FY 10–11 CHILD HEALTH PLAN *PLUS* MEMBER SATISFACTION REPORT

August 2011

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

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1. Executive Summary

The State of Colorado chose to administer member satisfaction surveys to members enrolled in the following Child Health Plan *Plus* (CHP+) plans: Colorado Access, Denver Health Medical Plan (DHMP), Kaiser Permanente (Kaiser), Rocky Mountain Health Plans (RMHP), and the State Managed Care Network (SMCN). 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 the CHP+ plans completed the survey from February to May 2011. Additional information on the survey administration protocol is included in the Reader's Guide Section beginning on page 4-1.

Performance Highlights

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

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

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

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 five CAHPS composite measures (Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Customer Service, and Shared Decision Making) were compared to NCQA's 2011 Healthcare Effectiveness Data and Information Set (HEDIS®) Benchmarks and Thresholds for Accreditation.[1-2,1-3,1-4,1-5,1-6] 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 2-12. Table 1-1 presents the highlights from this comparison.

Table 1-1
NCQA Comparisons Highlights

	Colorado Access	DHMP	Kaiser	RMHP	SMCN
Global Rating					
Rating of Health Plan	★	★	★★★	★★	★
Rating of All Health Care	★★	★	★★★★★	★★★★	★
Rating of Personal Doctor	★★★	★★★★	★★★★	★★★★	★
Rating of Specialist Seen Most Often	★★★	★+	★+	★★★★	★★★
Composite Measure					
Getting Needed Care	★★	★+	★★★	★★★★	★★
Getting Care Quickly	★★	★	★★★	★★★★★	★★
How Well Doctors Communicate	★★	★★	★★★	★★★★	★★
Customer Service	★	★+	★★	★	★
Shared Decision Making	★	★+	★★★★★	★★★★	★

★★★★★ 90th Percentile or Above ★★★★ 75th-89th Percentiles ★★★ 50th-74th Percentiles ★★ 25th-49th Percentiles ★ Below 25th Percentile

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

[1-2] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
[1-3] National Committee for Quality Assurance. *HEDIS Benchmarks and Thresholds for Accreditation 2011*. Washington, DC: NCQA, January 31, 2011.
[1-4] 2011 represents the first year NCQA HEDIS Benchmarks and Thresholds for Accreditation were released for the child Medicaid population.
[1-5] The star assignments for the Shared Decision Making composite are determined by comparing the plans' three-point mean scores to the distribution of NCQA's 2010 National Child Medicaid data. NCQA Distribution of 2010 Child Medicaid CAHPS Plan-level Results. Prepared by NCQA for HSAG on November 23, 2010.
[1-6] National data do not exist for the Coordination of Care and Health Promotion and Education individual measures.

Plan Comparisons

In order to identify performance differences in member satisfaction between the Colorado CHP+ plans, the case-mix adjusted results for each plan were compared to one another using standard statistical tests.[1-7] 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 2-28. Table 1-2 presents the statistically significant results from this comparison.[1-8]

Table 1-2
Plan Comparisons Highlights

Colorado Access	DHMP	Kaiser	RMHP	SMCN
None	↓+ Customer Service	↑ Customer Service	↑ Getting Care Quickly	↓ Rating of All Health Care
	↓+ Getting Needed Care	↑ Rating of All Health Care	↑ Getting Needed Care	↓ Rating of Health Plan
	↓ Getting Care Quickly	↑ Rating of Health Plan	↑ Rating of All Health Care	↓ Rating of Personal Doctor
		↑ Shared Decision Making	↑ Rating of Specialist Seen Most Often	

↑ Statistically better than the CHP+ Program Average

↓ Statistically worse than the CHP+ Program Average

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

[1-7] CAHPS results are known to vary due to differences in respondent age, respondent education level, and member health status. Therefore, results were case-mix adjusted for differences in these demographic variables.

[1-8] Caution should be exercised when evaluating health plan comparisons, given that population and health plan differences may impact results.

Priority Assignments

Based on the results of the NCQA comparisons, priority assignments were derived for each measure. Measures were assigned into one of four main categories for quality improvement (QI): top, high, moderate, and low priority. Table 1-3 presents the top and high priorities for each CHP+ plan.

Table 1-3
Top and High Priorities

Colorado Access	DHMP	Kaiser	RMHP	SMCN
◆ Rating of Health Plan	◆ Rating of Health Plan	◆ Customer Service	◆ Rating of Health Plan	◆ Rating of Health Plan
◆ Rating of All Health Care	◆ Rating of All Health Care	◆ Rating of Specialist Seen Most Often	◆ Customer Service	◆ Rating of All Health Care
◆ How Well Doctors Communicate	◆ Rating of Specialist Seen Most Often			◆ Rating of Personal Doctor
◆ Getting Care Quickly	◆ Getting Needed Care			◆ Getting Needed Care
◆ Getting Needed Care	◆ Getting Care Quickly			◆ Getting Care Quickly
◆ Customer Service	◆ Customer Service			◆ Customer Service
◆ Shared Decision Making	◆ Shared Decision Making			◆ Shared Decision Making
	◆ How Well Doctors Communicate			◆ How Well Doctors Communicate

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 Colorado Access, DHMP, Kaiser, RMHP, and the SMCN 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 2010. Child members eligible for sampling included those who were 17 years of age or younger as of December 31, 2010.

Survey Administration and Response Rates

Survey Administration

The standard NCQA 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] Colorado Access, RMHP, and the SMCN met the sample size requirements of 1,650. However, DHMP and Kaiser did not meet the minimum sample size criteria. According to NCQA protocol, only one survey can be sent to each household; therefore, after adjusting for duplicate addresses the actual sample sizes for DHMP and Kaiser were 1,014 and 1,348, respectively. The specifications also permit oversampling in increments of 5 percent. For Colorado Access, RMHP, and the SMCN, a 5 percent oversample was performed. Based on this rate, a total random sample of 1,733 child members was selected from these plans. 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 phase, or mail phase, consisted of a survey being mailed to the sampled members. For CHP+ plans, 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.

[2-1] National Committee for Quality Assurance. *HEDIS® 2011, Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2010.

[2-2] National Committee for Quality Assurance. *Quality Assurance Plan for HEDIS 2011 Survey Measures.* Washington, DC: NCQA Publication, 2010.

Response Rates

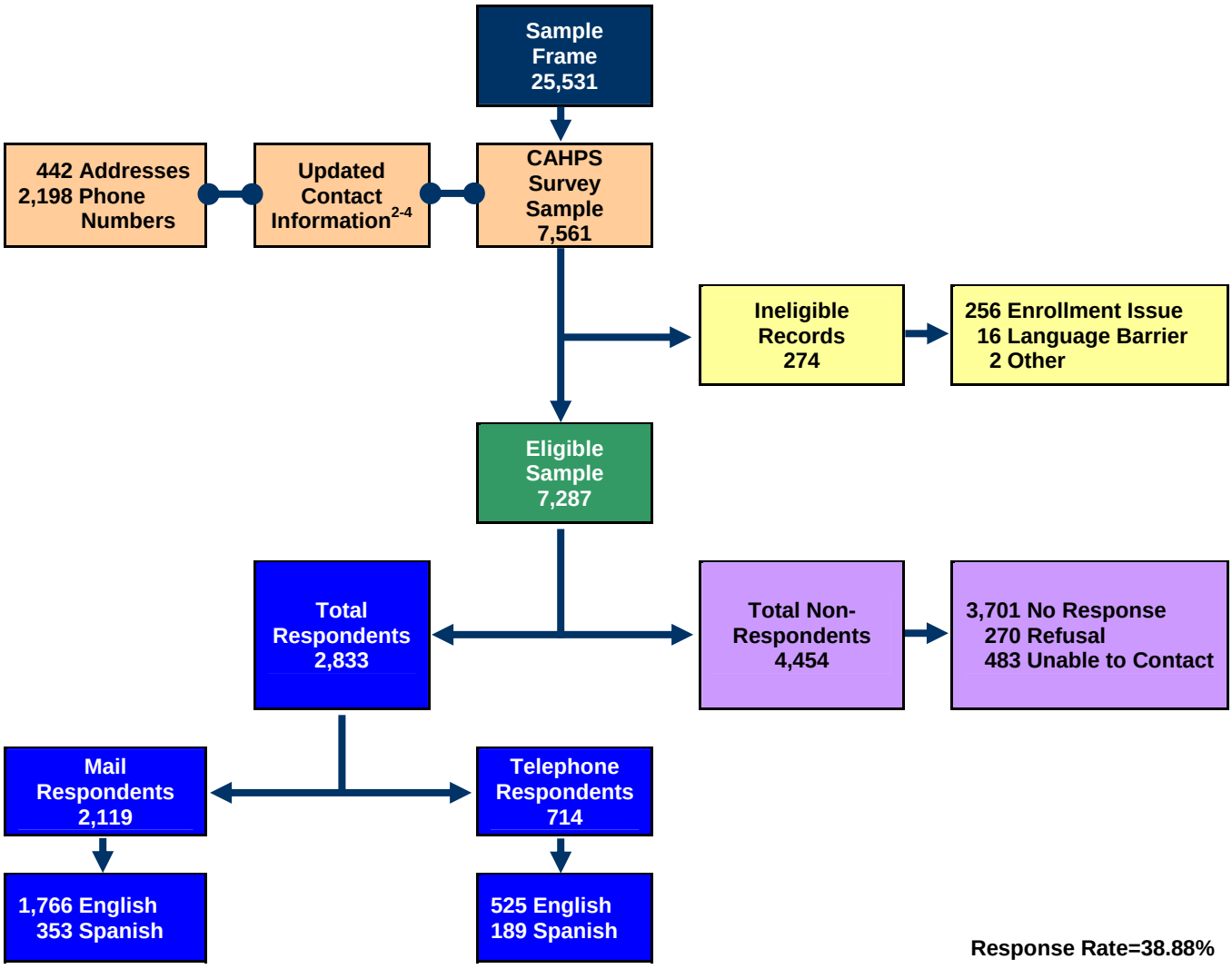
The CAHPS 4.0H Child Medicaid Health Plan Survey administration was designed to achieve the highest possible response rate. The CAHPS Survey response rate is the total number of completed surveys divided by all eligible members of the sample. A member's survey was assigned a disposition code of "completed" if at least one question was answered. Eligible members included 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 2,833 completed surveys were returned on behalf of child CHP+ members, including 647 Colorado Access, 387 DHMP, 490 Kaiser, 710 RMHP, and 599 SMCN child members.

