FY 08–09 CHILD HEALTH PLAN *PLUS* MEDICAID MEMBER SATISFACTION REPORT

August 2009

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

HSAG HEALTH SERVICES ADVISORY GROUP

1600 East Northern Avenue, Suite 100 • Phoenix, AZ 85020
Phone 602.264.6382 • Fax 602.241.0757

HSAG HEALTH SERVICES ADVISORY GROUP

CONTENTS

1. Executive Summary

The State of Colorado chose to administer member satisfaction surveys to members enrolled in the Child Health Plan *Plus* (CHP+) plan. The Colorado Department of Health Care Policy & Financing (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.[1-1] The goal of the CAHPS Health Plan Surveys is to provide performance feedback that is actionable and will aid in improving overall member satisfaction.

The standardized survey instrument selected was the CAHPS 4.0H Child Medicaid Health Plan Survey (without the children with chronic conditions [CCC] measurement set). The parents or caretakers of child members from CHP+ completed the survey from February to May 2009.

Changes to the Child Survey

In November 2006, the Agency for Healthcare Research and Quality (AHRQ) released the CAHPS 4.0 Health Plan Surveys. Based on the CAHPS 4.0 versions, the National Committee for Quality Assurance (NCQA) introduced new Healthcare Effectiveness Data and Information Set (HEDIS®) versions of the Child Health Plan Survey in 2009, which are referred to as the CAHPS 4.0H Child Medicaid Health Plan Surveys.[1-2,1-3] The following is a summary of the changes resulting from the transition to the CAHPS 4.0H Child Medicaid Health Plan Survey.[1-4]

Composite Measures

Getting Needed Care

Changes were made to the response choices, question language, and number of questions for the Getting Needed Care composite measure. All response choices were revised from "A Big Problem," "A Small Problem," and "Not a Problem" to "Never," "Sometimes," "Usually," and "Always." Question language was changed in order to accommodate these new responses. Also, three questions were dropped from the composite that addressed two composite items: "Finding a Personal Doctor" and "Getting Plan Approval."

Getting Care Quickly

For the Getting Care Quickly composite measure, changes were made to the question language and number of questions included in the composite. Two questions were deleted that addressed the following items: "Taken to Exam Room Within 15 Minutes" and "Getting Help by Phone."

[1-1] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).
[1-2] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
[1-3] National Committee for Quality Assurance. *HEDIS® 2009, Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2008.
[1-4] National Committee for Quality Assurance. *HEDIS 2009 Survey Vendor Update Training*. October 23, 2008.

How Well Doctors Communicate

All items in the How Well Doctors Communicate composite were reworded to ask about experiences with "your child's personal doctor," where previously the items had asked about "your child's doctors or other health providers."

Courteous and Helpful Office Staff

The Courteous and Helpful Office Staff composite was dropped upon implementation of the CAHPS 4.0H Health Plan Surveys.

Customer Service

Changes were made to the response choices, question language, and number of questions included in the Customer Service composite measure. All responses were revised from "A Big Problem," "A Small Problem," and "Not a Problem" to "Never," "Sometimes," "Usually," and "Always." Question language was changed in order to accommodate these new responses. One question was removed from the composite; however, an additional question item was added: "Being Treated with Courtesy and Respect."

Global Ratings

Rating of Health Plan

There were no changes made to the language or the placement of the question. The question is still in the section titled "Your Child's Health Plan."

Rating of All Health Care

There were no changes made to the question language for this global rating. The item was moved from the section of the survey after "Your Child's Personal Doctor or Nurse" and "Getting Health Care From a Specialist" to the section titled "Your Child's Health Care in the Last 6 Months"; however, negligible impact is expected due to this reordering.

Rating of Personal Doctor

Changes were made to the question language for this global rating. Question language was changed to ask respondents to only rate their child's "personal doctor" instead of their child's "personal doctor or nurse"; however, negligible impact is expected due to the changes in wording. The question is in the section titled "Your Child's Personal Doctor."

Rating of Specialist Seen Most Often

A minor change was made to the question language for this global rating. The wording of the question changed from "the specialist" to "that specialist"; however, negligible impact is expected due to the changes in wording. The question is in the section titled "Getting Health Care From Specialists."

New Content Areas

One additional composite measure was added to the CAHPS 4.0H Child Medicaid Health Plan Survey: Shared Decision Making. The Shared Decision Making composite includes two questions that have response choices of "Definitely Yes," "Somewhat Yes," "Somewhat No," and "Definitely No."

Furthermore, two individual item measures were added for further analysis: Coordination of Care and Health Promotion and Education. Both items have responses of "Never," "Sometimes," "Usually," and "Always."

Performance Highlights

The Results Section of this report details the CAHPS results for the CHP+ population. The following is a summary of the CAHPS performance highlights. The performance highlights are categorized into two major types of analyses performed on the CHP+ CAHPS data:

- National Committee for Quality Assurance (NCQA) Comparisons
- Plan Comparisons

NCQA Comparisons

Overall member satisfaction ratings for the four CAHPS global measures (Rating of Health Plan, Rating of All Health Care, Rating of Personal Doctor, and Rating of Specialist Seen Most Often) and one CAHPS composite measure (How Well Doctors Communicate) were compared to the NCQA National Distribution of 2008 Child Medicaid CAHPS Plan-level Results (which is referred to as NCQA national results throughout the rest of the document).[1-5,1-6,1-7] This comparison resulted in plan ratings of one (★) to five (★★★★★) stars on these CAHPS measures, where one is the lowest possible rating and five is the highest possible rating. The detailed results of this comparative analysis are described in the Results Section beginning on page 2-5. The following are highlights from this comparison:

- Colorado CHP+ scored between the 60th and 79th percentiles (i.e., ★★★★) on one CAHPS measure, Rating of Personal Doctor.
- Colorado CHP+ scored below the 20th percentile (i.e., ★) on two of the CAHPS measures: Rating of Health Plan and Rating of All Health Care.

[1-5] *NCQA National Distribution of 2008 Child Medicaid CAHPS Plan-level Results.* Prepared by NCQA for HSAG on November 17, 2008. NCQA does not publish NCQA Benchmarks and Thresholds for the Child Medicaid population. Therefore, star ratings are derived from a custom analysis performed annually by NCQA on behalf of HSAG. This custom analysis provided HSAG with the NCQA national results. This distribution is used to derive the star ratings.

[1-6] NCQA National Child Medicaid data for 2009 were not available at the time this report was prepared.

[1-7] Due to changes made from the CAHPS 3.0H Child Medicaid Health Plan Survey to the CAHPS 4.0H Child Medicaid Health Plan Survey, the Getting Needed Care, Getting Care Quickly, and Customer Service composites are not comparable to NCQA national results. In addition, the Shared Decision Making composite and Coordination of Care and Health Promotion and Education individual measures were added as first-year measures; therefore, national data do not exist.

