FY 15–16 CHILD HEALTH PLAN *PLUS* MEMBER SATISFACTION REPORT

September 2016

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

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HSAG HEALTH SERVICES ADVISORY GROUP

CONTENTS

1. Executive Summary

The State of Colorado was required to administer member satisfaction surveys to members enrolled in the following Child Health Plan *Plus* (CHP+) plans: Colorado Access, Colorado Choice, Denver Health Medical Plan (DHMP), Kaiser Permanente (Kaiser), and Rocky Mountain Health Plans (RMHP). 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 5.0 Child Medicaid Health Plan Survey with the Healthcare Effectiveness Data and Information Set (HEDIS®) supplemental item set without the Children with Chronic Conditions (CCC) measurement set.[1-2] The parents or caretakers of child members from the CHP+ plans completed the surveys from March to May 2016.

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 four major types of analyses performed on the CHP+ CAHPS data:

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

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

NCQA Comparisons

Overall member satisfaction ratings for four CAHPS global ratings (Rating of Health Plan, Rating of All Health Care, Rating of Personal Doctor, and Rating of Specialist Seen Most Often), four composite measures (Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, and Customer Service), and one individual item measure (Coordination of Care) were compared to NCQA's 2016 HEDIS Benchmarks and Thresholds for Accreditation.[1-3,1-4] This comparison resulted in plan ratings of one (★) to five (★★★★★) stars on these CAHPS measures, where one was the lowest possible rating and five was the highest possible rating. The detailed results of this comparative analysis are described in the Results Section beginning on page 2-5. Table 1-1 presents the highlights from this comparison.

Table 1-1
NCQA Comparisons Highlights

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

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

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

1-3 National Committee for Quality Assurance. *HEDIS Benchmarks and Thresholds for Accreditation 2016*. Washington, DC: NCQA, January 21, 2016.

1-4 NCQA does not publish benchmarks and thresholds for the Shared Decision Making composite measure, and Health Promotion and Education individual item measure; therefore, overall member satisfaction ratings could not be derived for these CAHPS measures.

Trend Analysis

In order to evaluate trends in CHP+ member satisfaction, HSAG performed a stepwise trend analysis, where applicable. The first step compared the 2016 CAHPS results to the 2015 CAHPS results. If the initial 2016 and 2015 trend analysis did not yield any significant differences, then an additional trend analysis was performed between 2016 and 2014 results. The detailed results of the trend analysis are described in the Results Section beginning on page 2-8. Table 1-2 presents the statistically significant results from this analysis.

Table 1-2
Trend Analysis Highlights

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

▲ *Indicates the 2016 score is significantly higher than the 2015 score*
▼ *Indicates the 2016 score is significantly lower than the 2015 score*
▲ *Indicates the 2016 score is significantly higher than the 2014 score*
▼ *Indicates the 2016 score is significantly lower than the 2014 score*

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

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.[1-5] 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 2-21. Table 1-3 presents the statistically significant results from this comparison.[1-6]

Table 1-3
Plan Comparisons Highlights

Colorado Access	Colorado Choice	DHMP	Kaiser	RMHP
↑ Getting Care Quickly	↓ Rating of All Health Care	↓ Getting Care Quickly	↑ Getting Care Quickly	↑ Rating of Specialist Seen Most Often
↑ Getting Needed Care	↓ Rating of Health Plan	↓ Getting Needed Care	↑ Getting Needed Care	
↑ Rating of All Health Care	↓ Rating of Personal Doctor			
↑ Rating of Health Plan	↑ Getting Needed Care			
↑ Rating of Personal Doctor				

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

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

[1-5] 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.

[1-6] Caution should be exercised when evaluating plan comparisons, given that population and plan differences may impact results.

Priority Assignments

Based on the results of the NCQA comparisons and trend analysis, 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 1-4 presents the top and high priorities for each CHP+ plan.

Table 1-4
Top and High Priorities

Colorado Access	Colorado Choice	DHMP	Kaiser	RMHP
◆ Rating of Health Plan ◆ Customer Service ◆ Coordination of Care	◆ Rating of Health Plan ◆ Rating of All Health Care ◆ Rating of Personal Doctor ◆ Customer Service + ◆ Coordination of Care+	◆ Rating of Health Plan ◆ Rating of All Health Care ◆ Rating of Specialist Seen Most Often+ ◆ Getting Needed Care ◆ Getting Care Quickly ◆ Customer Service	◆ Rating of Health Plan ◆ Rating of Specialist Seen Most Often+ ◆ Customer Service	◆ Rating of Health Plan ◆ Getting Needed Care ◆ Customer Service ◆ Coordination of Care

2. Results

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 5.0 Child Medicaid Health Plan Survey.[2-1] Members eligible for sampling included those who were enrolled in Colorado Access, Colorado Choice, DHMP, Kaiser, and RMHP 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 2015. Child members eligible for sampling included those who were 17 years of age or younger as of December 31, 2015.

Colorado Access, Kaiser, and RMHP met the sample size requirements of 1,650. However, Colorado Choice and DHMP did not meet the minimum sample size criteria. HSAG followed historical NCQA protocol where only one survey can be sent to each household; therefore, after adjusting for duplicate addresses, the actual sample sizes for Colorado Choice and DHMP were 987 and 1,408, respectively. Oversampling was not performed for any of the CHP+ plans.

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 cover letter included with the English version of the survey had a Spanish cover letter on the back side informing members that they could call the toll-free number to request a Spanish version of the CAHPS questionnaire. The cover letter provided with the Spanish version of the CAHPS questionnaire included a text box with a toll-free number that members could call to request a survey in another language (i.e., English). A reminder postcard was sent to all non-respondents, followed by a second survey mailing and reminder postcard. The second phase, or telephone phase, consisted of Computer Assisted Telephone Interviewing (CATI) for sampled members who had not mailed in a completed survey. A maximum of six CATI calls was made to each non-respondent. 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® 2016, Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA; 2015.

Response Rates

The Colorado CAHPS 5.0 Child Medicaid Health Plan Survey administration was designed to achieve the highest possible response rate. The CAHPS Survey response rate is the total number of completed surveys divided by all eligible members of the sample. A member's survey was assigned a disposition code of "completed" if at least three of the following five questions were answered: 3, 15, 27, 31, and 36. 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 2,281 completed surveys were returned on behalf of CHP+ members, including 516 Colorado Access, 312 Colorado Choice, 354 DHMP, 475 Kaiser, and 624 RMHP members.

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+	**7,345**	**327**	**7,018**	**2,281**	**32.50%**
Colorado Access	1,650	76	1,574	516	32.78%
Colorado Choice	987	40	947	312	32.95%
DHMP	1,408	73	1,335	354	26.52%
Kaiser	1,650	81	1,569	475	30.27%
RMHP	1,650	57	1,593	624	39.17%

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.[2-2]

Table 2-2 shows the demographic characteristics of children for whom a parent/caretaker completed a CAHPS 5.0 Child Medicaid Health Plan Survey.

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

	Colorado CHP+	Colorado Access	Colorado Choice	DHMP	Kaiser	RMHP
Age						
Less than 1	0.9%	0.4%	1.0%	1.4%	0.9%	1.0%
1 to 3	15.3%	14.3%	19.2%	17.6%	13.0%	14.7%
4 to 7	23.0%	22.9%	19.8%	23.3%	22.0%	25.2%
8 to 12	29.9%	31.9%	26.0%	27.1%	32.0%	30.1%
13 to 18	31.0%	30.5%	34.1%	30.5%	32.2%	29.1%
Gender						
Male	51.5%	52.1%	52.4%	54.0%	49.7%	50.6%
Female	48.5%	47.9%	47.6%	46.0%	50.3%	49.4%
Race						
Multi-Racial	10.6%	10.3%	10.5%	9.9%	12.6%	9.6%
White	68.2%	72.6%	81.0%	43.7%	60.0%	76.4%
Black	3.5%	2.6%	0.7%	9.9%	6.3%	0.5%
Asian	4.8%	4.5%	0.7%	11.3%	7.7%	1.6%
Other	12.9%	9.9%	7.1%	25.4%	13.3%	11.9%
Ethnicity						
Hispanic	43.7%	42.5%	35.8%	65.6%	38.9%	39.9%
Non-Hispanic	56.3%	57.5%	64.2%	34.4%	61.1%	60.1%
General Health Status						
Excellent	46.8%	46.1%	46.0%	47.7%	47.6%	46.5%
Very Good	35.4%	35.0%	37.9%	31.9%	35.9%	36.0%
Good	15.7%	15.6%	15.1%	17.5%	15.0%	15.7%
Fair	2.0%	2.9%	1.0%	2.9%	1.5%	1.8%
Poor	0.1%	0.4%	0.0%	0.0%	0.0%	0.0%

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

[2-2] 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 5.0 Child Medicaid Health Plan Survey.