Figure 2-1, on the following page, shows the distribution of survey dispositions and response rate for Colorado CHP+ (i.e., all five health plans combined). Figure 2-2 through Figure 2-6 show the individual distribution of survey dispositions and response rates for Colorado Access, DHMP, Kaiser, RMHP, and the SMCN, respectively. The Colorado CHP+ 2011 response rate of 38.88 percent was 3.48 percentage points higher than the 2010 NCQA national child Medicaid response rate, which was 35.40 percent.[2-3]

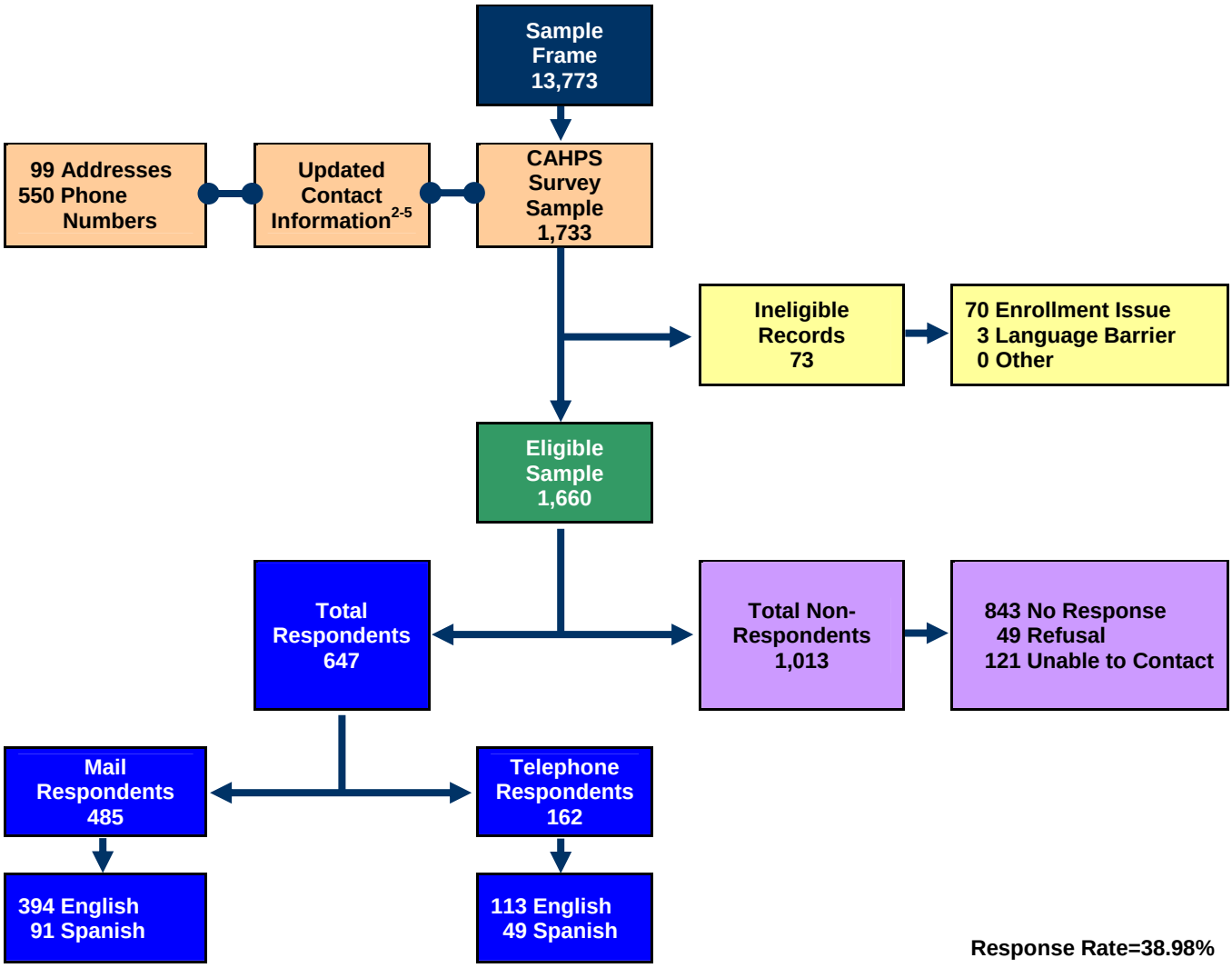
[2-3] National Committee for Quality Assurance. *HEDIS 2011 Survey Vendor Update Training*. October 21, 2010.

Figure 2-1—Distribution of Surveys for Colorado CHP+ (Colorado Access, DHMP, Kaiser, RMHP, and the SMCN Combined)



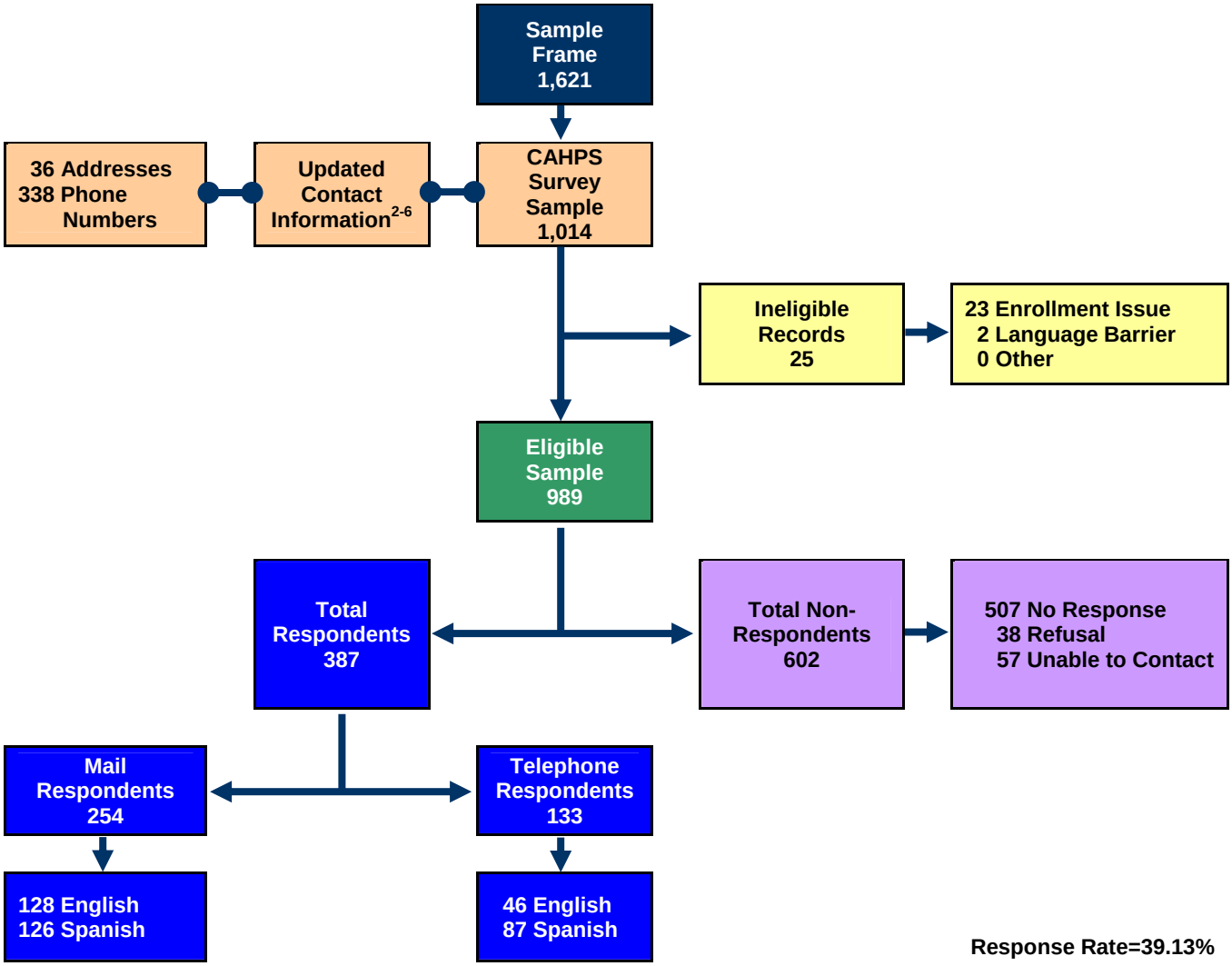
[2-4] Prior to survey administration, address and phone information is updated for members of the CAHPS sample using the United States Postal Service's National Change of Address (NCOA) and Telematch databases. The number of updated addresses and telephone numbers are provided for informational purposes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

Figure 2-2—Distribution of Surveys for Colorado Access



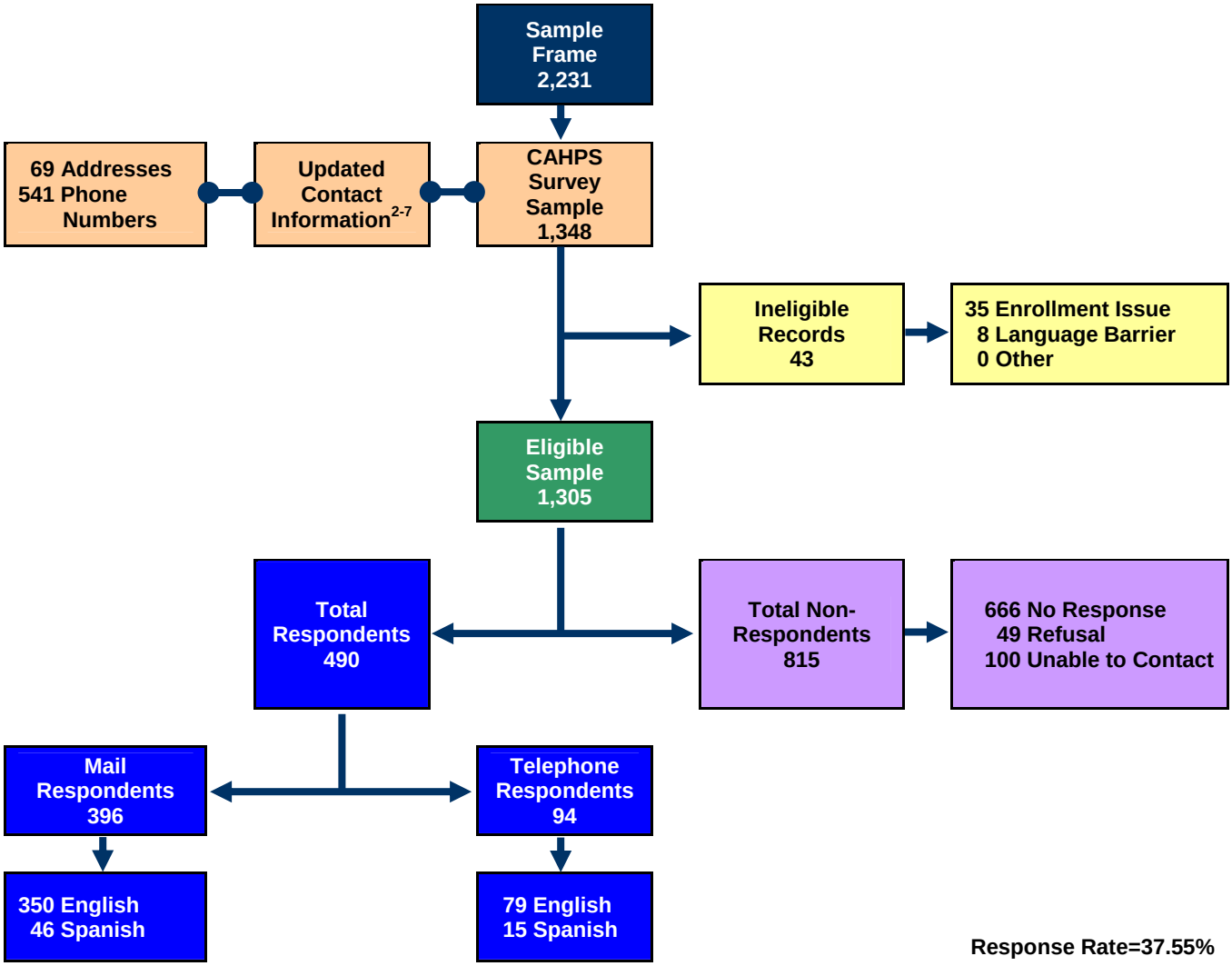
[2-5] Prior to survey administration, address and phone information is updated for members of the CAHPS sample using the United States Postal Service's NCOA and Telematch databases. The number of updated addresses and telephone numbers are provided for informational purposes only. Per NCQA HEDIS Specifications, these members are retained within the CAHPS Survey sample.