Plan Comparisons

In order to identify performance differences in member satisfaction, the case-mix adjusted results for the CHP+ population and was compared to the Colorado Medicaid child population using standard statistical tests.[1-8,1-9] These comparisons were performed on the four global ratings, five composite measures, and two individual item measures. The detailed results of the comparative analysis are described in the Results section beginning on page 2-7. The following are the statistically significant results from this comparison:

- There were no significant differences between CHP+ and Colorado Medicaid on five of the CAHPS measures: Rating of Specialist Seen Most Often, Getting Needed Care, Getting Care Quickly, Customer Service, and Shared Decision Making.
- CHP+ scored significantly lower than Colorado Medicaid on six of the CAHPS measures: Rating of Personal Doctor, Rating of All Health Care, Rating of Health Plan, How Well Doctors Communicate, Coordination of Care, and Health Promotion and Education.

[1-8] In this report, Colorado Medicaid encompasses the following Child Medicaid plans: fee-for-service (FFS), Primary Care Physicians Program (PCPP), Denver Health Medical Plan (DHMP), and Rocky Mountain Health Plan (RMHP). For additional information, please see the FY 08-09 Child Medicaid Client Satisfaction Report.

[1-9] CAHPS results are known to vary due to differences in member and respondent age, education level, and health status. Therefore, results were case-mix adjusted for differences in these demographic variables.

The Colorado CAHPS 4.0H Child Medicaid Health Plan Survey was administered in accordance with all NCQA specifications. Members eligible for sampling included those who were enrolled in CHP+ at the time the sample was drawn, and who were continuously enrolled in the plan for at least five of the last six months (July through December) of 2008. Members eligible for sampling included those who were 17 years of age or younger as of December 31, 2008.

Survey Administration and Response Rates

Survey Administration

The standard NCQA Healthcare Effectiveness Data and Information Set (HEDIS)® Specifications for Survey Measures requires a sample size of 1,650 members for the CAHPS 4.0H Child Medicaid Health Plan Survey.[2-1] The specifications also permit oversampling in increments of 5 percent. For CHP+, a 30 percent oversampling was performed. Based on this rate, a total random sample of 2,145 child members was selected from the plan. The oversampling was performed to ensure a greater number of respondents to each CAHPS measure.

The survey administration protocol was designed to achieve a high response rate from members, thus minimizing the potential effects of non-response bias. The survey process allowed members two methods by which they could complete the surveys. The first, or mail phase, consisted of a survey being mailed to the sampled members. For CHP+, those members who were identified as Spanish-speaking through administrative data were mailed a Spanish version of the survey. Members 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 members 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 Computer Assisted Telephone Interviewing (CATI) for sampled members who had not mailed in a completed survey. Up to six CATI calls were made to each non-respondent.[2-2] Additional information on the survey protocol is included in the Reader's Guide section beginning on page 4-3.

Response Rates

The CAHPS 4.0H Child Medicaid Health Plan Survey administration was designed to garner the highest possible response rate. The CAHPS Survey response rate is the total number of completed surveys divided by all eligible members of the sample. A member's survey was assigned a disposition code of "completed" if at least one question was answered. Eligible members included

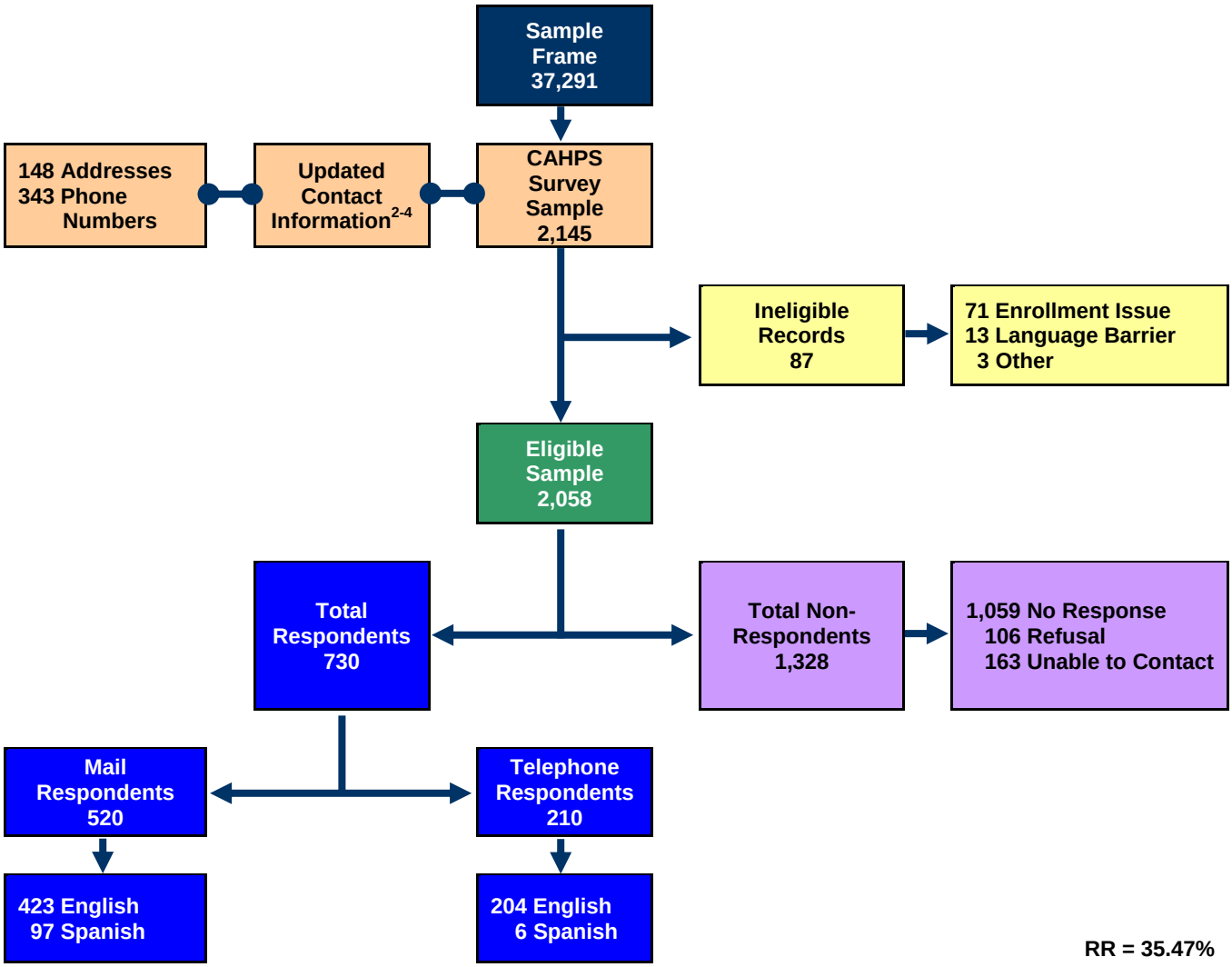
[2-1] National Committee for Quality Assurance. *HEDIS 2009, Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2008.

[2-2] National Committee for Quality Assurance. *Quality Assurance Plan for HEDIS 2009 Survey Measures.* Washington, DC: NCQA Publication, 2008.

the entire random sample (including any oversample) minus ineligible members. Ineligible members 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.