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

	Colorado CHP+	Colorado Access	Colorado Choice	DHMP	Kaiser	RMHP
Respondent Age						
Under 18	3.8%	4.3%	3.5%	4.7%	2.4%	4.1%
18 to 24	2.2%	1.2%	4.8%	3.2%	2.2%	1.1%
25 to 34	28.8%	30.2%	28.1%	32.4%	24.3%	29.3%
35 to 44	43.2%	45.3%	37.4%	37.6%	48.0%	43.9%
45 to 54	19.0%	16.7%	21.3%	20.3%	19.1%	18.8%
55 to 64	2.5%	1.8%	3.5%	1.5%	3.4%	2.6%
65 or Older	0.5%	0.6%	1.3%	0.3%	0.6%	0.2%
Respondent Education						
8th Grade or Less	7.3%	4.7%	3.2%	19.3%	3.7%	7.7%
Some High School	9.3%	8.9%	5.2%	16.3%	6.9%	9.6%
High School Graduate	23.6%	22.3%	22.4%	27.9%	23.6%	23.0%
Some College	32.6%	32.2%	44.8%	23.7%	32.9%	31.3%
College Graduate	27.2%	31.8%	24.4%	12.8%	32.9%	28.5%
Relationship to Child						
Mother or Father	98.9%	98.6%	99.0%	97.7%	98.9%	99.8%
Grandparent	0.4%	0.2%	0.6%	0.9%	0.4%	0.0%
Legal Guardian	0.2%	0.2%	0.3%	0.6%	0.0%	0.2%
Other	0.5%	1.0%	0.0%	0.9%	0.6%	0.0%

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

NCQA Comparisons

In order to assess the overall performance of the CHP+ plans, the four CAHPS global ratings, four CAHPS composite measures, and one individual item measure were scored on a three-point scale using the scoring methodology detailed in NCQA's HEDIS Specifications for Survey Measures.[2-3] The resulting three-point mean scores were compared to NCQA's HEDIS Benchmarks and Thresholds for Accreditation.[2-4] 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

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

[2-4] National Committee for Quality Assurance. *HEDIS Benchmarks and Thresholds for Accreditation 2016*. Washington, DC: NCQA; January 21, 2016.

Table 2-4 shows the plans' three-point mean scores and overall member satisfaction ratings on the four global ratings, four composite measures, and one individual item measure. NCQA does not provide benchmarks for the Shared Decision Making composite measure, and Health Promotion and Education individual item measure; therefore, overall member satisfaction ratings could not be determined.

Table 2-4
NCQA Comparisons
Overall Client Satisfaction Ratings

	Colorado Access	Colorado Choice	DHMP	Kaiser	RMHP
Global Rating					
Rating of Health Plan	★ 2.494	★ 2.350	★ 2.507	★ 2.449	★ 2.484
Rating of All Health Care	★★★★★ 2.652	★ 2.401	★★ 2.515	★★★★★ 2.599	★★★★ 2.581
Rating of Personal Doctor	★★★★★ 2.727	★ 2.504	★★★★★ 2.711	★★★★ 2.664	★★★★ 2.653
Rating of Specialist Seen Most Often	★★★★+ 2.620	★★★★★+ 2.705	★+ 2.472	★+ 2.512	★★★★★ 2.750
Composite Measure					
Getting Needed Care	★★★ 2.472	★★★ 2.487	★ 2.077	★★★ 2.489	★★ 2.458
Getting Care Quickly	★★★★ 2.682	★★★ 2.630	★ 2.306	★★★★ 2.678	★★★ 2.629
How Well Doctors Communicate	★★★★★ 2.817	★★★ 2.685	★★★ 2.694	★★★★★ 2.794	★★★★★ 2.754
Customer Service	★ 2.355	★+ 2.379	★ 2.375	★ 2.467	★ 2.310
Individual Measure					
Coordination of Care	★ 2.339	★+ 2.338	★★★★+ 2.483	★★★+ 2.449	★ 2.312

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

Summary of NCQA Comparisons Results

The following table summarizes the NCQA comparisons results.

Table 2-5
NCQA Comparisons Highlights

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

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

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

Trend Analysis

In 2014, Colorado Access, Colorado Choice, DHMP, Kaiser, and RMHP had 622, 321, 523, 549, and 556 completed CAHPS Child Medicaid Health Plan Surveys, respectively. In 2015, Colorado Access, Colorado Choice, DHMP, Kaiser, and RMHP had 502, 305, 430, 514, and 457 completed surveys, respectively. In 2016, Colorado Access, Colorado Choice, DHMP, Kaiser, and RMHP had 516, 312, 354, 475, and 624 completed CAHPS Child Medicaid Health Plan Surveys, respectively. These completed surveys were used to calculate the Colorado CHP+ program's and corresponding health plans' 2014, 2015, and 2016 CAHPS results presented in this section for trending purposes.[2-5] Additionally, the Colorado CHP+ program's 2014, 2015, and 2016 CAHPS results were weighted based on the total eligible population for each plan's CHP+ population.

For purposes of the trend analysis, question summary rates were calculated for each global rating and individual item measure, and global proportions were calculated for each composite measure. Both the question summary rates and global proportions were calculated in accordance with NCQA HEDIS Specifications for Survey Measures.[2-6] The scoring of the global ratings, composite measures, and individual item measures involved assigning top-level responses a score of one, with all other responses receiving a score of zero. After applying this scoring methodology, the percentage of top-level responses was calculated in order to determine the question summary rates and global proportions. For additional details, please refer to the *NCQA HEDIS 2016 Specifications for Survey Measures*, *Volume 3*.

In order to evaluate trends in CHP+ member satisfaction, HSAG performed a stepwise three-year trend analysis, where applicable.[2-7] The first step compared the 2016 Colorado CHP+ and plan-level CAHPS scores to the corresponding 2015 scores. If the initial 2016 and 2015 trend analysis did not yield any statistically significant differences, then an additional trend analysis was performed between 2016 and 2014 results. Figure 2-1 through Figure 2-11 show the results of this trend analysis. Statistically significant differences are noted with directional triangles. Scores that were statistically higher in 2016 than in 2015 are noted with black upward (▲) triangles. Scores that were statistically lower in 2016 than in 2015 are noted with black downward (▼) triangles. Scores that were statistically higher in 2016 than in 2014 are noted with red upward (▲) triangles. Scores that were statistically lower in 2016 than in 2014 are noted with red downward (▼) triangles. Scores in 2016 that were not statistically different from scores in 2015 or in 2014 are not noted with triangles. CAHPS scores with fewer than 100 respondents are denoted with a cross (+). Caution should be exercised when interpreting results for those measures with fewer than 100 respondents.

2-5 The CAHPS 5.0H Child Medicaid Health Plan Survey with CCC was administered to parents and/or caretakers of child members in DHMP and RMHP during the 2015 survey administration; therefore, DHMP's and RMHP's 2015 general child results were used for this trend analysis.

2-6 National Committee for Quality Assurance. *HEDIS® 2016, Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA; 2015.

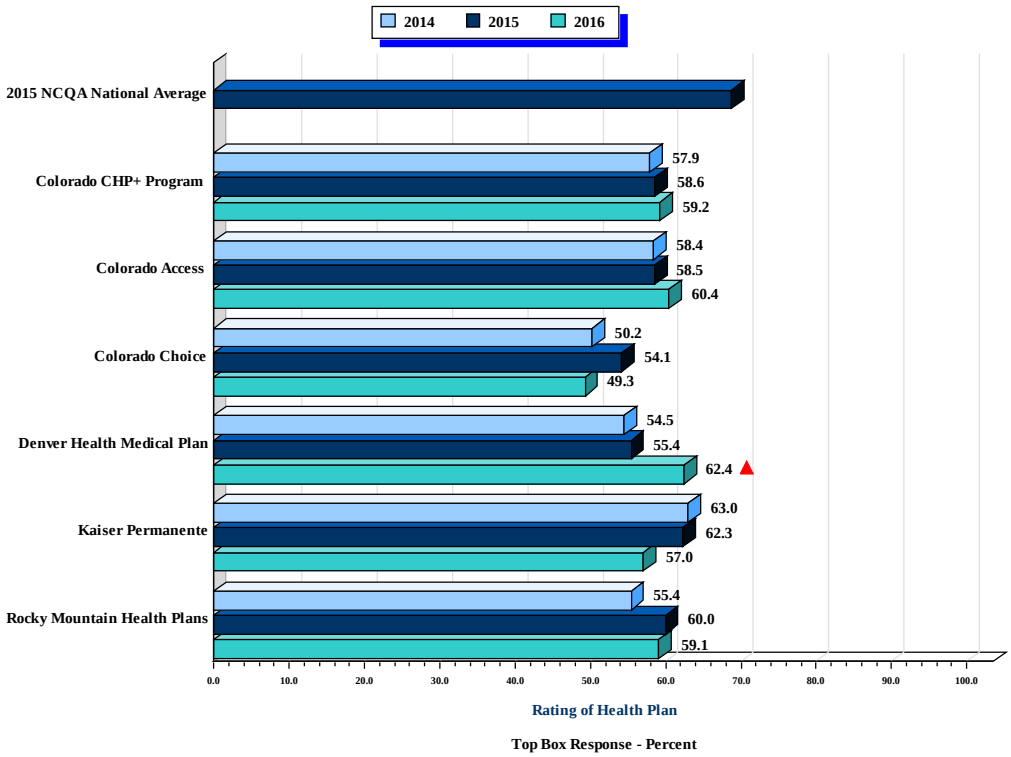
2-7 Due to the changes to the Shared Decision Making composite measure, a trend analysis of 2016 scores to 2014 scores could not be performed.

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 2-1 shows the 2015 NCQA national average, and the 2014, 2015, and 2016 Rating of Health Plan question summary rates for Colorado CHP+, Colorado Access, Colorado Choice, DHMP, Kaiser, and RMHP.[2-8,2-9,2-10,2-11]

Figure 2-1—Rating of Health Plan



Statistical Significance Note:
▲ indicates the 2016 score is significantly higher than the 2015 score
▼ indicates the 2016 score is significantly lower than the 2015 score
▲ indicates the 2016 score is significantly higher than the 2014 score
▼ indicates the 2016 score is significantly lower than the 2014 score

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2-8 The Colorado CHP+ scores in this section are derived from a weighted average of the five Colorado CHP+ plans: Colorado Access, Colorado Choice, DHMP, Kaiser, and RMHP.