Figure 2-3—Distribution of Surveys for DHMP



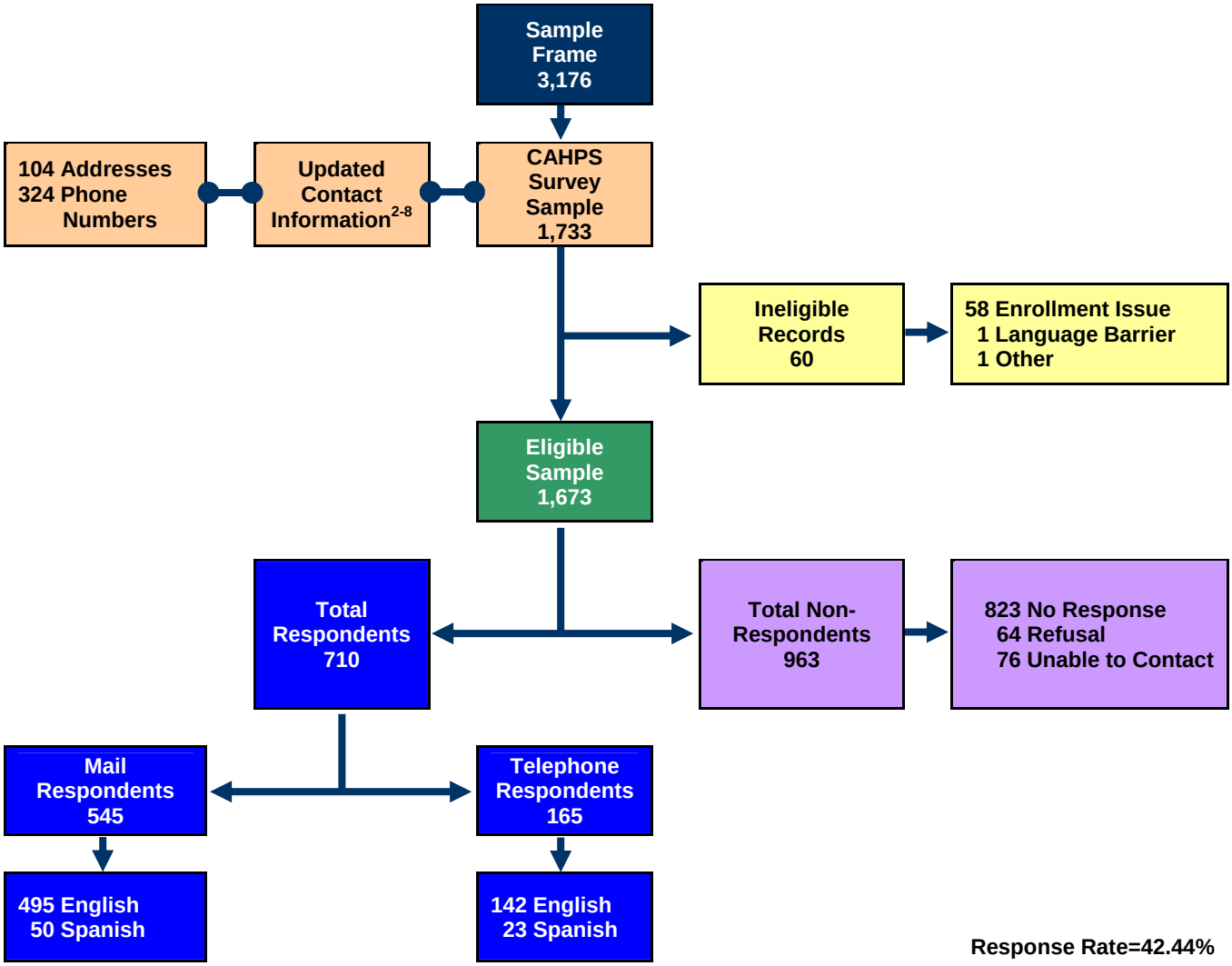
[2-6] Prior to survey administration, address and phone information is updated for members of the CAHPS sample using the United States Postal Service's NCOA and Telematch databases. The number of updated addresses and telephone numbers are provided for informational purposes only. Per NCQA HEDIS Specifications, these members are retained within the CAHPS Survey sample.

Figure 2-4—Distribution of Surveys for Kaiser



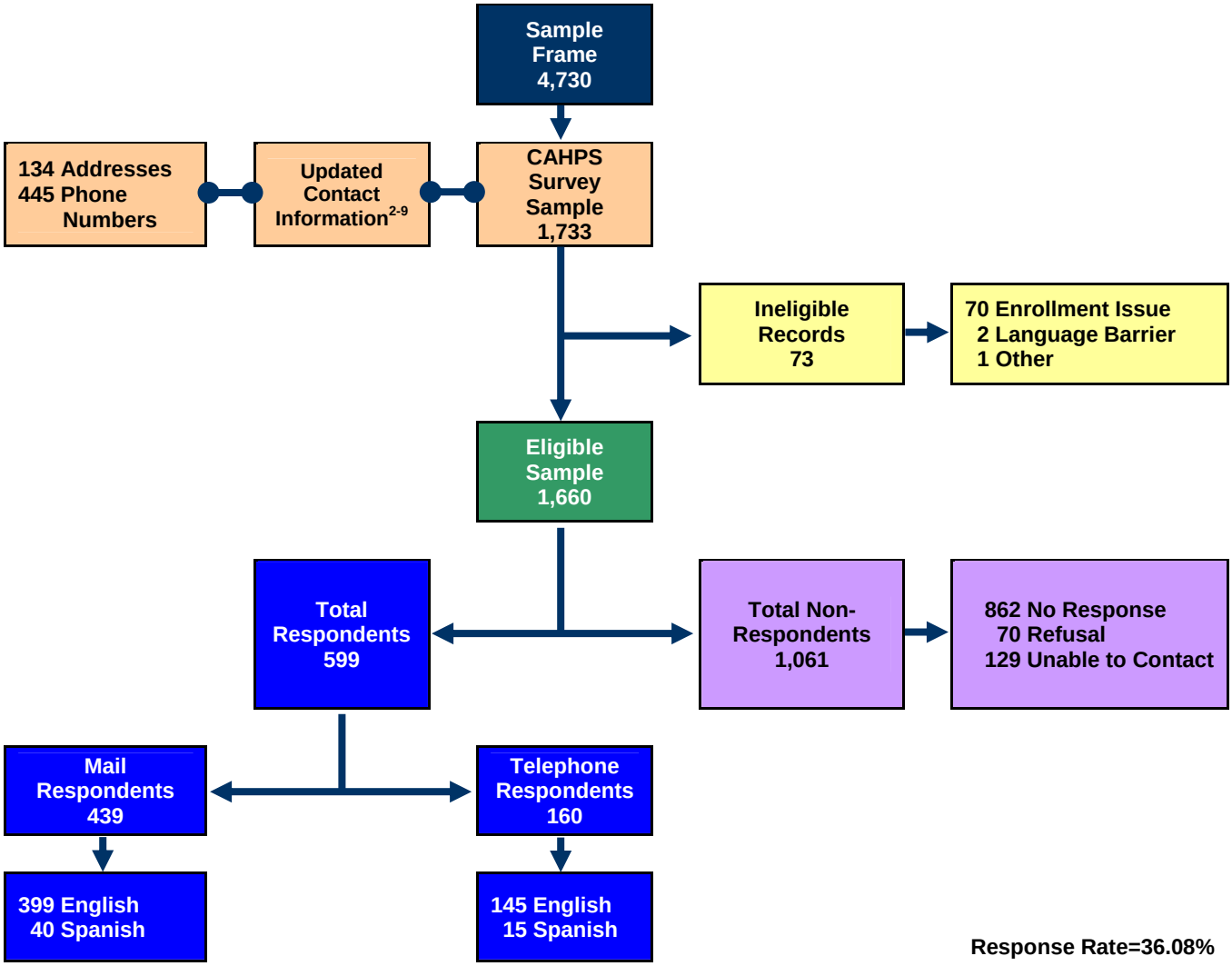
[2-7] Prior to survey administration, address and phone information is updated for members of the CAHPS sample using the United States Postal Service's NCOA and Telematch databases. The number of updated addresses and telephone numbers are provided for informational purposes only. Per NCQA HEDIS Specifications, these members are retained within the CAHPS Survey sample.

Figure 2-5—Distribution of Surveys for RMHP



[2-8] Prior to survey administration, address and phone information is updated for members of the CAHPS sample using the United States Postal Service's 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.

Figure 2-6—Distribution of Surveys for the SMCN



[2-9] Prior to survey administration, address and phone information is updated for members of the CAHPS sample using the United States Postal Service's 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.

Table 2-1 depicts the sample distribution and response rates for all participating health plans and the Colorado CHP+ aggregate.

Table 2-1
Colorado CHP+
Sample Distribution and Response Rate

Plan Name	Total Sample	Ineligible Records	Eligible Sample	Total Respondents	Response Rate
Colorado CHP+	**7,561**	**274**	**7,287**	**2,833**	**38.88%**
Colorado Access	1,733	73	1,660	647	38.98%
DHMP	1,014	25	989	387	39.13%
Kaiser	1,348	43	1,305	490	37.55%
RMHP	1,733	60	1,673	710	42.44%
SMCN	1,733	73	1,660	599	36.08%

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.[2-10]

Table 2-2 shows the demographic characteristics of children for whom a parent/caretaker completed a CAHPS 4.0H Child Medicaid Health Plan Survey.

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

	Colorado CHP+	Colorado Access	DHMP	Kaiser	RMHP	SMCN
Age						
Less than 1	**1.5%**	0.8%	1.6%	0.6%	2.2%	1.9%
1 to 3	**14.7%**	14.4%	10.2%	10.9%	19.1%	15.8%
4 to 7	**21.6%**	23.9%	20.9%	22.4%	20.1%	20.7%
8 to 12	**34.0%**	33.7%	34.0%	32.4%	35.3%	34.2%
13 to 18	**28.2%**	27.2%	33.2%	33.7%	23.3%	27.4%
Gender						
Male	**51.4%**	52.0%	53.1%	49.9%	51.2%	51.2%
Female	**48.6%**	48.0%	46.9%	50.1%	48.8%	48.8%
Race/Ethnicity						
Multi-Racial	**10.5%**	9.6%	8.5%	12.6%	8.9%	12.7%
White	**64.8%**	63.0%	46.6%	57.9%	76.8%	68.0%
Black	**4.3%**	4.8%	6.1%	8.0%	0.8%	3.8%
Asian	**3.8%**	4.6%	4.8%	8.2%	0.9%	2.2%
Other	**16.6%**	18.1%	34.0%	13.3%	12.6%	13.4%
General Health Status						
Excellent	**40.4%**	38.6%	33.4%	43.6%	44.9%	38.9%
Very Good	**37.4%**	37.0%	33.7%	38.6%	35.5%	41.7%
Good	**18.1%**	20.6%	25.9%	15.4%	15.2%	16.2%
Fair	**3.6%**	3.3%	7.0%	1.5%	3.9%	2.9%
Poor	**0.5%**	0.5%	0.0%	1.0%	0.4%	0.3%

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, 2010. Some children eligible for the CAHPS Survey turned age 18 between January 1, 2011, and the time of survey administration.

[2-10] 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 2-3 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.