A total of 730 completed surveys were returned on behalf of child CHP+ members. Figure 2-1 shows the individual distribution of survey dispositions and the response rate (RR) for CHP+. The response rate for the CHP+ population of 35.47 percent was 9.47 percentage points higher than the 2008 NCQA national response rate, which was 26.00 percent.[2-3]

Figure 2-1—Distribution of Surveys for Colorado CHP+



[2-3] National Committee for Quality Assurance. *HEDIS 2009 Survey Vendor Update Training*. October 23, 2008.

[2-4] Prior to survey administration, address and phone information is updated for members of the CAHPS sample using the United State Postal Services' NCOA and Telematch databases. The number of updated addresses and telephone numbers are provided for informational purposes only. Per NCQA HEDIS Specifications, these members are retained within the CAHPS Survey sample.

Child and Respondent Demographics

In general, the demographics of a response group influence overall member satisfaction scores. For example, older and healthier respondents tend to report higher levels of member satisfaction; therefore, caution should be exercised when comparing populations that have significantly different demographic properties.[2-5]

Table 2-1 shows the demographic characteristics of children for whom a parent/caretaker completed a CAHPS 4.0H Child Medicaid Health Plan Survey for CHP+. The Colorado Medicaid (FFS, PCPP, DHMP, and RMHP combined) child demographics are provided for comparison.[2-6]

Table 2-1
Child Demographics
Age, Gender, Race/Ethnicity, and General Health Status

	Colorado Medicaid (FFS, PCPP, DHMP, and RMHP)	Colorado CHP+
Age		
Less than 1	3.6%	0.7%
1 to 3	24.3%	17.3%
4 to 7	23.2%	23.1%
8 to 12	25.6%	33.1%
13 to 18	23.2%	25.8%
Gender		
Male	52.3%	44.2%
Female	47.7%	55.8%
Race/Ethnicity		
Multi-Racial	12.6%	10.4%
White	50.7%	57.3%
Black	7.0%	4.1%
Asian	3.2%	3.1%
Other	26.5%	25.0%
General Health Status		
Excellent	36.1%	38.6%
Very Good	38.1%	38.3%
Good	20.3%	17.8%
Fair	4.9%	4.9%
Poor	0.5%	0.4%

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, 2008. Some children eligible for the CAHPS Survey turned age 18 between January 1, 2009, and the time of survey administration.

[2-5] 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.

[2-6] For additional information on the Colorado Medicaid results, please see the FY 08-09 Child Medicaid Client Satisfaction Report.

Table 2-2 shows the self-reported age, level of education, and relationship to the child for the respondents who completed the CAHPS 4.0H Child Medicaid Health Plan Survey for CHP+. The Colorado Medicaid (FFS, PCPP, DHMP, and RMHP combined) respondent demographics are provided for comparison.[2-7]

Table 2-2
Respondent Demographics
Age, Education, and Relationship to Child

	Colorado Medicaid (FFS, PCPP, DHMP, and RMHP)	Colorado CHP+
Respondent Age		
Under 18	11.8%	4.9%
18 to 24	7.6%	3.4%
25 to 34	25.7%	27.4%
35 to 44	25.2%	35.8%
45 to 54	16.1%	21.9%
55 to 64	8.6%	5.2%
65 or Older	5.1%	1.4%
Respondent Education		
8th Grade or Less	7.1%	7.4%
Some High School	16.3%	13.2%
High School Graduate	31.3%	30.5%
Some College	33.2%	33.5%
College Graduate	12.1%	15.5%
Relationship to Child		
Mother or Father	85.2%	97.5%
Grandparent	10.0%	1.3%
Legal Guardian	3.2%	0.6%
Other	1.5%	0.7%

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

[2-7] For additional information on the Colorado Medicaid results, please see the FY 08-09 Child Medicaid Client Satisfaction Report.

NCQA Comparisons

In order to assess the overall performance of CHP+, each CAHPS measure was scored on a three-point scale using the scoring methodology detailed in NCQA's HEDIS Specifications for Survey Measures.[2-8] The resulting three-point mean scores were compared to the NCQA national results.[2-9,2-10] 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 80th percentile
★★★★	indicates a score between the 60th and 79th percentiles
★★★	indicates a score between the 40th and 59th percentiles
★★	indicates a score between the 20th and 39th percentiles
★	indicates a score below the 20th percentile
NA	indicates that the plan did not meet the minimum NCQA reporting threshold of 100 respondents

Table 2-3 shows the plan's three-point mean scores and overall member satisfaction ratings on each of the four global ratings and on the only comparable composite measure, How Well Doctors Communicate. In 2009, NCQA transitioned from the CAHPS 3.0H Child Medicaid Health Plan Survey to the CAHPS 4.0H Child Medicaid Health Plan Survey. Due to changes made in the survey, the Getting Needed Care, Getting Care Quickly, and Customer Service composites are not comparable to NCQA national results. In addition, the Shared Decision Making composite and Coordination of Care and Health Promotion and Education individual measures were added as first-year measures; therefore, national data do not exist.

2-8 National Committee for Quality Assurance. *HEDIS 2009, Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2008.

2-9 *NCQA National Distribution of 2008 Child Medicaid CAHPS Plan-level Results*. Prepared by NCQA for HSAG on November 17, 2008. NCQA does not publish NCQA Benchmarks and Thresholds for the Child Medicaid population. Therefore, star ratings are derived from a custom analysis performed annually by NCQA on behalf of HSAG. This custom analysis provided HSAG with the NCQA national results. This distribution is used to derive the star ratings.

2-10 NCQA national child Medicaid data for 2009 were not available at the time this report was prepared.

Table 2-3 NCQA Comparisons Overall Member Satisfaction Ratings		
Colorado CHP+	**Three-Point Mean**	**Star Rating**
Global Rating		
Rating of Personal Doctor	2.576	★★★★
Rating of Specialist Seen Most Often	2.487	★★
Rating of All Health Care	2.403	★
Rating of Health Plan	2.396	★
Composite Measure		
How Well Doctors Communicate	2.606	★★★
Please note: A minimum of 100 responses to each measure is required in order to report the measure as a CAHPS Survey Result. Measures that do not meet the minimum number of responses are denoted as Not Applicable (NA).		

Summary of NCQA Comparison Results

The NCQA comparisons revealed the following summary results:

- CHP+ scored between the 60th and 79th percentiles nationally on one CAHPS measure, Rating of Personal Doctor.
- CHP+ scored between the 20th and 39th percentiles nationally on one CAHPS measure, Rating of Specialist Seen Most Often.
- CHP+ scored below the 20th percentile nationally on two CAHPS measures: Rating of Health Plan and Rating of All Health Care.

Plan Comparisons

In order to identify performance differences in member satisfaction, the results for Colorado Medicaid (FFS, PCPP, DHMP, and RMHP combined) and CHP+ were compared to one another using standard tests for statistical significance.[2-11,2-12] For purposes of this analysis, results were case-mix adjusted. Case-mix refers to the characteristics of respondents used in adjusting the results for comparability among health plans. Results were case-mix adjusted for member general health status, respondent educational level, and respondent age.[2-13] Given that differences in case-mix can result in differences in ratings between plans 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 to determine the question summary rates and global proportions. For additional detail, please refer to the *NCQA HEDIS Specifications for Survey Measures, Volume 3*.