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

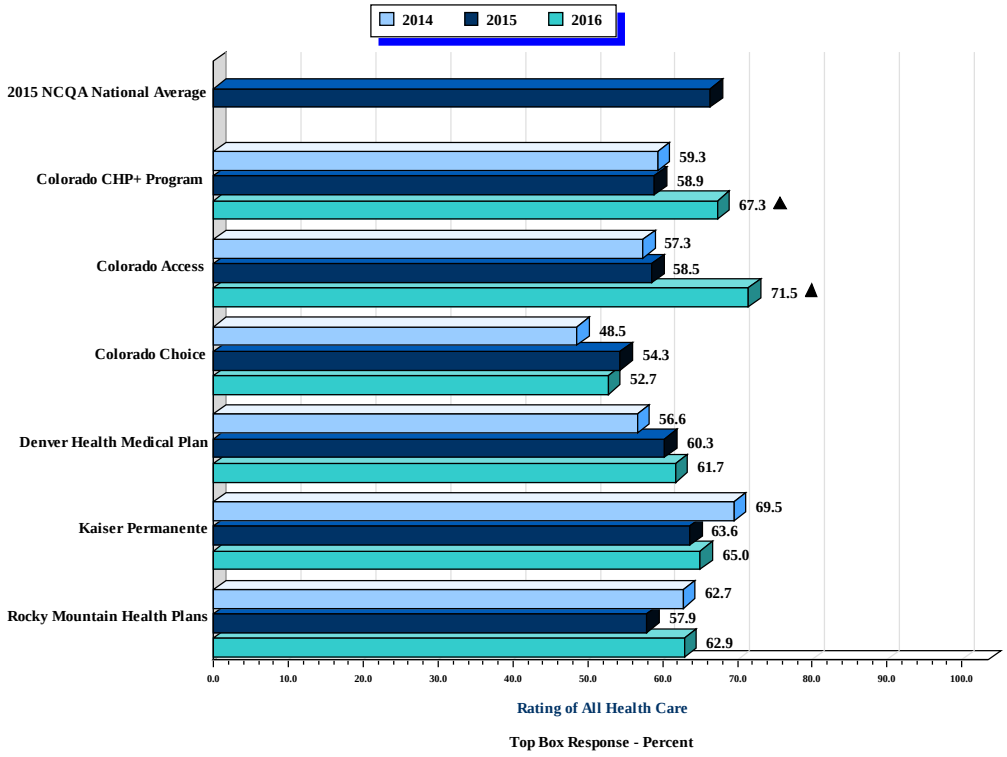
2-10 The source for the NCQA national averages contained in this publication is Quality Compass® 2015 data and is used with the permission of the National Committee for Quality Assurance (NCQA). Quality Compass 2015 includes certain CAHPS data. Any data display, analysis, interpretation, or conclusion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

2-11 NCQA national averages for the child Medicaid population are used for comparative purposes, since NCQA does not provide separate benchmarking data for the CHIP population.

Rating of All Health Care

Colorado CHP+ parents/caretakers of child members were asked to rate 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 2-2 shows the 2015 NCQA national average, and the 2014, 2015, and 2016 Rating of All Health Care question summary rates for Colorado CHP+, Colorado Access, Colorado Choice, DHMP, Kaiser, and RMHP.

Figure 2-2—Rating of All Health Care

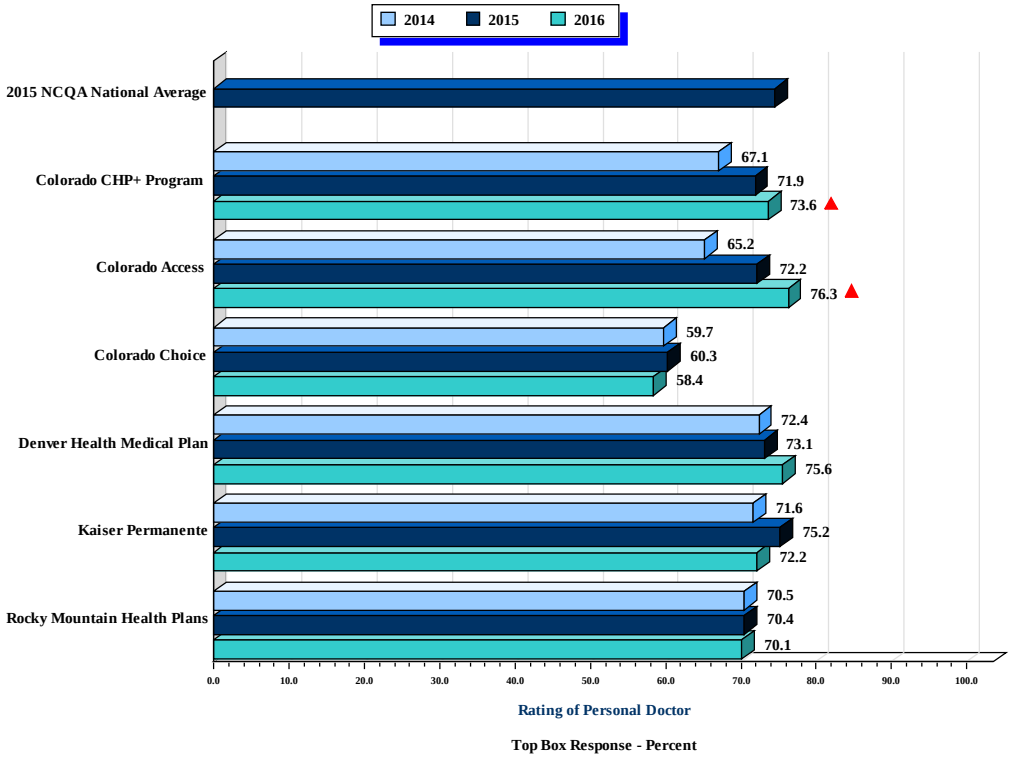


Statistical Significance Note:
▲ indicates the 2016 score is significantly higher than the 2015 score
▼ indicates the 2016 score is significantly lower than the 2015 score
▲ indicates the 2016 score is significantly higher than the 2014 score
▼ indicates the 2016 score is significantly lower than the 2014 score

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 2-3 shows the 2015 NCQA national average, and the 2014, 2015, and 2016 Rating of Personal Doctor question summary rates for Colorado CHP+, Colorado Access, Colorado Choice, DHMP, Kaiser, and RMHP.

Figure 2-3—Rating of Personal Doctor

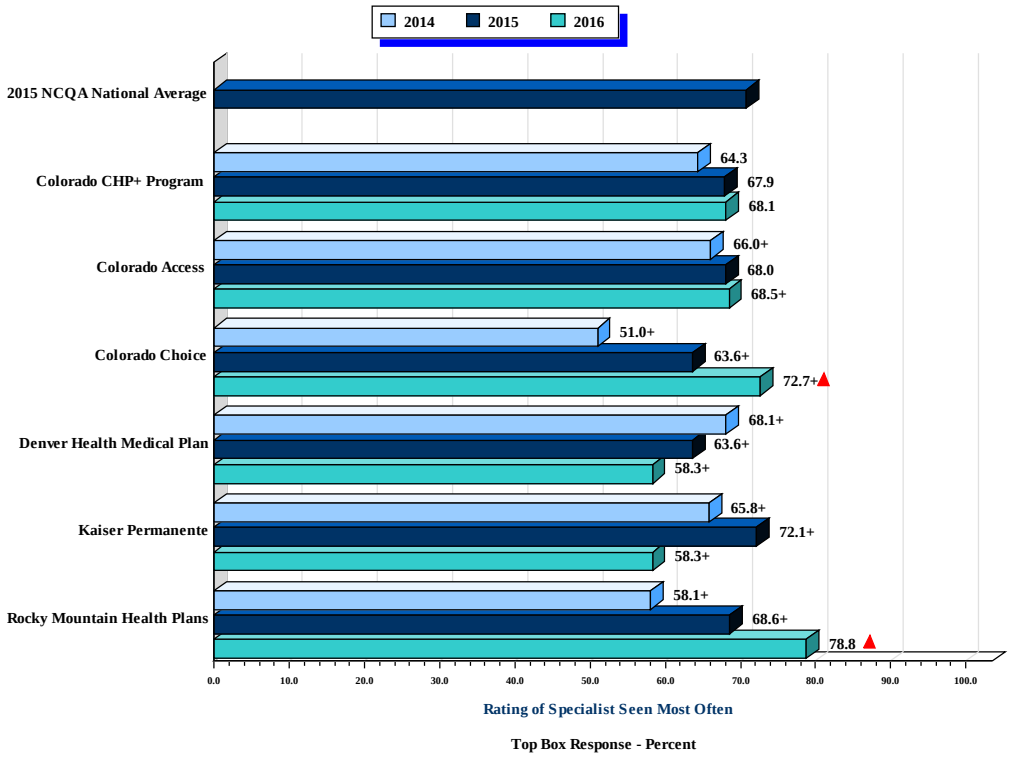


Statistical Significance Note:
▲ indicates the 2016 score is significantly higher than the 2015 score
▼ indicates the 2016 score is significantly lower than the 2015 score
▲ indicates the 2016 score is significantly higher than the 2014 score
▼ indicates the 2016 score is significantly lower than the 2014 score

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 2-4 shows the 2015 NCQA national average, and the 2014, 2015, and 2016 Rating of Specialist Seen Most Often question summary rates for Colorado CHP+, Colorado Access, Colorado Choice, DHMP, Kaiser, and RMHP.