Table 2-3
Respondent Demographics
Age, Education, and Relationship to Child

	Colorado CHP+	Colorado Access	DHMP	Kaiser	RMHP	SMCN
Respondent Age						
Under 18	**5.1%**	5.8%	5.1%	5.8%	5.1%	4.0%
18 to 24	**3.3%**	3.0%	2.7%	2.1%	4.3%	3.8%
25 to 34	**31.3%**	32.4%	24.2%	29.7%	35.7%	30.7%
35 to 44	**38.5%**	37.2%	43.6%	39.2%	36.7%	38.0%
45 to 54	**17.8%**	17.3%	19.4%	19.9%	15.1%	18.8%
55 to 64	**3.2%**	3.2%	4.3%	1.9%	2.9%	3.8%
65 or Older	**0.9%**	1.1%	0.8%	1.5%	0.3%	0.9%
Respondent Education						
8th Grade or Less	**9.2%**	9.8%	25.8%	4.6%	6.7%	4.8%
Some High School	**9.7%**	10.8%	23.7%	7.5%	5.5%	6.4%
High School Graduate	**27.8%**	27.4%	31.2%	26.1%	30.8%	24.1%
Some College	**36.4%**	36.1%	13.7%	42.4%	37.0%	45.7%
College Graduate	**16.8%**	15.8%	5.6%	19.4%	20.0%	19.0%
Relationship to Child						
Mother or Father	**98.7%**	98.2%	98.7%	98.1%	99.7%	98.6%
Grandparent	**0.8%**	1.1%	0.8%	1.2%	0.0%	1.2%
Legal Guardian	**0.2%**	0.5%	0.3%	0.0%	0.1%	0.2%
Other	**0.2%**	0.2%	0.3%	0.6%	0.1%	0.0%

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

NCQA Comparisons

In order to assess the overall performance of CHP+ plans, each CAHPS measure was scored on a three-point scale using the scoring methodology detailed in NCQA's HEDIS Specifications for Survey Measures.[2-11] The resulting three-point mean scores were compared to NCQA's HEDIS Benchmarks and Thresholds for Accreditation, except for the Shared Decision Making composite.[2-12] NCQA does not publish benchmarks and thresholds for the Shared Decision Making composite; therefore, the Shared Decision Making star ratings were based on NCQA's 2010 National Child Medicaid data.[2-13] 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

[2-11] National Committee for Quality Assurance. *HEDIS® 2011, Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2010.

[2-12] National Committee for Quality Assurance. *HEDIS Benchmarks and Thresholds for Accreditation 2011.* Washington, DC: NCQA, January 31, 2011.

[2-13] The star assignments for the Shared Decision Making composite are determined by comparing the plans' three-point mean scores to the distribution of NCQA's 2010 National Child Medicaid data. NCQA National Distribution of 2010 Child Medicaid CAHPS Plan-level Results. Prepared by NCQA for HSAG on November 23, 2010.

Table 2-4 shows the plans' three-point mean scores and overall member satisfaction ratings on each of the four global ratings and five composite measures. NCQA does not provide benchmarks for the Coordination of Care and Health Promotion and Education individual measures; therefore, overall member satisfaction ratings could not be determined.

Table 2-4
NCQA Comparisons
Overall Member Satisfaction Ratings

	Colorado Access	DHMP	Kaiser	RMHP	SMCN
Global Rating					
Rating of Health Plan	★ 2.421	★ 2.430	★★★ 2.546	★★ 2.488	★ 2.271
Rating of All Health Care	★★ 2.443	★ 2.359	★★★★★ 2.601	★★★★ 2.553	★ 2.319
Rating of Personal Doctor	★★★ 2.630	★★★★ 2.667	★★★★ 2.656	★★★★ 2.654	★ 2.481
Rating of Specialist Seen Most Often	★★★ 2.574	★+ 2.356	★+ 2.356	★★★★ 2.602	★★★ 2.569
Composite Measure					
Getting Needed Care	★★ 2.307	★+ 1.895	★★★ 2.354	★★★★ 2.447	★★ 2.242
Getting Care Quickly	★★ 2.508	★ 2.298	★★★ 2.640	★★★★★ 2.703	★★ 2.524
How Well Doctors Communicate	★★ 2.643	★★ 2.611	★★★ 2.696	★★★★ 2.706	★★ 2.644
Customer Service	★ 2.214	★+ 2.029	★★ 2.378	★ 2.240	★ 2.080
Shared Decision Making	★ 2.505	★+ 2.406	★★★★★ 2.697	★★★★ 2.632	★ 2.508

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

Summary of NCQA Comparisons Results

The following table summarizes the NCQA comparisons results.

Table 2-5
NCQA Comparisons Results

Colorado Access	DHMP	Kaiser	RMHP	SMCN
★ Customer Service	★+ Customer Service	★+ Rating of Specialist Seen Most Often	★ Customer Service	★ Customer Service
★ Rating of Health Plan	★+ Getting Needed Care	★★ Customer Service	★★ Rating of Health Plan	★ Rating of All Health Care
★ Shared Decision Making	★+ Rating of Specialist Seen Most Often	★★★ Getting Care Quickly	★★★★ Getting Needed Care	★ Rating of Health Plan
★★ Getting Care Quickly	★+ Shared Decision Making	★★★ Getting Needed Care	★★★★ How Well Doctors Communicate	★ Rating of Personal Doctor
★★ Getting Needed Care	★ Getting Care Quickly	★★★ How Well Doctors Communicate	★★★★ Rating of All Health Care	★ Shared Decision Making
★★ How Well Doctors Communicate	★ Rating of All Health Care	★★★ Rating of Health Plan	★★★★ Rating of Personal Doctor	★★ Getting Care Quickly
★★ Rating of All Health Care	★ Rating of Health Plan	★★★★ Rating of Personal Doctor	★★★★ Rating of Specialist Seen Most Often	★★ Getting Needed Care
★★★ Rating of Personal Doctor	★★ How Well Doctors Communicate	★★★★★ Rating of All Health Care	★★★★ Shared Decision Making	★★ How Well Doctors Communicate
★★★ Rating of Specialist Seen Most Often	★★★★ Rating of Personal Doctor	★★★★★ Shared Decision Making	★★★★★ Getting Care Quickly	★★★ Rating of Specialist Seen Most Often

★★★★★ 90th Percentile or Above ★★★★ 75th-89th Percentiles ★★★ 50th-74th Percentiles ★★ 25th-49th Percentiles ★ Below 25th Percentile

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

Rates and Proportions

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.[2-14] 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 Specifications for Survey Measures, Volume 3*.

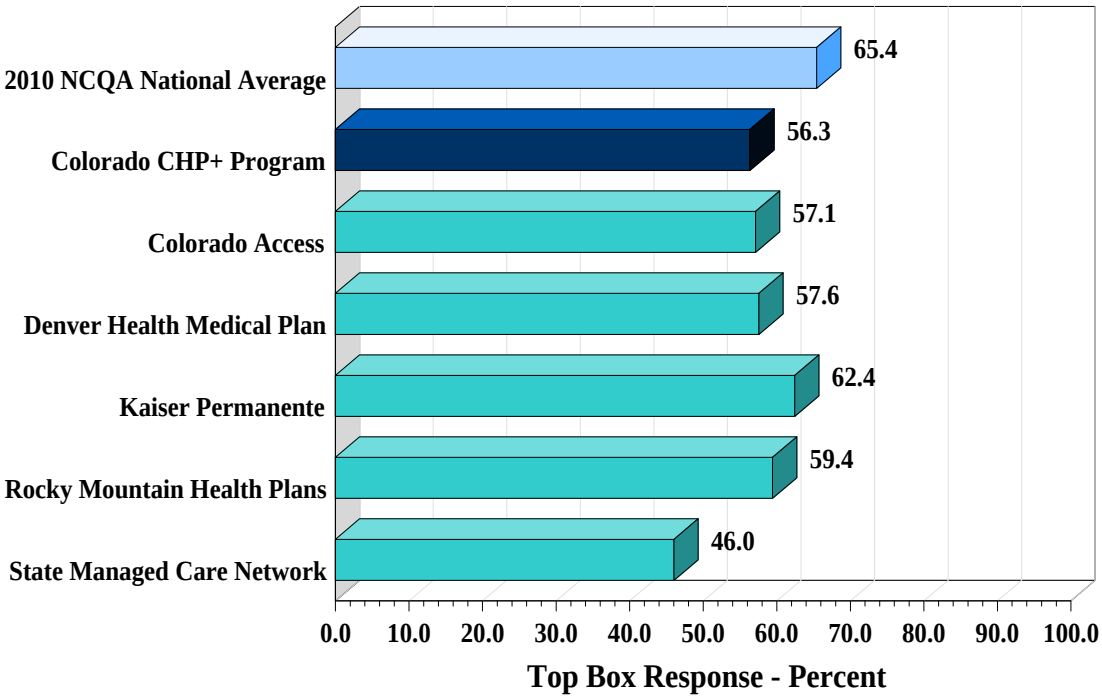
[2-14] National Committee for Quality Assurance. *HEDIS® 2011, Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA Publication, 2010.

Global Ratings

Rating of Health Plan

Colorado CHP+ parents/caretakers of child members 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 2-7 shows the 2011 Rating of Health Plan question summary rates for Colorado CHP+, Colorado Access, DHMP, Kaiser, RMHP, and the SMCN.[2-15,2-16]

Figure 2-7—Rating of Health Plan



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

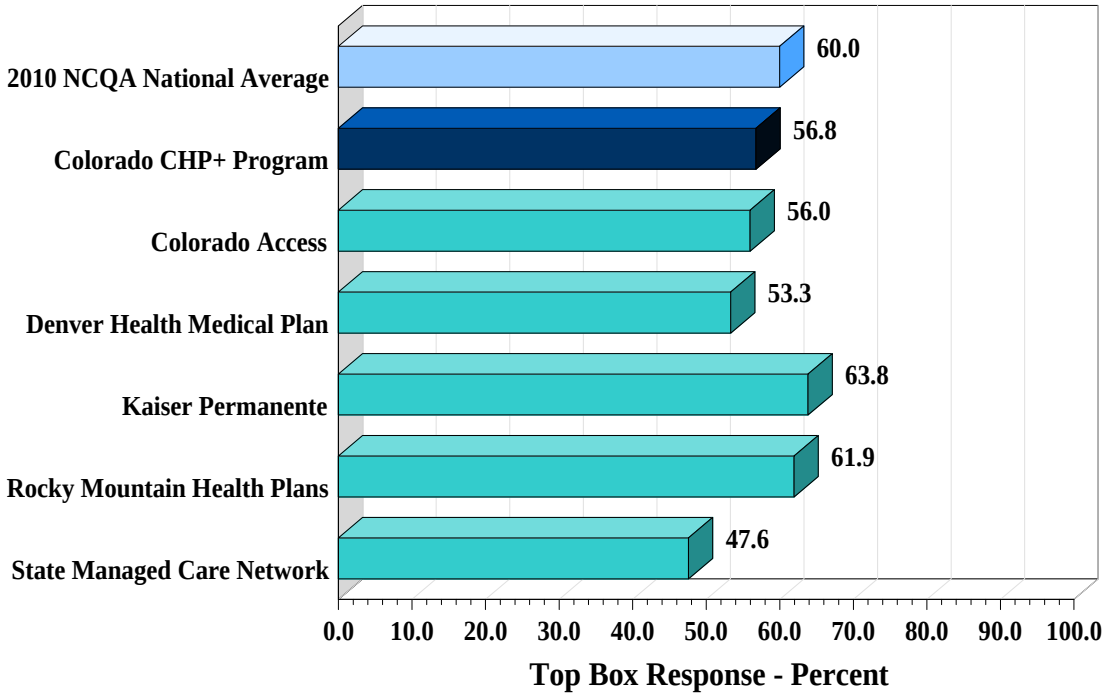
[2-15] Colorado CHP+ scores in this section include the combined results of the five Colorado CHP+ plans: Colorado Access, DHMP, Kaiser, RMHP, and the SMCN.

[2-16] NCQA national averages were not available for 2011 at the time this report was prepared; therefore, 2010 NCQA national averages are presented in this section.

Rating of All Health Care

Colorado CHP+ parents/caretakers of child members 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 2-8 shows the 2011 Rating of All Health Care question summary rates for Colorado CHP+, Colorado Access, DHMP, Kaiser, RMHP, and the SMCN.