Statistically significant differences are noted by arrows in the tables. When a statistically significant difference exists between the plans, the higher-performing plan is denoted by an upward (↑) arrow. Conversely, the lower performing plan is denoted by a downward (↓) arrow. If the differences are not statistically different, then both scores are denoted with a horizontal (↔) arrow.

Table 2-4 shows the question summary rates and global proportions of the plan comparisons analysis.

[2-11] Caution should be exercised when evaluating plan comparisons, given that population and plan differences may impact CAHPS results.

[2-12] The Colorado Medicaid results were calculated using the data of the four health plans from the FY 08-09 Child Medicaid Client Satisfaction Report. For more detailed information, please refer to the FY 08-09 Child Medicaid Client Satisfaction Report.

[2-13] 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 Plan Comparisons		
	Colorado Medicaid (FFS, PCPP, DHMP, and RMHP)	**Colorado CHP+**
Global Rating		
Rating of Personal Doctor	71.0% ↑	66.2% ↓
Rating of Specialist Seen Most Often	64.8% ↔	62.9% ↔
Rating of All Health Care	58.8% ↑	53.6% ↓
Rating of Health Plan	61.6% ↑	54.6% ↓
Composite Measure		
Getting Needed Care	54.0% ↔	52.0% ↔
Getting Care Quickly	70.7% ↔	66.4% ↔
How Well Doctors Communicate	74.7% ↑	68.5% ↓
Customer Service	48.0% ↔	50.2% ↔
Shared Decision Making	67.8% ↔	65.0% ↔
Individual Measure		
Coordination of Care	54.2% ↑	43.3% ↓
Health Promotion and Education	39.6% ↑	32.9% ↓
Please note: A minimum of 100 responses to each measure is required in order to report the measure as a CAHPS Survey Result. Measures that do not meet the minimum number of responses are denoted as Not Applicable (NA).		

Summary of Plan Comparisons Results

The plan comparisons revealed the following statistically significant results:

- There were no significant differences between CHP+ and Colorado Medicaid on five of the CAHPS measures: Rating of Specialist Seen Most Often, Getting Needed Care, Getting Care Quickly, Customer Service, and Shared Decision Making.
- CHP+ scored significantly lower than Colorado Medicaid on six of the CAHPS measures: Rating of Personal Doctor, Rating of All Health Care, Rating of Health Plan, How Well Doctors Communicate, Coordination of Care, and Health Promotion and Education.

General Recommendations

For fiscal year (FY) 2009-2010, HSAG recommends the continued administration of the CAHPS 4.0H Child Medicaid Health Plan Survey without the CCC measurement set. HSAG will be able to conduct a trend analysis between all global and composite measures if the Department continues to utilize the CAHPS 4.0H Child Medicaid Health Plan Survey.

Plan-Specific Recommendations

This section presents Child Medicaid CAHPS recommendations for CHP+. The recommendations are grouped into four main categories for quality improvement (QI): top, high, moderate, and low priority. The priority of the recommendations 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 health 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 4-9.

Table 3-1 shows how the priority assignments are determined for CHP+ on each CAHPS measure.

Table 3-1—Derivation of Priority Assignments on each CAHPS Measure

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

Please note:
Global ratings, composite measures, or individual item measures that do not meet the minimum number of responses are denoted as Not Applicable (NA).

Global Ratings

Rating of Health Plan

Table 3-2 shows the priority assignments for the overall Rating of Health Plan measure.

Table 3-2—Priority Assignments: Rating of Health Plan

NCQA Comparisons (Star Ratings)	Priority Assignment
★	Top

At the member level, the overall Rating of Health Plan measure is driven principally by member perception of both plan and physician office operations.

Plan operations include those services provided by the plan directly:

- Distribution of information about the plan.
- Customer service.
- Identification of a provider.

Physician office operations cover all activities that take place in physician offices:

- Scheduling of routine appointments.
- Obtaining interpreters.
- Members' satisfaction with their physicians.

In order to improve the overall Rating of Health Plan, QI activities should target both plan and physician office operations.

Rating of All Health Care

Table 3-3 shows the priority assignments for the Rating of All Health Care measure.

Table 3-3—Priority Assignments: Rating of All Health Care	
NCQA Comparisons (Star Ratings)	**Priority Assignment**
★	**Top**

At the member level, rating of physicians, perception of access to care, experience with care, and experience with the health plan principally drive the overall Rating of All Health Care measure. The rating of physicians includes the overall satisfaction with both personal doctors and specialists.

Access to care issues include:

- Problems obtaining the care that the member and/or physician thought were necessary.
- Problems obtaining urgent care in a timely fashion.
- Problems finding a personal doctor.
- Difficulty receiving assistance when calling physician offices.

Experience with care issues include:

- Receiving ample time with the physician.
- Having questions and concerns addressed by the physician.
- Receiving understandable and useful information from the physician.
- Being provided care in a timely fashion.

Experience with health plan issues include:

- Receiving accurate and understandable information from the plan.
- Receiving adequate customer service.
- Avoiding problems with health plan paperwork.

In order to improve the overall Rating of All Health Care measure, QI activities should target member satisfaction with physicians, member perception of access to care, experience with care, and experience with the health plan.

Rating of Personal Doctor

Table 3-4 shows the priority assignments for the Rating of Personal Doctor measure.

Table 3-4—Priority Assignments: Rating of Personal Doctor	
NCQA Comparisons (Star Ratings)	**Priority Assignment**
★★★★	**Low**

At the member level, communication and waiting time issues principally drive this rating.

Communication issues include:

- Being treated with courtesy and respect.
- Being listened to carefully.
- Receiving clear explanations.

Waiting time issues include:

- Problems receiving needed care when desired.
- Issues acquiring care quickly.

In order to improve the Rating of Personal Doctor, QI activities should target these communication and waiting time issues.

Rating of Specialist Seen Most Often

Table 3-5 shows the priority assignments for the Rating of Specialist Seen Most Often measure.

Table 3-5—Priority Assignments: Rating of Specialist Seen Most Often	
NCQA Comparisons (Star Ratings)	**Priority Assignment**
★★	**High**

At the member level, "red tape" issues principally drive the overall rating of specialist and include:

- Ease of obtaining plan approval for the specialist visit.
- Ease of obtaining a referral to see the specialist.
- Availability to see the specialist in a timely fashion.

In order to improve the overall Rating of Specialist Seen Most Often global rating, QI activities should target the ease of obtaining a referral and plan approval for a specialist visit. Additionally, the timeliness of specialist visits should be addressed if members report dissatisfaction with lengthy wait times.

Composite Measures

Getting Needed Care

Since this measure was modified with the implementation of the CAHPS 4.0H Child Medicaid Health Plan Survey, the results were not trendable and were not comparable to NCQA national data. Therefore, priority assignments could not be made.

At the member level, access-to-care issues principally drive this measure. Access-to-care issues include:

- Obtaining the care a doctor believed to be necessary.
- Helpfulness of office staff.

Some potential sources of access to care issues are resource and technical limitations, which include telephone systems and service expectations. In order to improve members' satisfaction under the Getting Needed Care measure, QI activities should target obtaining the care a doctor believes to be necessary and helpfulness of office staff. Other potential actions could include producing a flow chart of the process from the member's view from beginning to end, identifying barriers or unnecessary steps, and creating new avenues of information.