Figure 2-4—Rating of Specialist Seen Most Often



Statistical Significance Note:
▲ indicates the 2016 score is significantly higher than the 2015 score
▼ indicates the 2016 score is significantly lower than the 2015 score
▲ indicates the 2016 score is significantly higher than the 2014 score
▼ indicates the 2016 score is significantly lower than the 2014 score

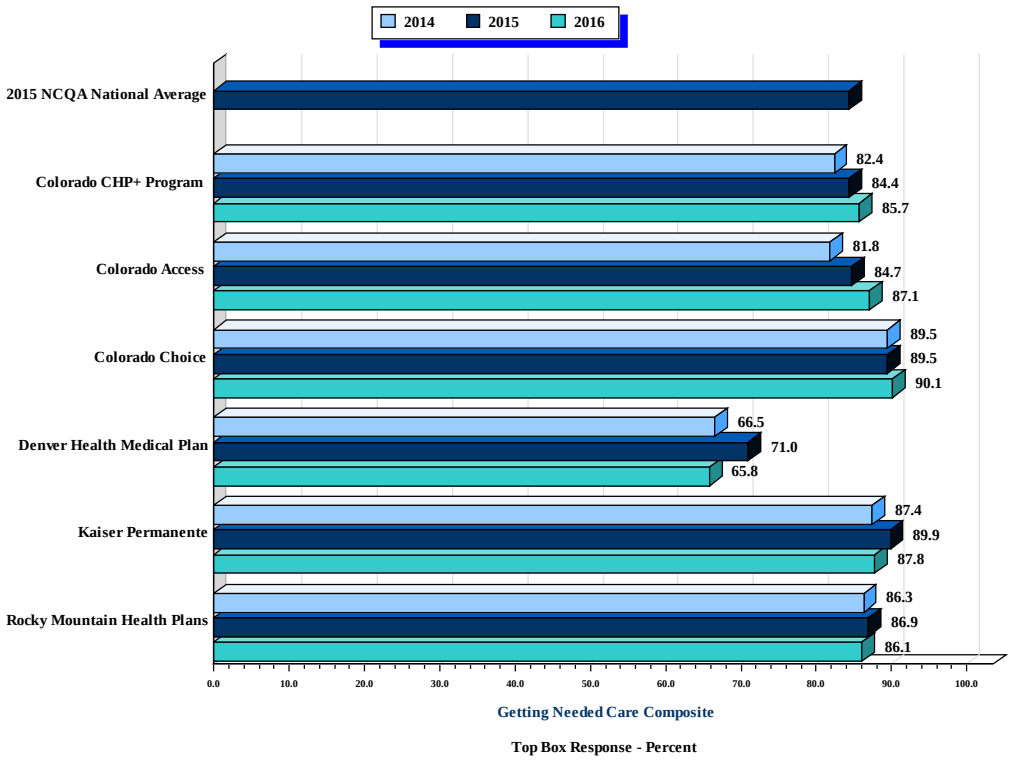
+ If the plan had fewer than 100 respondents for a measure, caution should be exercised when interpreting these results.

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 14 and 28), a top-level response was defined as a response of "Usually" or "Always." Figure 2-5 shows the 2015 NCQA national average, and the 2014, 2015, and 2016 Getting Needed Care global proportions for Colorado CHP+, Colorado Access, Colorado Choice, DHMP, Kaiser, and RMHP.

Figure 2-5—Getting Needed Care

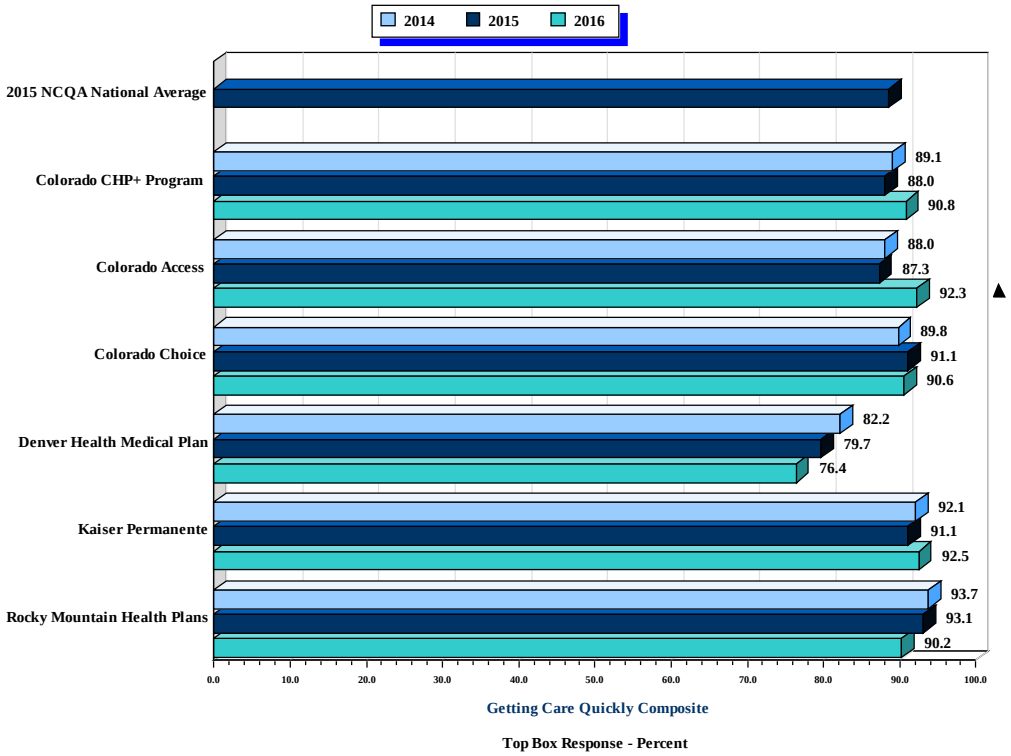


Statistical Significance Note:
▲ indicates the 2016 score is significantly higher than the 2015 score
▼ indicates the 2016 score is significantly lower than the 2015 score
▲ indicates the 2016 score is significantly higher than the 2014 score
▼ indicates the 2016 score is significantly lower than the 2014 score

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 "Usually" or "Always." Figure 2-6 shows the 2015 NCQA national average, and the 2014, 2015, and 2016 Getting Care Quickly global proportions for Colorado CHP+, Colorado Access, Colorado Choice, DHMP, Kaiser, and RMHP.

Figure 2-6—Getting Care Quickly

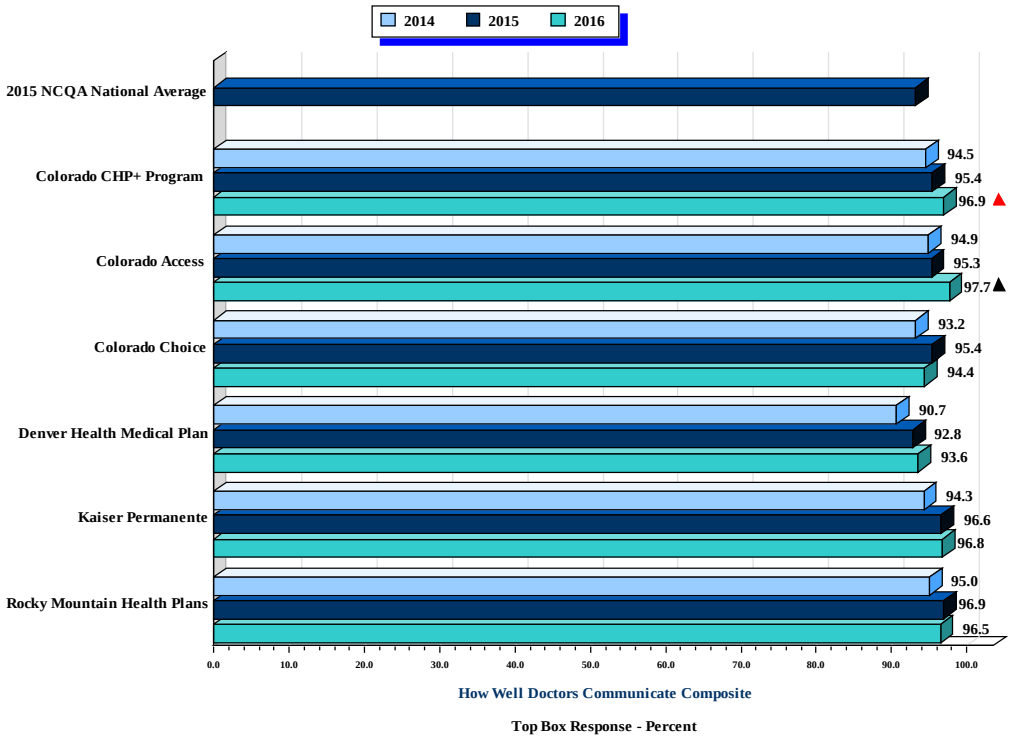


Statistical Significance Note:
▲ indicates the 2016 score is significantly higher than the 2015 score
▼ indicates the 2016 score is significantly lower than the 2015 score
▲ indicates the 2016 score is significantly higher than the 2014 score
▼ indicates the 2016 score is significantly lower than the 2014 score

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 17, 18, 19, and 22), a top-level response was defined as a response of "Usually" or "Always." Figure 2-7 shows the 2015 NCQA national average, and the 2014, 2015, and 2016 How Well Doctors Communicate global proportions for Colorado CHP+, Colorado Access, Colorado Choice, DHMP, Kaiser, and RMHP.