Figure 2-8—Rating of All Health Care

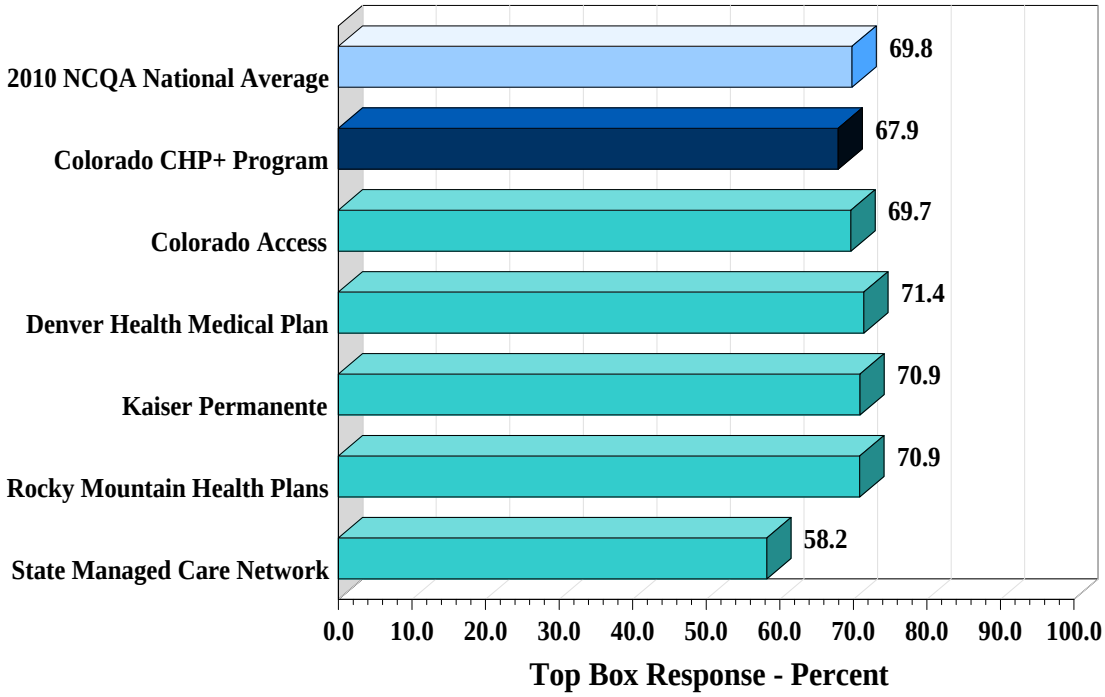


+ If the plan had fewer than 100 respondents for a measure, caution should be exercised when interpreting these results.

Rating of Personal Doctor

Colorado CHP+ parents/caretakers of child members 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 2-9 shows the 2011 Rating of Personal Doctor question summary rates for Colorado CHP+, Colorado Access, DHMP, Kaiser, RMHP, and the SMCN.

Figure 2-9—Rating of Personal Doctor

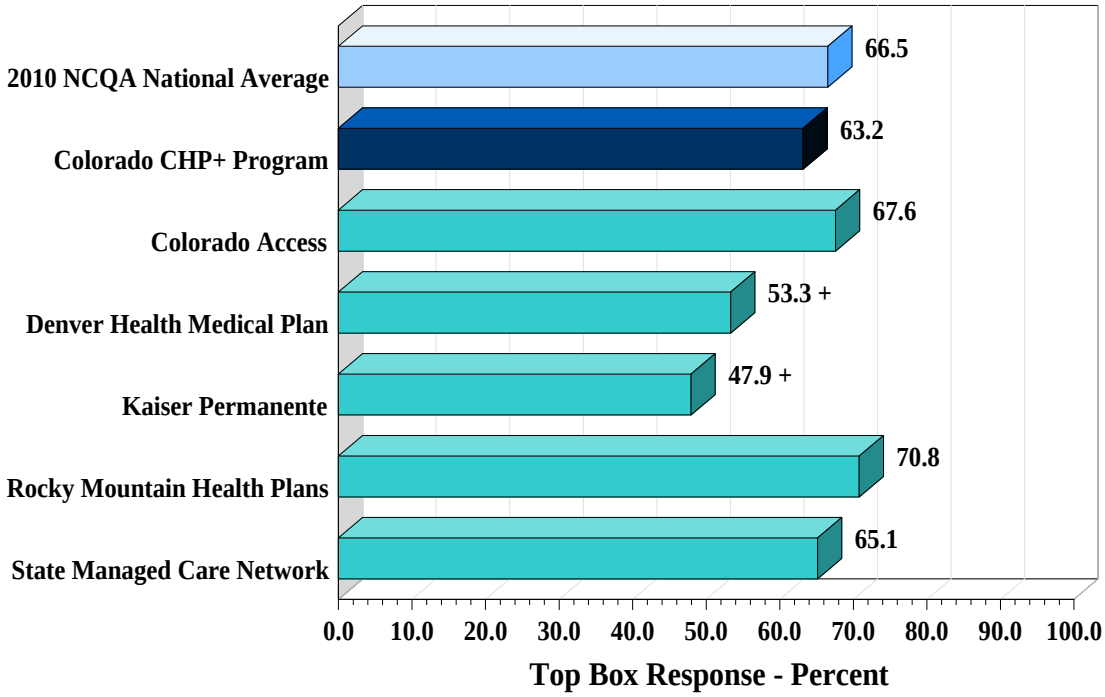


+ If the plan had fewer than 100 respondents for a measure, caution should be exercised when interpreting these results.

Rating of Specialist Seen Most Often

Colorado CHP+ parents/caretakers of child members 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 2-10 shows the 2011 Rating of Specialist Seen Most Often question summary rates for Colorado CHP+, Colorado Access, DHMP, Kaiser, RMHP, and the SMCN.

Figure 2-10—Rating of Specialist Seen Most Often



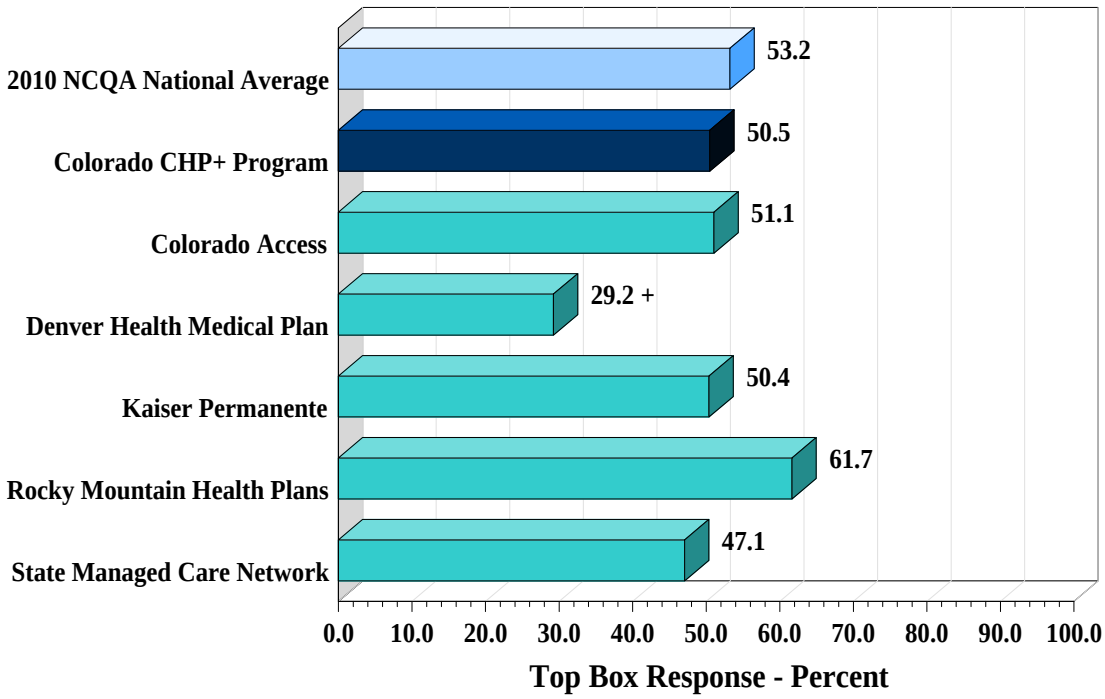
+ If the plan had fewer than 100 respondents for a measure, caution should be exercised when interpreting these results.

Composite Measures

Getting Needed Care

Colorado CHP+ parents/caretakers of child members were asked two questions to assess how often it was easy to get needed care for their child. For each of these questions (Questions 26 and 30), a top-level response was defined as a response of "Always." Figure 2-11 shows the 2011 Getting Needed Care global proportions for Colorado CHP+, Colorado Access, DHMP, Kaiser, RMHP, and the SMCN.

Figure 2-11—Getting Needed Care

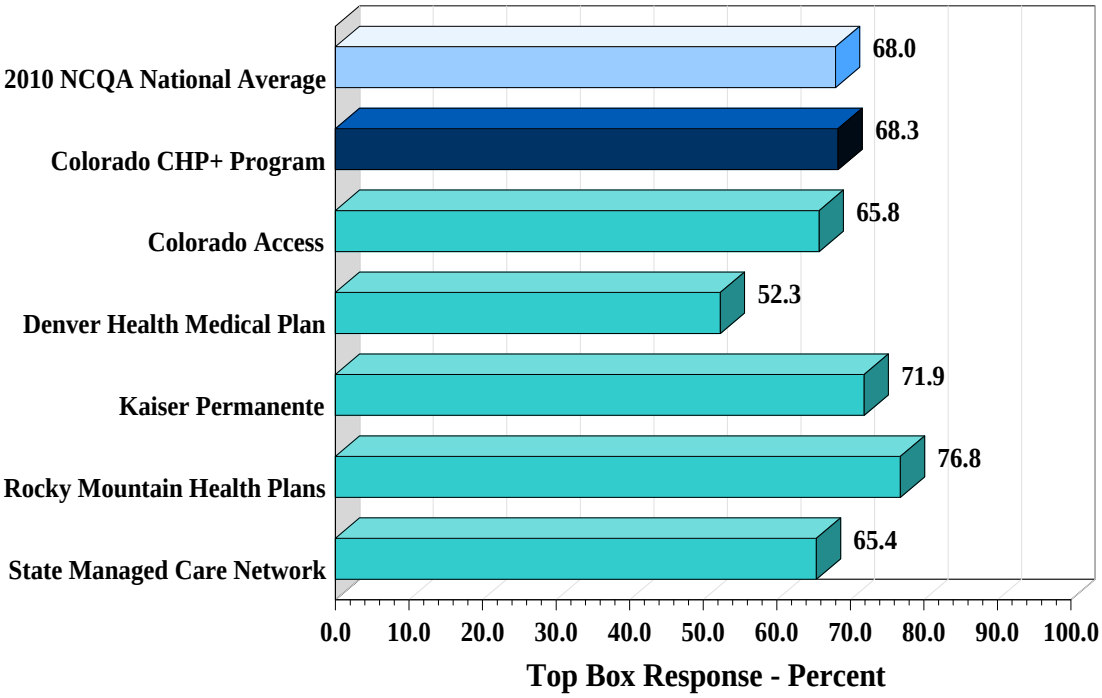


+ If the plan had fewer than 100 respondents for a measure, caution should be exercised when interpreting these results.

Getting Care Quickly

Colorado CHP+ parents/caretakers of child members 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 "Always." Figure 2-12 shows the 2011 Getting Care Quickly global proportions for Colorado CHP+, Colorado Access, DHMP, Kaiser, RMHP, and the SMCN.