Getting Care Quickly

Since this measure was modified with the implementation of the CAHPS 4.0H Child Medicaid Health Plan Survey, the results were not trendable and were not comparable to NCQA national data. Therefore, priority assignments could not be made.

At the member level, waiting time issues principally drive this measure. Waiting time issues include:

- Waiting for an appointment for routine care.
- Waiting more than 15 minutes beyond the start of an appointment to be seen in the doctor's office.

In order to improve members' satisfaction under the Getting Care Quickly measure, QI activities should target these wait time issues.

How Well Doctors Communicate

Table 3-6 shows the priority assignments for the How Well Doctors Communicate measure.

Table 3-6—Priority Assignments: How Well Doctors Communicate	
NCQA Comparisons (Star Ratings)	**Priority Assignment**
★★★	**Moderate**

At the member level, issues involving providing information to and receiving information from the provider principally drive this measure. These issues include:

- Careful listening by the providers.
- Clear explanations in response to questions.
- Spending a sufficient amount of time during the exchange of information.

Other possible sources of provider communication issues are time constraints; perceptions of the members; and differences in experience, education, culture, and expectations. In order to improve members' satisfaction under the How Well Doctors Communicate measure, QI activities should target careful listening by the providers, clear explanations in response to questions, and spending a sufficient amount of time during the exchange of information. Other potential actions could include staff training, mentoring or coaching, direct member feedback, and reviewing performance expectations and guidelines.

Customer Service

Since this measure was modified with the implementation of the CAHPS 4.0H Child Medicaid Health Plan Survey, the results were not trendable and were not comparable to NCQA national data. Therefore, priority assignments could not be made.

At the member level, issues that involve both obtaining and understanding information from the plan are the key drivers of the Customer Service composite score. These issues include:

- Difficulty getting help when calling customer service.
- Difficulty finding or understanding information about the plan.

In order to improve members' satisfaction under the Customer Service measure, QI activities should target perceptions of the accessibility and usefulness of the information provided. Other potential actions could include customer service training; allowing members to voice concerns and questions via a technical support line; and updating information to account for differences in experience, education, culture, and expectations.

Shared Decision Making

Since this measure is new with the implementation of the CAHPS 4.0H Child Medicaid Health Plan Survey, the results were not trendable and NCQA national data were not available. Therefore, priority assignments could not be made.

At the member level, a doctor's willingness to educate members about multiple treatment options and the pros and cons of each treatment option principally drives this measure. In order to improve member satisfaction scores under the Shared Decision Making measure, member QI activities should focus on:

- Encouragement of member participation in decision making by physicians/health providers.
- Assuring that an adequate amount of time is spent with members to allow for member education.[3-1]
- Providing provider education on the importance of shared decision making for member autonomy and improved member satisfaction.[3-2]

[3-1] Fraenkel L and McGraw S. "What are the Essential Elements to Enable Patient Participation in Medical Decision Making?" *Journal of General Internal Medicine*. May 2007. 22(5): 614-9.

[3-2] McGuire A, McCullough L, et al. "Missed Expectations? Physicians' View of Patients' Participation in Medical Decision Making." *Medical Care*. May 2005. 43(5): 466-70.

Individual Item Measures

Coordination of Care

Since this measure is new with the implementation of the CAHPS 4.0H Child Medicaid Health Plan Survey, the results were not trendable and NCQA national data were not available. Therefore, priority assignments could not be made.

At the member level, a personal doctor's knowledge of additional care received by other doctors and health providers principally drives this measure. Barriers to coordination of care include:

- Lack of coordinated follow-up between specialists and personal doctors.
- Lack of easy access to medical records or insufficient detail included in the records.
- Absence of a defined care plan maintained by the personal doctor.

Studies have demonstrated that effective coordination of care tends to lead to fewer complaints reported by members.[3-3] Further, coordination of care among physicians in primary care practices tends to yield better member outcomes.[3-4]

[3-3] Parchman M, Noel P, Lee S. "Primary Care Attributes, Health Care System Hassles, and Chronic Illness." *Medical Care*. Nov 2005. 43(11): 1123-9.
[3-4] Parkerton P, Smith D, Straley H. "Primary Care Practice Coordination Versus Physician Continuity." *Family Medicine*. Jan 2004. 36(1): 15-21.

Health Promotion and Education

Since this measure is new with the implementation of the CAHPS 4.0H Child Medicaid Health Plan Survey, the results were not trendable and NCQA national data were not available. Therefore, priority assignments could not be made.

At the member level, this measure is driven by the physician discussing health promotion and disease prevention with the patient. Health promotion includes enabling the patient to take control over their health. Health education is a component of health promotion that involves increasing patients' knowledge about their own health and well-being.[3-5] In addition to one-on-one modes of health promotion and education, other communication efforts can include: lectures, group/panel discussions, and presentations. However, demographics such as age, physical barriers, and race/ethnicity need to be considered in order to determine the most effective method of health promotion and education for a particular patient or patient group.[3-6]

[3-5] UNESCO Institute for Education. *Health Promotion and Health Education for Adults*. 1999. Hamburg, Germany.
[3-6] Saha A, Poddar E, and Mankad M. "Effectiveness of Different Methods of Health Education: A Comparative Assessment in a Scientific Conference." *BMC Public Health.* 2005; 5:88.

Accountability and Improvement of Care

Although the administration of the CAHPS survey takes place at the health plan level, the accountability for the performance lies at both the plan and provider network level. Table 3-7 provides a summary of the responsible parties for various aspects of care.[3-7]

Table 3-7—Accountability for Areas of Care

Domain	Composite	Who Is Accountable?	
		Health 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 CHP+ 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 member groups that tend to have lower levels of satisfaction (see Tab and Banner Book).
- Using other indicators to supplement CAHPS data such as member 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.

[3-7] Edgman-Levitan S, et al. *The CAHPS® Improvement Guide: Practical Strategies for Improving the Patient Care Experience.* Department of Health Care Policy Harvard Medical School, October 2003.

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 was the CAHPS 4.0H Child Medicaid Health Plan Survey (without the CCC measurement set). The CAHPS 4.0H 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 AHRQ, formerly known as the Agency for Health Care Policy and Research (AHCPR). 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.[4-1] 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 members' experiences with care.[4-2] 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, which are referred to as the CAHPS 4.0H Health Plan Surveys.[4-3] NCQA released the CAHPS 4.0H Child Medicaid Health Plan Survey in 2009.[4-4]

The HEDIS sampling and data collection procedures for the CAHPS 4.0H Health Plan Survey are designed to capture accurate and complete information about consumer-reported experiences with health care. The sampling and data collection procedures promote both the standardized administration of survey instruments and the comparability of the resulting health plan data. HSAG's administration of the surveys was completed with strict adherence to required specifications.

[4-1] National Committee for Quality Assurance. *HEDIS® 2002, Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2001.
[4-2] National Committee for Quality Assurance. *HEDIS® 2003, Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2002.
[4-3] National Committee for Quality Assurance. *HEDIS® 2007, Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2006.
[4-4] National Committee for Quality Assurance. *HEDIS® 2009, Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2008.