Figure 2-7—How Well Doctors Communicate

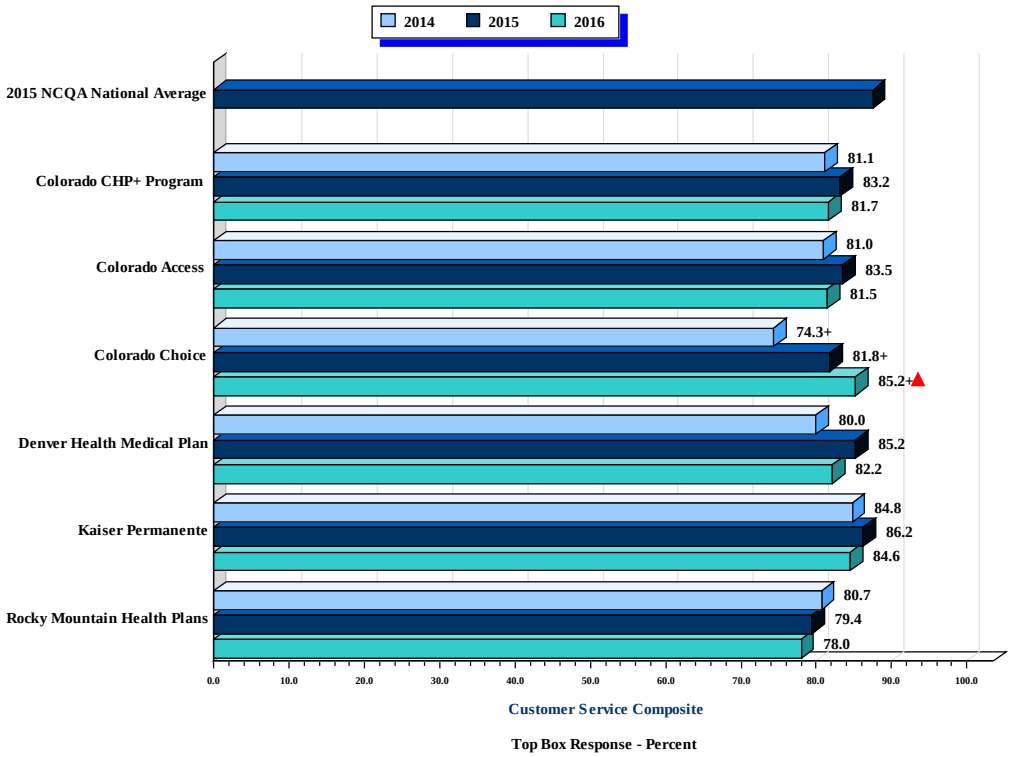


Statistical Significance Note:
▲ indicates the 2016 score is significantly higher than the 2015 score
▼ indicates the 2016 score is significantly lower than the 2015 score
▲ indicates the 2016 score is significantly higher than the 2014 score
▼ indicates the 2016 score is significantly lower than the 2014 score

Customer Service

Colorado CHP+ parents/caretakers of child members were asked two questions to assess how often they obtained needed help/information from the health plan's customer service. For each of these questions (Questions 32 and 33), a top-level response was defined as a response of "Usually" or "Always." Figure 2-8 shows the 2015 NCQA national average, and the 2014, 2015, and 2016 Customer Service global proportions for Colorado CHP+, Colorado Access, Colorado Choice, DHMP, Kaiser, and RMHP.

Figure 2-8—Customer Service



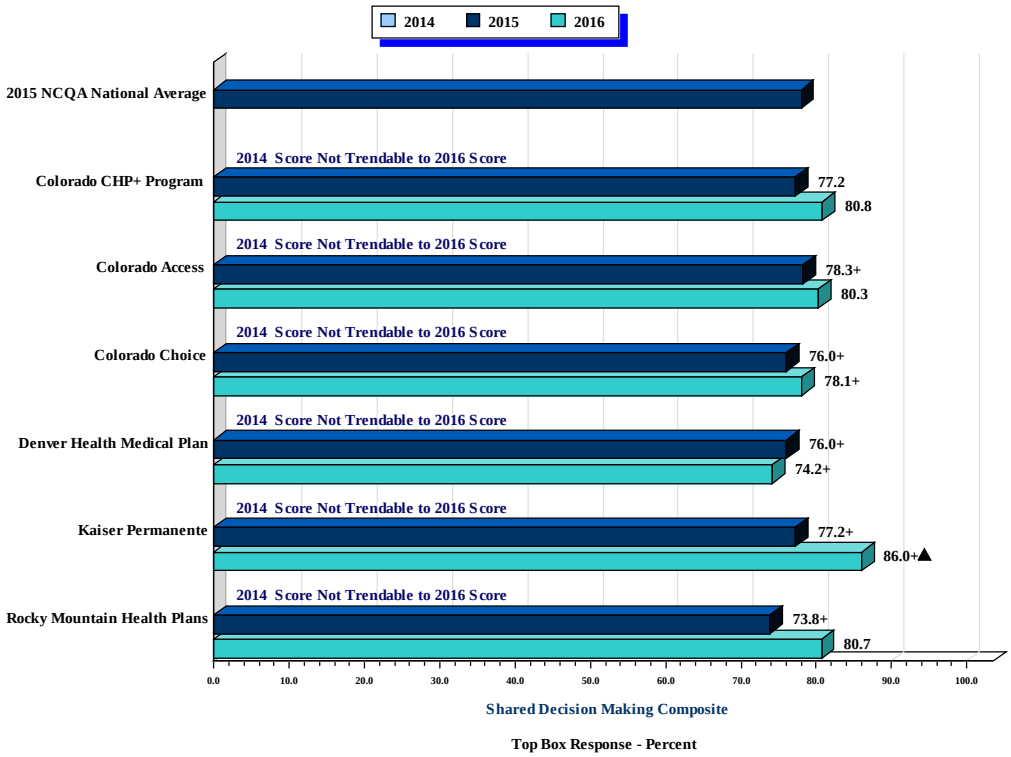
Statistical Significance Note:
▲ indicates the 2016 score is significantly higher than the 2015 score
▼ indicates the 2016 score is significantly lower than the 2015 score
▲ indicates the 2016 score is significantly higher than the 2014 score
▼ indicates the 2016 score is significantly lower than the 2014 score

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

Shared Decision Making

Colorado CHP+ parents/caretakers of child members were asked three questions to assess if their child's doctors discussed starting or stopping a prescription medicine with them. For each of these questions (Questions 10, 11, and 12), a top-level response was defined as a response of "Yes." Figure 2-9 shows the 2015 NCQA national average, and the 2015 and 2016 Shared Decision Making global proportions for Colorado CHP+, Colorado Access, Colorado Choice, DHMP, Kaiser, and RMHP.[2-12]

Figure 2-9—Shared Decision Making



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

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

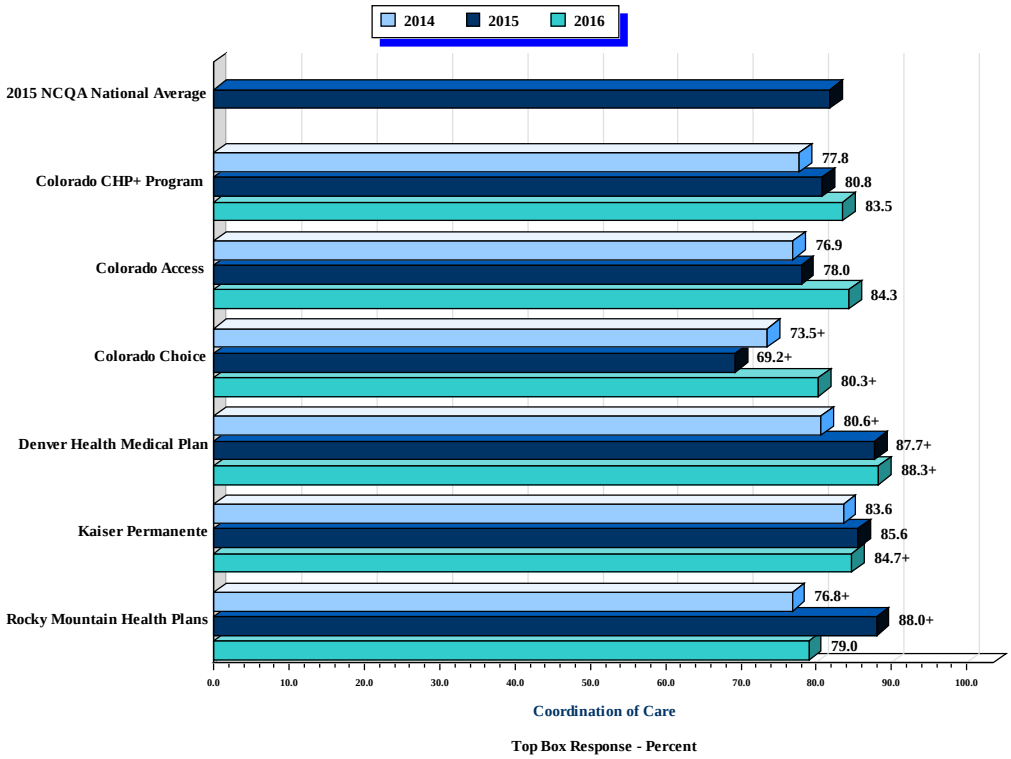
[2-12] As a result of the changes to the Shared Decision Making composite measure, trending of 2016 scores to 2014 scores could not be performed.

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 25), a top-level response was defined as a response of "Usually" or "Always." Figure 2-10 shows the 2015 NCQA national average, and the 2014, 2015, and 2016 Coordination of Care question summary rates for Colorado CHP+, Colorado Access, Colorado Choice, DHMP, Kaiser, and RMHP.