Figure 2-12—Getting Care Quickly

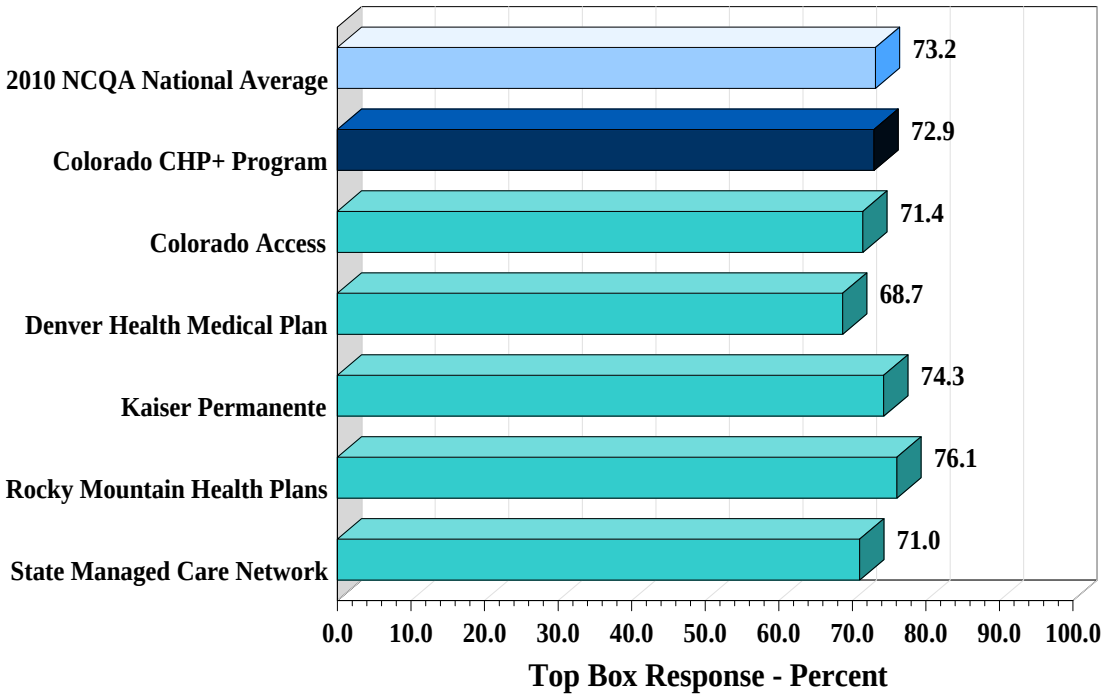


+ If the plan had fewer than 100 respondents for a measure, caution should be exercised when interpreting these results.

How Well Doctors Communicate

Colorado CHP+ parents/caretakers of child members were asked four questions to assess how often their child's doctors communicated well. For each of these questions (Questions 15, 16, 17 and 20), a top-level response was defined as a response of "Always." Figure 2-13 shows the 2011 How Well Doctors Communicate global proportions for Colorado CHP+, Colorado Access, DHMP, Kaiser, RMHP, and the SMCN.

Figure 2-13—How Well Doctors Communicate

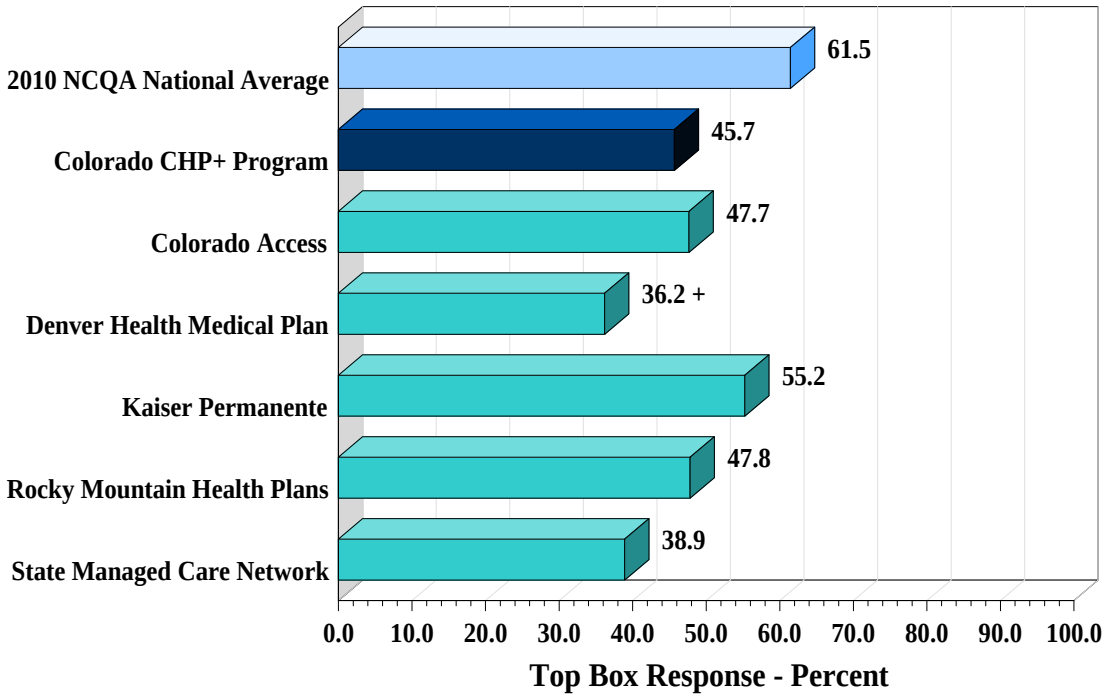


+ If the plan had fewer than 100 respondents for a measure, caution should be exercised when interpreting these results.

Customer Service

Colorado CHP+ parents/caretakers of child members 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 "Always." Figure 2-14 shows the 2011 Customer Service global proportions for Colorado CHP+, Colorado Access, DHMP, Kaiser, RMHP, and the SMCN.

Figure 2-14—Customer Service

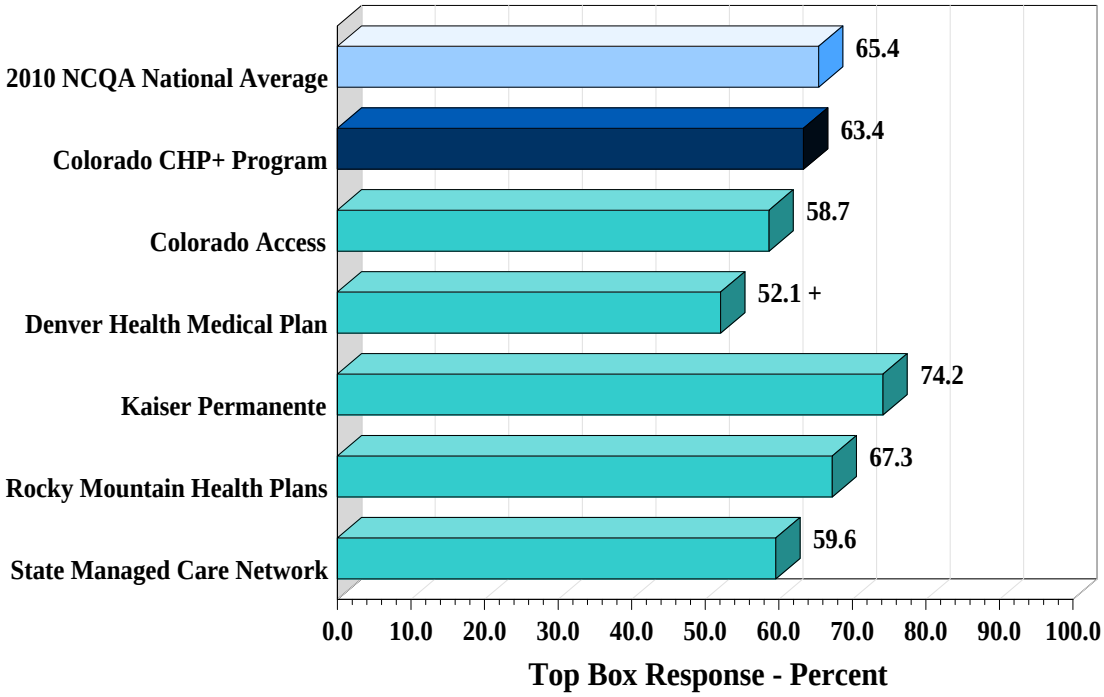


+ If the plan had fewer than 100 respondents for a measure, caution should be exercised when interpreting these results.

Shared Decision Making

Colorado CHP+ parents/caretakers of child members were asked two questions to assess if their child's doctors discussed treatment choices with them. For each of these questions (Questions 10 and 11), a top-level response was defined as a response of "Definitely Yes." Figure 2-15 shows the 2011 Shared Decision Making global proportions for Colorado CHP+, Colorado Access, DHMP, Kaiser, RMHP, and the SMCN.

Figure 2-15—Shared Decision Making



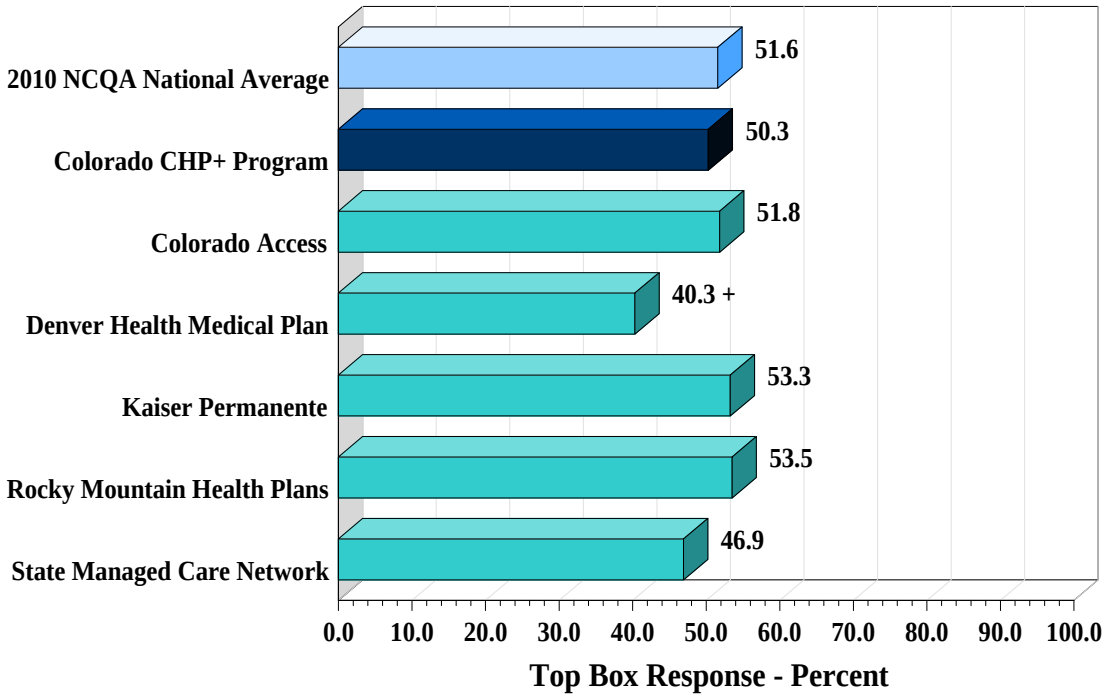
+ If the plan had fewer than 100 respondents for a measure, caution should be exercised when interpreting these results.

Individual Item Measures

Coordination of Care

Colorado CHP+ parents/caretakers of child members 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 23), a top-level response was defined as a response of "Always." Figure 2-16 shows the 2011 Coordination of Care question summary rates for Colorado CHP+, Colorado Access, DHMP, Kaiser, RMHP, and the SMCN.