The CAHPS 4.0H Child Medicaid Health Plan Survey includes 47 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").

Table 4-1 lists the global ratings, composite measures, and individual item measures included in the CAHPS 4.0H Child Medicaid Health Plan Survey (without the CCC measurement set).

Table 4-1—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

The members eligible for sampling included those who were CHP+ members at the time the sample was drawn, and who were continuously enrolled for at least five of the last six months (July through December) of 2008. The members eligible for sampling included those who were age 17 or younger (as of December 31, 2008).

A random sample of 2,145 child members was selected from the Colorado CHP+ plan. The NCQA protocol permits oversampling in 5 percent increments. For CHP+, a 30 percent oversampling was performed. This oversampling was performed to ensure a greater number of respondents to each CAHPS measure.

Survey Protocol

The CAHPS 4.0H Health Plan Survey process allowed for two methods by which members could complete the surveys. The first, or mail phase, consisted of a survey being mailed to all sampled members. For CHP+, those members who were identified as Spanish-speaking through administrative data were mailed a Spanish version of the survey. Members 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 members 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 members who had not mailed in a completed survey. A series of up to six CATI calls was made to each non-respondent.[4-5] It has been shown that the addition of the telephone phase aids in the reduction of non-response bias by increasing the number of respondents who are more demographically representative of a plan's population.[4-6]

HEDIS specifications require that HSAG be provided a list of all eligible members for the sampling frame. Following HEDIS requirements, HSAG sampled members who met the following criteria:

- Were age 17 or younger as of December 31, 2008.
- Were currently enrolled in CHP+.
- Had been continuously enrolled for at least five of the last six months of 2008.
- Had Medicaid as the primary payer.

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 members who had moved (if they had given the Postal Service a new address). Following NCQA requirements, the survey samples were random samples with no more than one member being selected per household.

The HEDIS specifications require that the name of the plan appear in the questionnaires, letters, and postcards; that the letters and cards 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 complied with these specifications.

[4-5] National Committee for Quality Assurance. *Quality Assurance Plan for HEDIS 2009 Survey Measures.* Washington, DC: NCQA Publication, 2008.

[4-6] 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.

Table 4-2 shows the CAHPS timeline used in the administration of the CAHPS 4.0H Child Medicaid Health Plan Surveys. The timeline is based on NCQA HEDIS Specifications for Survey Measures.[4-7]

Table 4-2—CAHPS 4.0H Survey Timeline

Task	Timeline
Send first questionnaire with cover letter to the respondent.	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 six 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

[4-7] National Committee for Quality Assurance. *HEDIS 2009, Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2008.

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 member satisfaction within CHP+. This section provides an overview of each analysis.

Response Rates

The administration of the CAHPS 4.0H Child Medicaid Health Plan Survey is comprehensive and is designed to garner the highest possible response rate. NCQA defines the response rate as the total number of completed surveys divided by all eligible members of the sample.[4-8] A member's survey was assigned a disposition code of "completed" if at least one question was answered within the survey. Eligible members include the entire random sample (including any oversample) minus ineligible members. Ineligible members of the sample met one or more of the following criteria: were deceased, were invalid (did not meet criteria described on page 4-3), or had a language barrier.

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

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 member 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, then caution must be exercised when extrapolating the CAHPS results to the entire population.

NCQA Comparisons

An analysis of the CHP+ CAHPS 4.0H Child Medicaid Health Plan Survey results was conducted using NCQA HEDIS Specifications for Survey Measures. 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.

[4-8] National Committee for Quality Assurance. *HEDIS 2009, Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2008.

In order to perform the NCQA comparisons, a three-point mean score was determined for each CAHPS measure. The resulting three-point mean scores were compared to the NCQA national results to derive the overall member satisfaction ratings (i.e., star ratings) for the global ratings and composite measures. For detailed information on the derivation of three-point mean scores, please refer to *NCQA HEDIS 2009 Specifications for Survey Measures, Volume 3*.

Plan ratings of one (★) to five (★★★★★) stars were determined for each CAHPS measure using the following percentile distributions:

★★★★★	indicates a score at or above the 80th percentile
★★★★	indicates a score between the 60th and 79th percentiles
★★★	indicates a score between the 40th and 59th percentiles
★★	indicates a score between the 20th and 39th percentiles
★	indicates a score below the 20th percentile
NA	indicates that the plan did not meet the minimum NCQA reporting threshold of 100 respondents

Table 4-3 shows the NCQA national distributions used to derive the overall member satisfaction ratings on comparable CAHPS measures.

Table 4-3—Overall Member Satisfaction Ratings Crosswalk

Measure	80th Percentile	60th Percentile	40th Percentile	20th Percentile
Rating of Health Plan	2.590	2.544	2.494	2.441
Rating of All Health Care	2.603	2.566	2.543	2.494
Rating of Personal Doctor	2.590	2.561	2.539	2.508
Rating of Specialist Seen Most Often	2.566	2.533	2.508	2.476
How Well Doctors Communicate	2.656	2.626	2.596	2.547

Plan Comparisons

A comparison was performed to identify member satisfaction differences between CHP+ and Colorado Medicaid (FFS, PCPP, DHMP, and RMHP combined).[4-9] For purposes of this 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.[4-10] 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 2009 Specifications for Survey Measures, Volume 3*.

Given that differences in case-mix can result in differences in ratings between plans that are not due to differences in quality, that data were adjusted to account for disparities in these characteristics. Case-mix refers to the characteristics of members and respondents used in adjusting the results for comparability among health plans. Results were case-mix adjusted for member general health status, respondent educational level, and respondent age.

The difference in performance is considered significant if the two-sided *p* value of the *t* test is less than 0.05. Statistically significant differences are noted by arrows in the results section table. When a statistically significant difference exists between the plans, the higher-performing plan is denoted by an upward (↑) arrow. Conversely, the lower performing plan is denoted by a downward (↓) arrow. If the differences are not statistically different, then both scores are denoted with a horizontal (↔) arrow.

[4-9] For additional information on the FFS, PCPP, DMHP, RMHP child CAHPS results, please see the FY 08-09 Child Medicaid Client Satisfaction Report.

[4-10] National Committee for Quality Assurance. HEDIS 2009, Volume 3: Specifications for Survey Measures. Washington, DC: NCQA Publication, 2008.

Limitations and Cautions

The findings presented in the 2009 Colorado CHP+ 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 plan comparisons have been adjusted for differences in survey-reported general health status, age, and education, it was not possible to account for differences in member and respondent characteristics that were not measured. These characteristics include income, employment, or any other characteristics that may not be under the plan'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 plan. Therefore, the potential for non-response bias should be considered when interpreting CAHPS results.

Causal Inferences

Although this report examines whether members of various plans report differences in satisfaction with various aspects of their health care experiences, these differences may not be completely attributable to the Medicaid plan. These analyses identify whether members in various types of plans give different ratings of satisfaction with their Medicaid plan. The survey by itself does not necessarily reveal the exact cause of these differences.

Quality Improvement References

The CAHPS surveys were originally developed to meet the need for usable, relevant information on quality of care from the patient's perspective. However, the surveys 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.[4-11] The following references offer guidance on possible approaches to CAHPS-related QI activities.