Figure 2-10—Coordination of Care



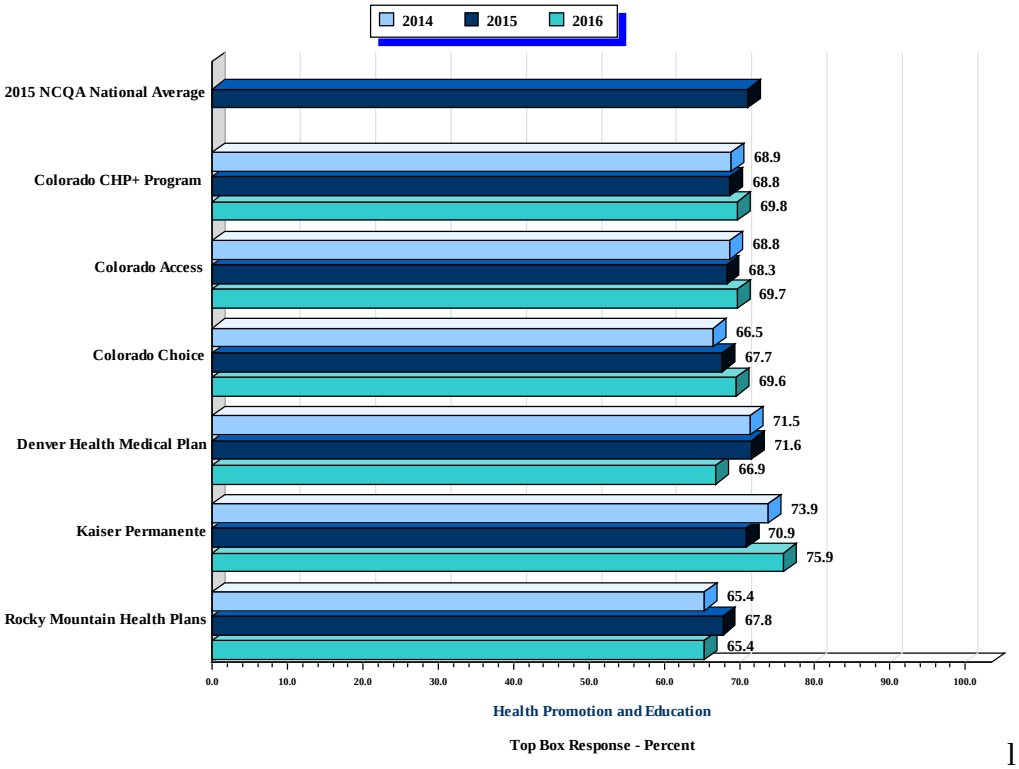
Statistical Significance Note:
▲ indicates the 2016 score is significantly higher than the 2015 score
▼ indicates the 2016 score is significantly lower than the 2015 score
▲ indicates the 2016 score is significantly higher than the 2014 score
▼ indicates the 2016 score is significantly lower than the 2014 score

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

Health Promotion and Education

Colorado CHP+ parents/caretakers of child members were asked a question to assess if their child's doctor talked with them about specific things they could do to prevent illness in their child. For this question (Question 8), a top-level response was defined as a response of "Yes." Figure 2-11 shows the 2015 NCQA national average, and the 2014, 2015, and 2016 Health Promotion and Education question summary rates for Colorado CHP+, Colorado Access, Colorado Choice, DHMP, Kaiser, and RMHP.

Figure 2-11—Health Promotion and Education



Statistical Significance Note:
▲ indicates the 2016 score is significantly higher than the 2015 score
▼ indicates the 2016 score is significantly lower than the 2015 score
▲ indicates the 2016 score is significantly higher than the 2014 score
▼ indicates the 2016 score is significantly lower than the 2014 score

Summary of Trend Analysis Results

The following table summarizes the statistically significant differences from the trend analysis.

Table 2-6
Trend Analysis Highlights

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

▲ *Indicates the 2016 score is significantly higher than the 2015 score*
▼ *Indicates the 2016 score is significantly lower than the 2015 score*
▲ *Indicates the 2016 score is significantly higher than the 2014 score*
▼ *Indicates the 2016 score is significantly lower than the 2014 score*

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

Plan Comparisons

In order to identify performance differences in member satisfaction between the five Colorado CHP+ plans, the results for Colorado Access, Colorado Choice, DHMP, Kaiser, and RMHP were compared to the Colorado CHP+ program average using standard tests for statistical significance.[2-13] For purposes of this comparison, 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.[2-14] 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 in order to determine the question summary rates and global proportions. For additional detail, please refer to the *NCQA HEDIS 2016 Specifications for Survey Measures, Volume 3*.

Statistically significant differences are noted in the tables by arrows. A 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.

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

Table 2-7, on the following page, shows the results of the plan comparisons analysis. **NOTE: These results may differ from those presented in the trend analysis figures because they have been adjusted for differences in case mix (i.e., the percentages presented have been case-mix adjusted).**

[2-13] Caution should be exercised when evaluating plan comparisons, given that population and plan differences may impact CAHPS results.

[2-14] 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 2-7 Plan Comparisons					
	Colorado Access	**Colorado Choice**	**DHMP**	**Kaiser**	**RMHP**
Global Rating					
Rating of Health Plan	61.6% ↑	50.1% ↓	59.0% ↔	58.1% ↔	59.3% ↔
Rating of All Health Care	72.6% ↑	53.3% ↓	58.6% ↔	66.0% ↔	63.2% ↔
Rating of Personal Doctor	77.1% ↑	58.6% ↓	74.1% ↔	72.5% ↔	70.3% ↔
Rating of Specialist Seen Most Often	69.2%+ ↔	72.9%+ ↔	57.4%+ ↔	58.7%+ ↔	78.5% ↑
Composite Measure					
Getting Needed Care	87.6% ↑	90.6% ↑	64.7% ↓	87.8% ↑	86.3% ↔
Getting Care Quickly	92.2% ↑	90.6% ↔	76.6% ↓	92.4% ↑	90.2% ↔
How Well Doctors Communicate	97.7% ↔	94.4% ↔	94.0% ↔	96.7% ↔	96.3% ↔
Customer Service	82.8% ↔	85.4%+ ↔	79.8% ↔	85.8% ↔	77.7% ↔
Shared Decision Making	80.2% ↔	78.2%+ ↔	74.2%+ ↔	85.9%+ ↔	80.9% ↔
Individual Measure					
Coordination of Care	85.2% ↔	80.9%+ ↔	85.6%+ ↔	85.4%+ ↔	79.5% ↔
Health Promotion and Education	69.3% ↔	69.3% ↔	68.0% ↔	75.6% ↔	65.3% ↔

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

Summary of Plan Comparisons Results

The plan comparisons revealed the following statistically significant results.

- Colorado Access scored significantly higher than the Colorado CHP+ program average on five CAHPS measures: Rating of Health Plan, Rating of All Health Care, Rating of Personal Doctor, Getting Needed Care, and Getting Care Quickly.
- Colorado Choice scored significantly higher than the Colorado CHP+ program average on one CAHPS measure, Getting Needed Care. Additionally, Colorado Choice 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.
- DHMP scored significantly lower than the Colorado CHP+ program average on two CAHPS measures: Getting Needed Care and Getting Care Quickly.
- Kaiser scored significantly higher than the Colorado CHP+ program average on two CAHPS measures: Getting Needed Care and Getting Care Quickly.
- RMHP scored significantly higher than the Colorado CHP+ program average on one CAHPS measure, Rating of Specialist Seen Most Often.

Supplemental Items

The Department elected to add six supplemental items to the standard CAHPS 5.0 Child Medicaid Health Plan Survey for the Colorado CHP+ plans. Table 2-8 details the survey language and response options for each of the supplemental items. Table 2-9 through Table 2-14 show the results for each supplemental item. For all Colorado CHP+ plans, the number and percentage of responses for each item are presented.

Table 2-8
Supplemental Items

Question		Response Options
Q48a.	In the last 6 months, not counting the times your child needed health care right away, how many days did you usually have to wait between making an appointment and your child actually seeing a health provider?	Same day 1 day 2 to 3 days 4 to 7 days 8 to 14 days 15 to 30 days 31 to 60 days 61 to 90 days 91 days or longer
Q48b.	In the last 6 months, how often was it easy to get appointments for your child with specialists?	Never Sometimes Usually Always
Q48c.	In the last 6 months, how often were you able to get the care your child needed from his or her doctor or other health provider during evenings, weekends, or holidays?	Never Sometimes Usually Always
Q48d.	In the last 6 months, did you and your child's doctor or other health provider talk about the kinds of behaviors that are normal for your child at this age?	Yes No
Q48e.	In the last 6 months, did you and your child's doctor or other health provider talk about whether there are any problems in your household that might affect your child?	Yes No
Q48f.	What is your preferred method of contact regarding your child's health care?	Mail Email Text message Phone

Number of Days Waiting to See Health Provider

Parents/caretakers of child members were asked how many days were between making an appointment and their child actually seeing a health provider (Question 48a). Table 2-9 displays the responses for this question.

Table 2-9
Number of Days Waiting to See Health Provider

	Same day		1 day		2 to 3 days		4 to 7 days		8 to 14 days		15 to 30 days		31 to 60 days		61 to 90 days		91 days or longer	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Colorado Access	135	32.9%	72	17.6%	77	18.8%	46	11.2%	37	9.0%	27	6.6%	14	3.4%	1	0.2%	1	0.2%
Colorado Choice	81	33.8%	42	17.5%	43	17.9%	33	13.8%	19	7.9%	14	5.8%	2	0.8%	4	1.7%	2	0.8%
DHMP	40	16.3%	41	16.7%	53	21.6%	47	19.2%	34	13.9 %	17	6.9%	10	4.1%	0	0%	3	1.2%
Kaiser	84	23.2%	78	21.5%	95	26.2%	64	17.7%	25	6.9%	8	2.2%	7	1.9%	1	0.3%	0	0%
RMHP	153	32.7%	92	19.7%	88	18.8%	55	11.8%	36	7.7%	24	5.1%	13	2.8%	3	0.6%	4	0.9%

Appointments with Specialists

Parents/caretakers of child members were asked to assess how often it was easy to get appointments for their child with specialists (Question 48b). Table 2-10 displays the responses for this question.