Figure 2-16—Coordination of Care

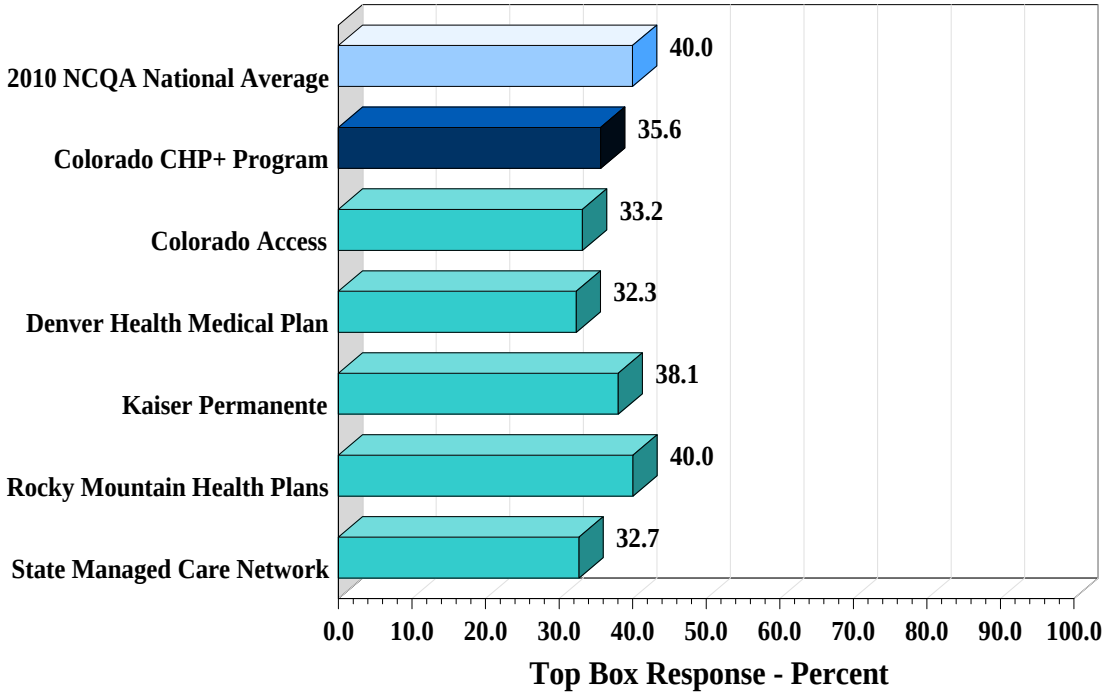


+ If the plan had fewer than 100 respondents for a measure, caution should be exercised when interpreting these results.

Health Promotion and Education

Colorado CHP+ parents/caretakers of child members were asked a question to assess how often 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 "Always." Figure 2-17 shows the 2011 Health Promotion and Education question summary rates for Colorado CHP+, Colorado Access, DHMP, Kaiser, RMHP, and the SMCN.

Figure 2-17—Health Promotion and Education



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

Summary of Rates and Proportions Results

Evaluation of the rates and proportions revealed the following summary results.

- The Colorado CHP+ program scored above the NCQA National Child Medicaid average on one CAHPS measure, Getting Care Quickly.
- Colorado Access scored above the NCQA National Child Medicaid average on two CAHPS measures: Rating of Specialist Seen Most Often and Coordination of Care.
- DHMP scored above the NCQA National Child Medicaid average on one CAHPS measure, Rating of Personal Doctor.
- Kaiser scored above the NCQA National Child Medicaid average on six CAHPS measures: Rating of All Health Care, Rating of Personal Doctor, Getting Care Quickly, How Well Doctors Communicate, Shared Decision Making, and Coordination of Care.
- RMHP scored at or above the NCQA National Child Medicaid average on nine CAHPS measures: Rating of All Health Care, Rating of Personal Doctor, Rating of Specialist Seen Most Often, Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Shared Decision Making, Coordination of Care, and Health Promotion and Education.
- The SMCN did not score above the NCQA National Child Medicaid average on any of the CAHPS measures.

Plan Comparisons

In order to identify performance differences in member satisfaction between the five Colorado CHP+ plans, the results for Colorado Access, DHMP, Kaiser, RMHP, and the SMCN were compared to the Colorado CHP+ program average using standard tests for statistical significance.[2-17] 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 for the CHP+ plans were case-mix adjusted for member general health status, respondent educational level, and respondent age.[2-18] 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 details, please refer to the *NCQA HEDIS Specifications for Survey Measures, Volume 3*.

Statistically significant differences are noted by arrows in the table. A plan that performed statistically better than the Colorado CHP+ program average is denoted with an upward (↑) arrow. Conversely, a plan that performed statistically worse than the Colorado CHP+ program average is denoted with a downward (↓) arrow. A plan that is not statistically different than the Colorado CHP+ program average is denoted with a horizontal (↔) arrow.

Table 2-6 shows the question summary rates and global proportions of the plan comparisons analysis. **NOTE: These results may differ from those presented in the figures because they have been adjusted for differences in case mix (i.e., the percentages presented have been case-mix adjusted).**

[2-17] Caution should be exercised when evaluating plan comparisons, given that population and plan differences may impact CAHPS results.

[2-18] 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 2-6
Plan Comparisons

	Colorado Access	DHMP	Kaiser	RMHP	SMCN
Global Rating					
Rating of Health Plan	57.3% ↔	54.4% ↔	63.4% ↑	60.0% ↔	47.6% ↓
Rating of All Health Care	56.5% ↔	52.9% ↔	63.0% ↑	61.8% ↑	48.4% ↓
Rating of Personal Doctor	70.0% ↔	71.0% ↔	70.9% ↔	70.8% ↔	58.4% ↓
Rating of Specialist Seen Most Often	67.1% ↔	46.1% ↔+	51.6% ↔+	72.5% ↑	67.6% ↔
Composite Measure					
Getting Needed Care	51.2% ↔	30.8% ↓+	49.2% ↔	61.1% ↑	47.1% ↔
Getting Care Quickly	65.7% ↔	54.5% ↓	70.4% ↔	76.1% ↑	65.5% ↔
How Well Doctors Communicate	70.9% ↔	72.5% ↔	72.5% ↔	75.5% ↔	70.0% ↔
Customer Service	47.6% ↔	35.0% ↓+	55.7% ↑	48.4% ↔	39.2% ↔
Shared Decision Making	58.4% ↔	54.7% ↔+	73.3% ↑	65.9% ↔	59.5% ↔
Individual Measure					
Coordination of Care	51.2% ↔	42.1% ↔+	52.1% ↔	53.5% ↔	46.9% ↔
Health Promotion and Education	33.1% ↔	34.3% ↔	37.2% ↔	39.2% ↔	32.4% ↔

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

Summary of Plan Comparisons Results

The plan comparisons revealed the following statistically significant results.

- Colorado Access did not score significantly higher or lower than the Colorado CHP+ program average on any of the CAHPS measures.
- DHMP scored significantly lower than the Colorado CHP+ program average on three CAHPS measures: Getting Needed Care, Getting Care Quickly, and Customer Service.
- Kaiser scored significantly higher than the Colorado CHP+ program average on four CAHPS measures: Rating of Health Plan, Rating of All Health Care, Customer Service, and Shared Decision Making.
- RMHP scored significantly higher than the Colorado CHP+ program average on four CAHPS measures: Rating of All Health Care, Rating of Specialist Seen Most Often, Getting Needed Care, and Getting Care Quickly.
- The SMCN scored significantly lower than the Colorado CHP+ program average on three CAHPS measures: Rating of Health Plan, Rating of All Health Care, and Rating of Personal Doctor.

General Recommendations

During the generation of the 2011 CAHPS CHP+ sample frame files, the following issues were identified:

- The Department did not appropriately apply the enrollment criteria for the selection of the CAHPS sample frame. Per *NCQA HEDIS Specifications for Survey Measures, Volume 3*, members are eligible for the CAHPS survey if they have five out of six months of continuous enrollment during the last six months of the measurement year (i.e., July through December 2010). However, after review of the Department's source code for producing the sample frame files, it was determined that this criteria was not being applied appropriately. The source code was requiring that members be continuously enrolled for at least six months of the specified time period in order to be eligible for the CAHPS survey.
- Member enrollment data in the Department's membership data processing system was incomplete and eligible members were missing from the system.

Prior to the start of any future CAHPS survey administration to the CHP+ population, HSAG recommends that the Department resolve these programming and data issues in order to ensure sample frame files are accurate and complete.

Plan-Specific Recommendations

This section presents Child Medicaid CAHPS recommendations for the five Colorado CHP+ plans. The recommendations are grouped into four main categories for QI: top, high, moderate, and low priority. The priority of the recommendations is based on the results of the NCQA comparisons.[3-1]

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.[3-2] 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 each CHP+ plan on each CAHPS measure.

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

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

[3-1] NCQA does not provide benchmarks for the Coordination of Care and Health Promotion and Education individual measures; therefore, priority assignments cannot be derived.

[3-2] Agency for Healthcare Research and Quality. *The CAHPS Improvement Guide*. Available at: http://www.cahps.ahrq.gov/qiguide/default.aspx. Accessed on: July 22, 2011.

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

Plan	NCQA Comparisons (Star Ratings)	Priority Assignments
Colorado Access	★	Top
DHMP	★	Top
Kaiser	★★★	Moderate
RMHP	★★	High
SMCN	★	Top

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

In order to improve the overall Rating of Health Plan, QI activities should target health plan operations and promoting QI initiatives.

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.

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.

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

Plan	NCQA Comparisons (Star Ratings)	Priority Assignments
Colorado Access	★★	High
DHMP	★	Top
Kaiser	★★★★★	Low
RMHP	★★★★	Low
SMCN	★	Top

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

In order to improve the overall Rating of All Health Care measure, QI activities should target access to care, experience with care, and patient and family advisory councils.

Access to Care

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 health plan should attempt to reduce any hindrances a patient might encounter while seeking care.

Health Care Experiences

To improve patients' health care experience, health plans should identify and eliminate patient challenges when receiving health care. This includes ensuring that patients receive adequate time with a physician so that questions and concerns may be appropriately addressed and providing patients with ample information that is understandable. Furthermore, ensuring that patients receive quality care in a timely manner can help improve patients' perceptions of their health care.

Patient and Family 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, health plans should consider creating patient and family advisory councils, composed of the patients and families who represent the population(s) they serve. These councils 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, these councils can provide a structure and process for ongoing dialogue and creative problem-solving between the health plan and its members. The councils' roles 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.

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

Plan	NCQA Comparisons (Star Ratings)	Priority Assignments
Colorado Access	★★★	Moderate
DHMP	★★★★	Low
Kaiser	★★★★	Low
RMHP	★★★★	Low
SMCN	★	Top

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

In order to improve the Rating of Personal Doctor, QI activities should target physician-patient communication and appointment scheduling.

Physician-Patient Communication

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. 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, and 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.

Maintain Truth in Scheduling

Health plans should 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. 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 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.

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

Plan	NCQA Comparisons (Star Ratings)	Priority Assignments
Colorado Access	★★★	Moderate
DHMP	★+	Top
Kaiser	★+	Top
RMHP	★★★★	Low
SMCN	★★★	Moderate

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

In order to improve the overall performance on the Rating of Specialist Seen Most Often global rating, QI activities should target skills training and telemedicine.

Skills Training for Specialists

Specialized workshops or seminars that focus on training specialists in the skills they need to effectively communicate with patients can 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.

Telemedicine

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. This allows for the local provider to be more involved in the consultation process and more informed about the care the patient is receiving.

Composite Measures

Getting Needed Care

Table 3-6 shows the priority assignments for the Getting Needed Care measure.

Table 3-6
Priority Assignments
Getting Needed Care Composite

Plan	NCQA Comparisons (Star Ratings)	Priority Assignments
Colorado Access	★★	High
DHMP	★+	Top
Kaiser	★★★	Moderate
RMHP	★★★★	Low
SMCN	★★	High

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

In order to improve members' satisfaction under the Getting Needed Care measure, QI activities should target provider directories and appropriate health care providers.