Backer LA. Strategies for better patient flow and cycle time. *Family Practice Management*. 2002; 9(6): 45-50. Available at: http://www.aafp.org/fpm/20020600/45stra.html. Accessed on: July 23, 2009.

Berwick DM. A user's manual for the IOM's 'Quality Chasm' report. *Health Affairs*. 2002; 21(3): 80-90.

Bonomi AE, Wagner EH, Glasgow RE, et al. Assessment of chronic illness care (ACIC): a practical tool to measure quality improvement. *Health Services Research*. 2002; 37(3): 791-820.

Camp R, Tweet AG. Benchmarking applied to health care. *Joint Commission Journal on Quality Improvement*. 1994; 20: 229-238.

Edgman-Levitan S, Shaller D, McInnes K, Joyce R, Coltin K, Cleary P. *The CAHPS® Improvement Guide: Practical Strategies for Improving the Patient Care Experience*. Department of Health Care Policy, Harvard Medical School; 2003. Available at: http://www.cahps-sun.org/Whatsnew/QI%20guide.pdf. Accessed on: July 23, 2009.

Garwick AW, Kohrman C, Wolman C, et al. Families' recommendations for improving services for children with chronic conditions. *Archives of Pediatric and Adolescent Medicine*. 1998; 152(5): 440-8.

Gerteis M, Edgman-Levitan S, Daley J. *Through the Patient's Eyes: Understanding and Promoting Patient-Centered Care*. San Francisco, CA: Jossey-Bass; 1993.

Grumbach K, Selby JV, Damberg C, et al. Resolving the gatekeeper conundrum: what patients value in primary care and referrals to specialists. *Journal of the American Medical Association*. 1999; 282(3): 261-6.

Institute of Medicine. *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington, DC: National Academy Press; 2001.

Keating NL, Green DC, Kao AC, et al. How are patients' specific ambulatory care experiences related to trust, satisfaction, and considering changing physicians? *Journal of General Internal Medicine*. 2002; 17(1): 29-39.

[4-11] AHRQ Website. *CAHPS User Resources: Quality Improvement Resources.* Available at: https://www.cahps.ahrq.gov/content/resources/QI/RES_QI_Intro.asp?p=103&s=31. Accessed on: July 23, 2009.

Korsch BM, Harding C. *The Intelligent Patient's Guide to the Doctor-Patient Relationship: Learning How to Talk So Your Doctor Will Listen*. New York, NY: Oxford University Press; 1998.

Langley GJ, Nolan KM, Norman CL, Provost LP, Nolan TW. *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance*. San Francisco, CA: Jossey-Bass; 1996.

Leebov W, Scott G. *Service Quality Improvement: The Customer Satisfaction Strategy for Health Care*. Chicago, IL: American Hospital Publishing, Inc.; 1994.

Leebov W, Scott G, Olson L. *Achieving Impressive Customer Service: 7 Strategies for the Health Care Manager*. San Francisco, CA: Jossey-Bass; 1998.

Maly RC, Bourque LB, Engelhardt RF. A randomized controlled trial of facilitating information given to patients with chronic medical conditions: Effects on outcomes of care. *Journal of Family Practice*. 1999; 48(5): 356-63.

Molnar C. Addressing challenges, creating opportunities: fostering consumer participation in Medicaid and Children's Health Insurance managed care programs. *Journal of Ambulatory Care Management*. 2001; 24(3): 61-7.

Murray M. Reducing waits and delays in the referral process. *Family Practice Management*. 2002; 9(3): 39-42. Available at: http://www.aafp.org/fpm/20020300/39redu.html. Accessed on: July 23, 2009.

Murray M, Berwick DM. Advanced access: reducing waiting and delays in primary care. *Journal of the American Medical Association*. 2003; 289(8): 1035-40.

Nelson AM, Brown SW. *Improving Patient Satisfaction Now: How to Earn Patient and Payer Loyalty*. New York, NY: Aspen Publishers, Inc.; 1997.

Spicer J. Making patient care easier under multiple managed care plans. *Family Practice Management*. 1998; 5(2): 38-42, 45-8, 53.

Wasson JM, Godfrey M, Nelson E, et al. Microsystems in health care: Part 4. Planning patient-centered care. *Joint Commission Journal on Quality and Safety*. 2003; 29(5): 227-237. Available at: http://howsyourhealth.com/html/CARE.pdf. Accessed on: July 23, 2009.

5. Survey Instrument

The survey instrument selected for the 2009 Colorado CHP+ Member Satisfaction Survey was the CAHPS 4.0H Child Medicaid Health Plan Survey. This section provides a copy of the survey instrument.

CAHPS® 4.0H, Child Questionnaire (Without CCC Measure)

SURVEY INSTRUCTIONS

- Answer <u>all</u> the questions by checking the box to the left of your answer.
- You are sometimes told to skip over some questions in this survey. When this happens you will see an arrow with a note that tells you what question to answer next, like this:

☑ Yes ➔**If Yes, Go to Question 1**

☐ No

All information that would let someone identify you or your family will be kept private. **Synovate** ***will not share your personal information with anyone without your OK. You may choose to answer this survey or not. If you choose not to, this will not affect the benefits you get.***

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 **1-800-914-2283.**

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?**
   - [1] ☐ Yes ➔ **If Yes, Go to Question 3**
   - [2] ☐ 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 <u>not</u> include care your child got when he or she stayed overnight in a hospital. Do <u>not</u> 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 <u>needed care right away</u> in a clinic, emergency room, or doctor's office?**
   - [1] ☐ Yes
   - [2] ☐ No ➔ **If No, Go to Question 5**

4. **In the last 6 months, when your child <u>needed care right away</u>, how often did your child get care as soon as you thought he or she needed?**
   - [1] ☐ Never
   - [2] ☐ Sometimes
   - [3] ☐ Usually
   - [4] ☐ Always

5. **In the last 6 months, <u>not</u> counting the times your child needed care right away, did you make any appointments for your child's health care at a doctor's office or clinic?**
   - [1] ☐ Yes
   - [2] ☐ No ➔ **If No, Go to Question 7**

6. **In the last 6 months, <u>not</u> counting the times your child needed care right away, how often did you get an appointment for health care at a doctor's office or clinic as soon as you thought your child needed?**
   - [1] ☐ Never
   - [2] ☐ Sometimes
   - [3] ☐ Usually
   - [4] ☐ Always

7. **In the last 6 months, <u>not</u> 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?**
   - [0] ☐ None ➔ **If None, Go to Question 13**
   - [1] ☐ 1
   - [2] ☐ 2
   - [3] ☐ 3
   - [4] ☐ 4
   - [5] ☐ 5 to 9
   - [6] ☐ 10 or more

8. **In the last 6 months, how often did you and your child's doctor or other health provider talk about specific things you could do to prevent illness in your child?**
   - [1] ☐ Never
   - [2] ☐ Sometimes
   - [3] ☐ Usually
   - [4] ☐ Always

9. **Choices for your child's treatment or health care can include choices about medicine, surgery, or other treatment. In the last 6 months, did your child's doctor or other health provider tell you there was more than one choice for your child's treatment or health care?**
   - [1] ☐ Yes
   - [2] ☐ No ➔ **If No, Go to Question 12**

10. **In the last 6 months, did your child's doctor or other health provider talk with you about the pros and cons of each choice for your child's treatment or health care?**
    - [1] ☐ Definitely yes
    - [2] ☐ Somewhat yes
    - [3] ☐ Somewhat no
    - [4] ☐ Definitely no

11. **In the last 6 months, when there was more than one choice for your child's treatment or health care, did your child's doctor or other health provider ask you which choice you thought was best for your child?**
    - [1] ☐ Definitely yes
    - [2] ☐ Somewhat yes
    - [3] ☐ Somewhat no
    - [4] ☐ Definitely no

12. 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?