Table 2-10
Appointments with Specialists

	Never		Sometimes		Usually		Always	
	N	%	N	%	N	%	N	%
Colorado Access	29	16.4%	25	14.1%	65	36.7%	58	32.8%
Colorado Choice	18	18.8%	11	11.5%	31	32.3%	36	37.5%
DHMP	32	23.5%	38	27.9%	35	25.7%	31	22.8%
Kaiser	32	18.7%	20	11.7%	52	30.4%	67	39.2%
RMHP	22	10.3%	28	13.1%	61	28.6%	102	47.9%

Access to After-Hours Care

Parents/caretakers of child members were asked to assess how often they were able to get the care their child needed from their child's doctor or other health provider during evenings, weekends, or holidays (Question 48c). Table 2-11 displays the responses for this question.

Table 2-11
Access to After-Hours Care

	Never		Sometimes		Usually		Always	
	N	%	N	%	N	%	N	%
Colorado Access	38	20.3%	30	16.0%	49	26.2%	70	37.4%
Colorado Choice	31	26.7%	22	19.0%	25	21.6%	38	32.8%
DHMP	50	36.5%	37	27.0%	16	11.7%	34	24.8%
Kaiser	45	28.1%	28	17.5%	27	16.9%	60	37.5%
RMHP	58	26.9%	32	14.8%	54	25.0%	72	33.3%

Talked About Child's Behavior

Parents/caretakers of child members were asked if they and their child's doctor or other health provider talked about the kinds of behaviors that are normal for their child's age (Question 48d). Table 2-12 displays the responses for this question.

Table 2-12
Talked About Child's Behavior

	Yes		No	
	N	%	N	%
Colorado Access	257	65.1%	138	34.9%
Colorado Choice	141	60.5%	92	39.5%
DHMP	135	53.8%	116	46.2%
Kaiser	237	65.8%	123	34.2%
RMHP	286	61.8%	177	38.2%

Talked About Household Problems That Might Affect Child

Parents/caretakers of child members were asked if they and their child's doctor or other health provider talked about any problems in their household that might affect their child (Question 48e). Table 2-13 displays the responses for this question.

Table 2-13
Talked About Household Problems That Might Affect Child

	Yes		No	
	N	%	N	%
Colorado Access	137	35.2%	252	64.8%
Colorado Choice	73	32.6%	151	67.4%
DHMP	69	28.6%	172	71.4%
Kaiser	128	36.6%	222	63.4%
RMHP	150	33.3%	301	66.7%

Preferred Method of Contact Regarding Child's Health Care

Parents/caretakers of child members were asked what their preferred method of contact regarding their child's health care is (Question 48f). Table 2-14 displays the responses for this question.

Table 2-14
Preferred Method of Contact Regarding Child's Health Care

	Mail		Email		Text Message		Phone	
	N	%	N	%	N	%	N	%
Colorado Access	123	30.2%	96	23.6%	21	5.2%	167	41.0%
Colorado Choice	101	40.4%	37	14.8%	5	2.0%	107	42.8%
DHMP	68	26.2%	33	12.7%	15	5.8%	144	55.4%
Kaiser	83	22.4%	105	28.3%	15	4.0%	168	45.3%
RMHP	160	33.5%	101	21.1%	18	3.8%	199	41.6%

3. Recommendations

General Recommendations

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

Plan-Specific Priority Assignments

This section presents the results of the priority assignments for the five Colorado CHP+ plans. The priority assignments are grouped into four main categories for QI: top, high, moderate, and low priority. The priority of the CAHPS measure is based on the results of the NCQA comparisons and trend analysis.[3-1] This section also presents general best practices and recommendations based on the information available in the CAHPS literature.

The priorities presented in this section should be viewed as potential suggestions for QI. Additional sources of QI information, such as other HEDIS results, should be incorporated into a comprehensive QI plan. A number of resources are available to assist state Medicaid agencies and plans with the implementation of CAHPS-based QI initiatives. A comprehensive list of these resources is included in the Reader's Guide Section, beginning on page 4-10.

[3-1] NCQA does not provide benchmarks for the Shared Decision Making composite measure and Health Promotion and Education individual item measure; therefore, priority assignments cannot be derived for these measures.

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

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

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

Please note: Trend analysis results reflect those between either the 2016 and 2015 results or the 2016 and 2014 results.[3-2] *If statistically significant differences were not identified during the trend analysis, this lack of statistical significance is denoted with a hyphen (—) in the table above.*

[3-2] For more detailed information on the trend analysis results, please see the Results Section of this report.

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)	Trend Analysis	Priority Assignment
Colorado Access	★	—	**Top**
Colorado Choice	★	—	**Top**
DHMP	★	▲	**Top**
Kaiser	★	—	**Top**
RMHP	★	—	**Top**

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

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

Alternatives to One-on-One Visits

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

Health Plan Operations

It is important for health plans to view their organization as a collection of microsystems (such as providers, administrators, and other staff that provide services to members) that provide the health plan's health care "products." Health care microsystems include: a team of health providers, patient/population to whom care is provided, environment that provides information to providers and patients, support staff, equipment, and office environment. The goal of the microsystems approach is to focus on small, replicable, functional service systems that enable health plan staff to

provide high-quality, patient-centered care. The first step to this approach is to define a measurable collection of activities. Once the microsystems are identified, new processes that improve care should be tested and implemented. Effective processes can then be rolled out throughout the health plan.

Enhance Online Patient Portals

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

Promote QI Initiatives

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

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

Coordination of Health Services

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

The planning approach focuses on the developing aspect of providing care management services to children and their families. Some of the key elements involved in the planning process include a

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

Rating of All Health Care

Table 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)	Trend Analysis	Priority Assignment
Colorado Access	★★★★★	▲	Low
Colorado Choice	★	—	Top
DHMP	★★	—	High
Kaiser	★★★★★	—	Low
RMHP	★★★★	—	Moderate

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

In order to improve the Rating of All Health Care measure, CHP+ plans could explore QI activities that target member perception of access to care, patient and family engagement advisory councils, patient- and family-centered care, and involving families in care coordination.

Access to Care

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. Standard practices and established protocols can assist in this process by ensuring access to care issues are handled consistently across all practices. For example, health plans can develop standardized protocols and scripts for common occurrences within the provider office setting, such as late patients. With proactive polices and scripts in place, the late patient can be notified the provider has moved onto the next patient and will work the late patient into the rotation as time permits. This type of structure allows the late patient to still receive care without causing delay in the appointments of other patients. Additionally, having a well-written script prepared in the event of an uncommon but expected situation allows staff to work quickly in providing timely access to care while following protocol.

Patient and Family Engagement Advisory Councils

Since both patients and families have the direct experience of an illness or health care system, their perspectives can provide significant insight when performing an evaluation of health care processes. Therefore, health plans should consider creating opportunities and functional roles that include the patients and families who represent the populations they serve. Patient and family members could serve as advisory council members providing new perspectives and serving as a resource to health care processes. Patient interviews on services received and family inclusion in care planning can be an effective strategy for involving members in the design of care and obtaining their input and

feedback on how to improve the delivery of care. Further, involvement in advisory councils can provide a structure and process for ongoing dialogue and creative problem-solving between the health plan and its members. The councils' roles within a health plan organization can vary and responsibilities may include input into or involvement in: program development, implementation, and evaluation; marketing of health care services; and design of new materials or tools that support the provider-patient relationship.

Patient- and Family-Centered Care

Building on actively engaging patients and families to serve as advisory council members to aid in improving health care processes, health plans can also utilize patient- and family-centered care as an approach to the planning, delivery, and evaluation of healthcare that is grounded in mutually beneficial partnerships among healthcare providers, patients, and families. It is founded on the understanding that the family plays a vital role in ensuring the health and well-bring of patients of all ages.[3-3] Research has shown that patient- and family-centered care results in improved care, and more efficient use of resources (e.g., reduced non-urgent emergency department visits in children), ultimately leading to improved healthcare for children and their families. By incorporating the strategies listed below, plans and programs can provide patient- and family-centered care management services to children with chronic conditions and their families.

Involving Families in Care Coordination

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

[3-3] Institute for Patient- and Family-Centered Care. Frequently asked questions. Available at: http://www.ipfcc.org/faq.html. Accessed on: March 13, 2015.

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)	Trend Analysis	Priority Assignment
Colorado Access	★★★★★	▲	Low
Colorado Choice	★	—	Top
DHMP	★★★★★	—	Low
Kaiser	★★★★	—	Moderate
RMHP	★★★★	—	Moderate

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

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

Maintain Truth in Scheduling

Health plans can request that all providers monitor appointment scheduling to ensure that scheduling templates accurately reflect the amount of time it takes to provide patient care during a scheduled office visit. Health plans could provide assistance or instructions to those physicians unfamiliar with this type of assessment. Patient dissatisfaction can often be the result of prolonged wait times and delays in receiving care at the scheduled appointment time. One method for evaluating appropriate scheduling of various appointment types is to measure the amount of time it takes to complete the scheduled visit. This type of monitoring will allow providers to identify if adequate time is being scheduled for each appointment type and if appropriate changes can be made to scheduling templates to ensure patients are receiving prompt, adequate care. Patient wait times for routine appointments should also be recorded and monitored to ensure that scheduling can be optimized to minimize these wait times. Additionally, by measuring the amount of time it takes to provide care, both health plans and physician offices can identify where streamlining opportunities exist. If providers are finding bottlenecks within their patient flow processes, they may consider implementing daily staff huddles to improve communication or working in teams with cross-functionalities to increase staff responsibility and availability.