Enhanced Provider Directories

Enhancing provider directories will allow patients to effectively choose a physician that will meet their needs. Frequent production of provider directories is essential to ensure that the most current information is available. The utility of the provider directory can be enhanced by highlighting/emphasizing those providers who are currently accepting new patients. This simplifies patients' options when choosing a new physician. In addition to listing those providers that are accepting new patients, it is helpful to include expanded information on each physician. For example, providing information on training, board certification(s), background information, specialty, and language(s) spoken will allow patients to choose a physician that best meets their needs. Furthermore, developing and publishing physician-level performance measures would give patients the ability to compare providers and make decisions accordingly.

Appropriate Health Care Providers

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.

Getting Care Quickly

Table 3-7 shows the priority assignments for the Getting Care Quickly measure.

Table 3-7
Priority Assignments
Getting Care Quickly Composite

Plan	NCQA Comparisons (Star Ratings)	Priority Assignments
Colorado Access	★★	High
DHMP	★	Top
Kaiser	★★★	Moderate
RMHP	★★★★★	Low
SMCN	★★	High

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

In order to improve members' satisfaction under the Getting Care Quickly measure, QI activities should target open access scheduling, patient flow, electronic communication, and nurse advice help lines.

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

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.

A patient flow analysis should include measuring the amount of time it takes to complete a scheduled visit for various appointment types. By creating a schedule template that accurately

reflects patient flow, providers can reduce patient dissatisfaction with prolonged wait times and office staff time spent explaining appointment delays.

Electronic Communication

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, providing prescription refills, answering patient questions, educating patients on health topics, and disseminating lab results. It should be noted that Health Insurance Portability and Accountability Act (HIPAA) regulations must be carefully reviewed when implementing this form of communication.

Nurse Advice Help Line

Health plans can establish a nurse advice help line to direct members to the most appropriate level of care for their health problem. Members unsure if their health problem requires immediate care or a physician visit, can be directed to the help line, where nurses can assess their situation and provide advice for receiving care and/or offer steps they can take to manage symptoms of minor conditions. Additionally, a 24-hour help line can improve members' perceptions of getting care quickly by providing quick, easy access to the resources and expertise of clinical staff.

How Well Doctors Communicate

Table 3-8 shows the priority assignments for the How Well Doctors Communicate measure.

Table 3-8
Priority Assignments
How Well Doctors Communicate Composite

Plan	NCQA Comparisons (Star Ratings)	Priority Assignments
Colorado Access	★★	High
DHMP	★★	High
Kaiser	★★★	Moderate
RMHP	★★★★	Low
SMCN	★★	High

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

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

Communication Tools for Patients

Health plans can encourage patients to take a more active role in the management of their health care by providing them with the tools necessary to effectively communicate with their 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 nonadherence and poor health outcomes. To address this issue, 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 to them. 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.

Customer Service

Table 3-9 shows the priority assignments for the Customer Service measure.

Table 3-9
Priority Assignments
Customer Service Composite

Plan	NCQA Comparisons (Star Ratings)	Priority Assignments
Colorado Access	★	Top
DHMP	★+	Top
Kaiser	★★	High
RMHP	★	Top
SMCN	★	Top

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

In order to improve members' satisfaction under the Customer Service measure, QI activities should focus on service recovery, performance measures, and employee training and empowerment.

Service Recovery

Service recovery can include listening to a patient who is upset, handing out incentives to patients who have had to wait longer than a specified time for a doctor visit, and assessing events to identify the source of the problem. Some issues arise from experiences with a specific staff person in the service process, which can reflect a training problem, while others may be the result of system problems that require an entirely different process to resolve. Service recovery programs that include implementing a process for tracking problems and complaints can help ensure correct improvement processes are put into place.

Customer Service Performance Measures

Setting plan-level customer service standards can assist in addressing areas of concern and serve as domains for which health plans 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 staff members. Additionally, by tracking and reporting progress internally and modifying measures as needed, customer service performance is more likely to improve.

Employee Training and Empowerment

Employees who have the necessary skills and tools to appropriately communicate with members and answer their questions and/or complete their requests are more likely to provide exceptional customer service. Therefore, it is important to ensure that staff have adequate training on all pertinent business processes. Furthermore, staff members should feel empowered to resolve most issues a member might have. This will eliminate transferring members to multiple employees and will help to resolve a complaint in a more timely manner.

Shared Decision Making

Table 3-10 shows the priority assignments for the Shared Decision Making measure.

Table 3-10
Priority Assignments
Shared Decision Making Composite

Plan	NCQA Comparisons (Star Ratings)	Priority Assignments
Colorado Access	★	Top
DHMP	★+	Top
Kaiser	★★★★★	Low
RMHP	★★★★	Low
SMCN	★	Top

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

In order to improve member satisfaction scores under the Shared Decision Making measure, QI activities should focus on skills training for physicians and shared decision making materials.

Skills Training for Physicians

Implementing a shared decision making model 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 skills to facilitate the shared decision making process; ensuring that physicians understand the importance of taking each patient's values into consideration; understanding patients' preferences and needs; and improving communication skills. Effective and efficient training methods include seminars and workshops.

Shared Decision Making Materials

Patients may become more involved in the management of their health care if physicians promote shared decision making. Physicians will be able to better encourage their patients to participate if the health plan provides the physicians with literature that conveys the importance of the shared decision making model. In addition, materials such as health care goal-setting handouts and forms can assist physicians in facilitating the shared decision making process with their patients. Health plans can also provide members with pre-structured question lists to assist them in asking all the necessary questions so the appointment is as efficient and effective as possible.

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 3-11 provides a summary of the responsible parties for various aspects of care.[3-3]

Table 3-11—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 Colorado Access, DHMP, Kaiser, RMHP, and the SMCN 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.

[3-3] 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 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.[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 and the Child Health Plan Survey in 2009, which are referred to as the CAHPS 4.0H Health Plan Surveys.[4-3,4-4]

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.

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

[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.

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 Colorado Access, DHMP, Kaiser, RMHP, and the SMCN 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 2010. The members eligible for sampling included those who were age 17 or younger (as of December 31, 2010).

NCQA specifications require a sample size of 1,650 members for the CAHPS 4.0H Child Medicaid Health Plan Survey. DHMP and Kaiser did not meet the minimum sample size criteria; therefore, 1,014 and 1,348 child members were selected from DHMP's and Kaiser's eligible population, respectively. The specifications also permit oversampling in 5 percent increments. For Colorado Access, RMHP, and the SMCN, a 5 percent oversample was performed on the child population. Based on this rate, a total random sample of 1,733 child members was selected from these plans.

Survey Protocol

The CAHPS 4.0H Health Plan Survey process allowed for two methods by which members could complete the surveys. The first phase, or mail phase, consisted of a survey being mailed to all sampled members. For CHP+ plans, 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, 2010.
- Were currently enrolled in Colorado Access, DHMP, Kaiser, RMHP, or the SMCN.
- Had been continuously enrolled for at least five of the last six months of 2010.
- 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 2011 Survey Measures.* Washington, DC: NCQA Publication, 2010.

[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 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 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® 2011, Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2010.

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 achieve 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.

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

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. For purposes of this report, plans' 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.

[4-8] National Committee for Quality Assurance. *HEDIS® 2011, Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2010.

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 published NCQA Benchmarks and Thresholds to derive the overall member satisfaction ratings (i.e., star ratings) for each CAHPS measure, except for the Shared Decision Making composite measure. NCQA does not publish benchmarks and thresholds for the Shared Decision Making composite; therefore, the Shared Decision Making star ratings were based on NCQA's 2010 National Child Medicaid data. For detailed information on the derivation of three-point mean scores, please refer to *NCQA HEDIS 2011 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 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 4-3 shows the benchmarks and thresholds used to derive the overall member satisfaction ratings on each CAHPS measure.[4-9,4-10,4-11]

Table 4-3—Overall Member Satisfaction Ratings Crosswalk

Measure	90th Percentile	75th Percentile	50th Percentile	25th Percentile
Rating of Health Plan	2.65	2.61	2.53	2.47
Rating of All Health Care	2.58	2.52	2.48	2.43
Rating of Personal Doctor	2.68	2.65	2.60	2.57
Rating of Specialist Seen Most Often	2.64	2.60	2.54	2.49
Getting Needed Care	2.47	2.43	2.32	2.22
Getting Care Quickly	2.68	2.65	2.59	2.47
How Well Doctors Communicate	2.73	2.70	2.66	2.61
Customer Service	2.57	2.51	2.43	2.34
Shared Decision Making	2.64	2.61	2.56	2.51

4-9 2011 represents the first year NCQA HEDIS Benchmarks and Thresholds for Accreditation were released for the child Medicaid population.

4-10 National Committee for Quality Assurance. *HEDIS Benchmarks and Thresholds for Accreditation 2011*. Washington, DC: NCQA, January 31, 2011.

4-11 The star assignments for the Shared Decision Making composite are determined by comparing the plans' three-point mean scores to the distribution of NCQA's 2010 National Child Medicaid data. NCQA National Distribution of 2010 Child Medicaid CAHPS Plan-Level Results. Prepared by NCQA for HSAG on November 23, 2010.

Plan Comparisons

Plan comparisons were performed to identify member satisfaction differences that were statistically different than the CHP+ program average using standard tests for statistical significance. 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.[4-12] 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 2011 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, the 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.

Two types of hypothesis tests were applied to these results. First, a global *F* test was calculated, which determined whether the difference between health plans' scores was significant. If the *F* test demonstrated health plan-level differences (i.e., $p < 0.05$), then a *t* test was performed for each health plan. The *t* test determined whether each health plan's score was significantly different from the overall results of the other CHP+ health plans.

Statistically significant differences are noted by arrows in the Results Section table. A plan that performed statistically better than the CHP+ program average is denoted with an upward (↑) arrow. Conversely, a plan that performed statistically worse than the CHP+ program average is denoted with a downward (↓) arrow. If the differences are not statistically different, then scores are denoted with a horizontal (↔) arrow.

[4-12] National Committee for Quality Assurance. *HEDIS® 2011, Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA Publication, 2010.

Limitations and Cautions

The findings presented in the 2011 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 plans' 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 the parents or caretakers of members of various plans report differences in satisfaction with various aspects of their child's health care experiences, these differences may not be completely attributable to the CHP+ plan. These analyses identify whether parents or caretakers of members in various types of plans give different ratings of satisfaction with their child's CHP+ plan. The survey by itself does not necessarily reveal the exact cause of these differences.

Incomplete Sample Frame Files

It is important to note that during the sample frame validation process, HSAG's certified HEDIS Compliance auditors identified that the membership data processing system used to generate the CAHPS sample frames for each of the CHP+ plans did not contain complete member enrollment data. After further review, it was determined that the issue impacted all of the CHP+ health plans' sample frames in a similar way and that members missing from the sample frames were random and not unique from the total membership population. While it was established that this issue would not significantly bias the survey results, caution should still be taken when evaluating the results.

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.[4-13] The following references offer guidance on possible approaches to CAHPS-related QI activities.

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[4-13] Agency for Healthcare Research and Quality. *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 22, 2011.

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5. Survey Instrument

The survey instrument selected for the 2011 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 all 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 Child Health Plan Plus. 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.

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 for Colorado Access, DHMP, Kaiser, RMHP, and the SMCN.

CD Contents

- Colorado CHP+ Child CAHPS Report
- Overall Colorado CHP+ Child Cross-tabulations (Tab and Banner Book)
- Colorado Access CHP+ Child Cross-tabulations (Tab and Banner Book)
- DHMP CHP+ Child Cross-tabulations (Tab and Banner Book)
- Kaiser CHP+ Child Cross-tabulations (Tab and Banner Book)
- RMHP CHP+ Child Cross-tabulations (Tab and Banner Book)
- SMCN CHP+ Child 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.