00 ☐ 0 Worst health care possible
01 ☐ 1
02 ☐ 2
03 ☐ 3
04 ☐ 4
05 ☐ 5
06 ☐ 6
07 ☐ 7
08 ☐ 8
09 ☐ 9
10 ☐ 10 Best health care possible

YOUR CHILD'S PERSONAL DOCTOR

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

1 ☐ Yes
2 ☐ No ➔ **If No, Go to Question 25**

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

0 ☐ None ➔ **If None, Go to Question 24**
1 ☐ 1
2 ☐ 2
3 ☐ 3
4 ☐ 4
5 ☐ 5 to 9
6 ☐ 10 or more

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

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

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

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

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

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

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

1 ☐ Yes
2 ☐ No ➔ **If No, Go to Question 20**

19. 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?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

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

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

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

1 ☐ Yes
2 ☐ No

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

1 ☐ Yes
2 ☐ No ➔ **If No, Go to Question 24**

23. 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?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

24. 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?

00 ☐ 0 Worst personal doctor possible
01 ☐ 1
02 ☐ 2
03 ☐ 3
04 ☐ 4
05 ☐ 5
06 ☐ 6
07 ☐ 7
08 ☐ 8
09 ☐ 9
10 ☐ 10 Best personal doctor possible

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.

25. 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 try to make any appointments for your child to see a specialist?

1 ☐ Yes

2 ☐ No ➔ **If No, Go to Question 29**

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

1 ☐ Never

2 ☐ Sometimes

3 ☐ Usually

4 ☐ Always

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

0 ☐ None ➔ **If None, Go to Question 29**

1 ☐ 1 specialist

2 ☐ 2

3 ☐ 3

4 ☐ 4

5 ☐ 5 or more specialists

28. 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?

00 ☐ 0 Worst specialist possible

01 ☐ 1

02 ☐ 2

03 ☐ 3

04 ☐ 4

05 ☐ 5

06 ☐ 6

07 ☐ 7

08 ☐ 8

09 ☐ 9

10 ☐ 10 Best specialist possible

YOUR CHILD'S HEALTH PLAN

The next questions ask about your experience with your child's health plan.

29. In the last 6 months, did you try to get any kind of care, tests, or treatment for your child through his or her health plan?

1 ☐ Yes

2 ☐ No ➔ **If No, Go to Question 31**

30. In the last 6 months, how often was it easy to get the care, tests, or treatment you thought your child needed through his or her health plan?

1 ☐ Never

2 ☐ Sometimes

3 ☐ Usually

4 ☐ Always

31. In the last 6 months, did you try to get information or help from customer service at your child's health plan?

1 ☐ Yes

2 ☐ No ➔ **If No, Go to Question 34**

32. In the last 6 months, how often did customer service at your child's health plan give you the information or help you needed?

1 ☐ Never

2 ☐ Sometimes

3 ☐ Usually

4 ☐ Always

33. In the last 6 months, how often did customer service staff at your child's health plan treat you with courtesy and respect?

1 ☐ Never

2 ☐ Sometimes

3 ☐ Usually

4 ☐ Always

34. In the last 6 months, did your child's health plan give you any forms to fill out?

1 ☐ Yes

2 ☐ No ➔ **If No, Go to Question 36**

35. In the last 6 months, how often were the forms from your child's health plan easy to fill out?

1 ☐ Never

2 ☐ Sometimes

3 ☐ Usually

4 ☐ Always

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

00 ☐ 0 Worst health plan possible

01 ☐ 1

02 ☐ 2

03 ☐ 3

04 ☐ 4

05 ☐ 5

06 ☐ 6

07 ☐ 7

08 ☐ 8

09 ☐ 9

10 ☐ 10 Best health plan possible

ABOUT YOUR CHILD AND YOU

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

1 ☐ Excellent
2 ☐ Very Good
3 ☐ Good
4 ☐ Fair
5 ☐ Poor

38. What is <u>your child's</u> age?

00 ☐ Less than 1 year old
_____ YEARS OLD *(write in)*

39. Is your child male or female?

1 ☐ Male
2 ☐ Female

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

1 ☐ Yes, Hispanic or Latino
2 ☐ No, not Hispanic or Latino

41. What is your child's race? Please mark one or more.

a ☐ White
b ☐ Black or African-American
c ☐ Asian
d ☐ Native Hawaiian or other Pacific Islander
e ☐ American Indian or Alaska Native
f ☐ Other

42. What is <u>your</u> age?

0 ☐ Under 18
1 ☐ 18 to 24
2 ☐ 25 to 34
3 ☐ 35 to 44
4 ☐ 45 to 54
5 ☐ 55 to 64
6 ☐ 65 to 74
7 ☐ 75 or older

43. Are you male or female?

1 ☐ Male
2 ☐ Female

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

1 ☐ 8th grade or less
2 ☐ Some high school, but did not graduate
3 ☐ High school graduate or GED
4 ☐ Some college or 2-year degree
5 ☐ 4-year college graduate
6 ☐ More than 4-year college degree

45. How are you related to the child?

1 ☐ Mother or father
2 ☐ Grandparent
3 ☐ Aunt or uncle
4 ☐ Older sibling
5 ☐ Other relative
6 ☐ Legal guardian

46. Did someone help you complete this survey?

1 ☐ Yes ➔ **If Yes, Go to Question 47**
2 ☐ No ➔ **Thank you. Please return the completed survey in the postage-paid envelope.**

47. How did that person help you? Check all that apply.

a ☐ Read the questions to me
b ☐ Wrote down the answers I gave
c ☐ Answered the questions for me
d ☐ Translated the questions into my language
e ☐ Helped in some other way

THANK YOU

Please return the completed survey in the postage-paid envelope.

6. CD-ROM

The accompanying CD includes all of the information from the Executive Summary, Results, Recommendations, Reader's Guide, and Survey Instrument sections of this report. The CD also contains electronic copies of comprehensive cross-tabulations (Tab and Banner books) on each survey question.

CD Contents

- Colorado CHP+ Child Medicaid CAHPS Report
- CHP+ Child Medicaid Cross-tabulations (Tab and Banner Book)

Please note, the CD contents are in the form of an Adobe Acrobat portable document format (PDF) file. Internal PDF bookmarks can be used to navigate from section to section within the PDF file.

A free Adobe Acrobat Reader can be downloaded from Adobe's Web site at:
http://www.adobe.com/products/acrobat/readstep2.htm