doctor during evenings, weekends, or holidays?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

43. Using any number from 0 to 10, where 0 is the worst personal doctor possible and 10 is the best personal doctor possible, what number would you use to rate your child's personal doctor?

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

Worst Personal Doctor Possible — Best Personal Doctor Possible

44. In the last 6 months, did your child's personal doctor or other health provider talk to you about resources in your neighborhood to support you in managing your child's health?

- ○ Yes
- ○ No

GETTING HEALTH CARE FROM SPECIALISTS

When you answer the next questions, do <u>not</u> include dental visits or care your child got when he or she stayed overnight in a hospital.

45. Specialists are doctors like surgeons, heart doctors, allergy doctors, skin doctors, and other doctors who specialize in one area of health care.

In the last 6 months, did you make any appointments for your child to see a specialist?

- ○ Yes
- ○ No ➔ ***Go to Question 50***

46. In the last 6 months, how often was it easy to get appointments for your child with specialists?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

47. In the last 6 months, how often did you get an appointment for your child to see a specialist as soon as you needed?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

48. How many specialists has your child seen in the last 6 months?

- ○ None ➔ ***Go to Question 50***
- ○ 1 specialist
- ○ 2
- ○ 3
- ○ 4
- ○ 5 or more specialists

49. We want to know your rating of the specialist your child saw most often in the last 6 months. Using any number from 0 to 10, where 0 is the worst specialist possible and 10 is the best specialist possible, what number would you use to rate that specialist?

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

Worst Specialist Possible — Best Specialist Possible

ABOUT YOUR CHILD AND YOU

50. In general, how would you rate your child's overall health?

- ○ Excellent
- ○ Very good
- ○ Good
- ○ Fair
- ○ Poor

51. In general, how would you rate your child's overall mental or emotional health?

- ○ Excellent
- ○ Very good
- ○ Good
- ○ Fair
- ○ Poor

52. What is your child's age?

- ○ Less than 1 year old

☐☐ YEARS OLD (write in)

53. Is your child male or female?

- ○ Male
- ○ Female

54. Is your child of Hispanic or Latino origin or descent?

- ○ Yes, Hispanic or Latino
- ○ No, Not Hispanic or Latino

55. What is your child's race? Mark one or more.

- ○ White
- ○ Black or African-American
- ○ Asian
- ○ Native Hawaiian or other Pacific Islander
- ○ American Indian or Alaska Native
- ○ Other

56. What is your age?

- ○ Under 18
- ○ 18 to 24
- ○ 25 to 34
- ○ 35 to 44
- ○ 45 to 54
- ○ 55 to 64
- ○ 65 to 74
- ○ 75 or older

57. Are you male or female?

- ○ Male
- ○ Female

58. 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

59. How are you related to the child?

- ○ Mother or father
- ○ Grandparent
- ○ Aunt or uncle
- ○ Older brother or sister
- ○ Other relative
- ○ Legal guardian
- ○ Someone else

60. Did someone help you complete this survey?

- ○ Yes ➔ ***Go to Question 61***
- ○ No ➔ ***Thank you. Please return the completed survey in the postage-paid envelope.***

61. How did that person help you? 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

THANK YOU

Thanks again for taking the time to complete this survey! Your answers are greatly appreciated.

When you are done, please use the enclosed prepaid envelope to mail the survey to:

DataStat, 3975 Research Park Drive, Ann Arbor, MI 48108