Patient-Direct Feedback

Health plans can explore additional methods for obtaining direct patient feedback to improve patient satisfaction, such as comment cards. Comment cards have been utilized and found to be a simple method for engaging patients and obtaining rapid feedback on their recent physician office visit experiences. Health plans can assist in this process by developing comment cards that physician office staff can provide to patients following their visit. Comment cards can be provided to patients

with their office visit discharge paperwork or via postal mail or e-mail. Asking patients to describe what they liked most about the care they received during their recent office visit, what they liked least, and one thing they would like to see changed can be an effective means for gathering feedback (both positive and negative). Comment card questions may also prompt feedback regarding other topics, such as providers' listening skills, wait time to obtaining an appointment, customer service, and other items of interest. Research suggests the addition of the question, "Would you recommend this physician's office to a friend?" greatly predicts overall patient satisfaction. This direct feedback can be helpful in gaining a better understanding of the specific areas that are working well and areas which can be targeted for improvement.

Physician-Patient Communication

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, collaborative communication which involves allowing the patient to discuss and share in the decision making process, as well as effectively communicating expectations and goals of health care treatment. In addition, workshops can include training on the use of tools that improve physician-patient communication. Examples of effective tools include visual medication schedules and the "Teach Back" method, which has patients communicate back the information the physician has provided.

Improving Shared Decision Making

Health plans should encourage skills training in shared decision making for all physicians. Implementing an environment of shared decision making and physician-patient collaboration requires physician recognition that patients have the ability to make choices that affect their health care. Therefore, one key to a successful shared decision making model is ensuring that physicians are properly trained. Training should focus on providing physicians with the skills necessary to facilitate the shared decision making process; ensuring that physicians understand the importance of taking each patient's values into consideration; and understanding patients' preferences and needs. Effective and efficient training methods include seminars and workshops.

Care Manager Training

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

In order to relieve family tension and improve the health care of the child, health plans should contemplate training their personal doctors to consider the medical and emotional needs of both the child and the family. Doctors should be evaluated on several core competencies, such as caring and

compassion, communication and listening, job skills and functional knowledge, customer service, leadership, outcome orientation, team orientation, and talent assessment and development.

Rating of Specialist Seen Most Often

Table 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)	Trend Analysis	Priority Assignment
Colorado Access	★★★★+	—	Moderate+
Colorado Choice	★★★★★+	▲	Low+
DHMP	★+	—	Top+
Kaiser	★+	—	Top+
RMHP	★★★★★	▲	Low

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

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

Planned Visit Management

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

Skills Training for Specialists

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

Telemedicine

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

Care Coordination Team

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

Composite Measures

Getting Needed Care

Table 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)	Trend Analysis	Priority Assignment
Colorado Access	★★★	—	**Moderate**
Colorado Choice	★★★	—	**Moderate**
DHMP	★	—	**Top**
Kaiser	★★★	—	**Moderate**
RMHP	★★	—	**High**

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

In order to improve members' satisfaction under the Getting Needed Care measure, CHP+ plans could explore QI activities that target identifying appropriate health care providers, providing interactive workshops, "max-packing," language concordance programs, and facilitating coordinated care.

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

Interactive Workshops

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

"Max-Packing"

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

Language Concordance Programs

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

Facilitate Coordinated Care

Health plans should assist in facilitating the process of coordinated care between providers and care coordinators to ensure child members are receiving the care and services most appropriate for their health care needs. Coordinated care is most effective when care coordinators and providers organize their efforts to deliver the same message to parents and caretakers of child members. Members are more likely to play an active role in the management of their child's health care and benefit from care coordination efforts if they are receiving the same information from both care coordinator and providers. Improving the system-level coordination between providers and care coordinators will enhance the service and care received by members. Additionally, providing patient registries or clinical information systems that allow providers and care coordinators to enter information on patients (e.g., notes from a telephone call or a physician visit) can help reduce duplication of services and facilitate care coordination.

Getting Care Quickly

Table 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)	Trend Analysis	Priority Assignment
Colorado Access	★★★★	▲	Low
Colorado Choice	★★★	—	Moderate
DHMP	★	—	Top
Kaiser	★★★★	—	Moderate
RMHP	★★★	—	Moderate

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

In order to improve members' satisfaction under the Getting Care Quickly measure, CHP+ plans could explore QI activities that target open access scheduling, monitoring patient flow, decreasing no-show appointments, and electronic communication.

Open Access Scheduling

Health plans should encourage providers to explore open access scheduling. An open access scheduling model can be used to match the demand for appointments with physician supply. This type of scheduling model allows for appointment flexibility and for patients to receive same-day appointments. Instead of booking appointments weeks or months in advance, an open access scheduling model includes leaving part of a physician's schedule open for same-day appointments. Open access scheduling has been shown to have the following benefits: 1) reduces delays in patient care; 2) increases continuity of care; and 3) decreases wait times and number of no-shows resulting in cost savings.

Patient Flow Analysis

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

Decrease No-Show Appointments

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

Electronic Communication

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

How Well Doctors Communicate

Table 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)	Trend Analysis	Priority Assignment
Colorado Access	★★★★★	▲	**Low**
Colorado Choice	★★★	—	**Moderate**
DHMP	★★★	—	**Moderate**
Kaiser	★★★★★	—	**Low**
RMHP	★★★★★	—	**Low**

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

In order to improve members' satisfaction under the How Well Doctors Communicate measure, CHP+ plans could explore QI activities that focus on communication tools, improving health literacy, and language barriers.

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 necessary tools to effectively communicate with physicians. This can include items such as "visit preparation" handouts, sample symptom logs, and health care goals and action planning forms that facilitate physician-patient communication. Furthermore, educational literature and information on medical conditions specific to their needs can encourage patients to communicate with their physicians any questions, concerns, or expectations they may have regarding their health care and/or treatment options.

Improve Health Literacy

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

Additionally, health literacy coaching can be implemented to ease the inclusion of health literacy into physician practice. Health plans can offer a workshop where physicians have the opportunity to participate in simulation training resembling the clinical setting. Workshops also provide an

opportunity for health plans to introduce physicians to the *AHRQ Health Literacy Universal Precautions Toolkit*, which can serve as a reference for devising health literacy plans.

Language Barriers

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

Customer Service

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

Table 3-9
Priority Assignments
Customer Service Composite

Plan	NCQA Comparisons (Star Ratings)	Trend Analysis	Priority Assignment
Colorado Access	★	—	**Top**
Colorado Choice	★+	▲	**Top+**
DHMP	★	—	**Top**
Kaiser	★	—	**Top**
RMHP	★	—	**Top**

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

In order to improve members' satisfaction under the Customer Service measure, CHP+ plans could explore QI activities that focus on evaluating call centers, customer service training programs, and performance measures.

Call Centers

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

Creating an Effective Customer Service Training Program

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

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

The key to ensuring that employees carry out the skills they learned in training is to not only provide motivation but implement a support structure when they are back on the job so that they are

held responsible. It is advised that all employees sign a commitment statement to affirm the course of action agreed upon. Health plans should ensure leadership is involved in the training process to help establish camaraderie between managers and employees and to help employees realize the impact of their role in making change.

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 providers and staff members. Additionally, by tracking and reporting progress internally and modifying measures as needed, customer service performance is more likely to improve.

Coordination of Care

Table 3-10 shows the priority assignments for the Coordination of Care measure.

Table 3-10
Priority Assignments
Coordination of Care

Plan	NCQA Comparisons (Star Ratings)	Trend Analysis	Priority Assignment
Colorado Access	★	—	Top
Colorado Choice	★+	—	Top+
DHMP	★★★★+	—	Moderate+
Kaiser	★★★+	—	Moderate+
RMHP	★	—	Top

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

In order to improve members' satisfaction under the Coordination of Care measure, CHP+ plans could explore QI activities that focus on training to advance physicians' communication skills, tools to help patients communicate their needs, and planned visits.

Training to Advance Physicians' Communication Skills

Health plans should encourage training clinicians in the communication skills they need either through in-house programs or through outside organizations that offer communications programs. Health plans can offer physician-patient communication training in the form of seminars or workshops and discuss strategies for improving communication. Additional training topics can include cultural communication issues, communication with difficult patients, interviewing techniques, gathering information about the patient's history, empathic responses, and written communication.

Tools to Help Patients Communicate Their Needs

Patients' ability to express themselves clearly, process and interpret information received from providers, and maintain their health contributes to their experience of care. Health plans could help patients improve their ability to share information with providers by suggesting or even giving them one or more simple and inexpensive communication tools. Patients who can communicate effectively with clinicians may lead to more satisfaction with the care and improved health outcomes. Health plans can utilize several strategies to increase patient communication, such as sharing patients' medical record, encouraging patients to write down questions they want to ask prior to doctor visits, and implementing coached care programs to teach patients how to ask the right questions and get their needs met during the doctor visit.

Planned Visits

Health plans should encourage their clinicians and other health professionals to schedule planned visits with patients, especially their high-risk patient population, which allows clinicians and

patients the opportunity to review and strengthen the patient's self-management of his or her health care, and can lead to improved overall health, fewer acute care visits, and greater patient satisfaction. Planned visits could be used for specialty services or one-on-one visits with primary care providers.

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.[3-4]

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, Colorado Choice, DHMP, Kaiser, and RMHP that exhibited low performance suggest that additional analysis may be required to identify what is truly causing low performance in these areas. Methods that could be used include:

- Conducting a correlation analysis to assess if specific issues are related to overall ratings (i.e., those question items or composites that are predictors of rating scores).
- Drawing on the analysis of population sub-groups (e.g., health status, race, age) to determine if there are 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.

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

4. Reader's Guide

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

Survey Administration

Survey Overview

The survey instrument selected was the CAHPS 5.0 Child Medicaid Health Plan Survey with the HEDIS supplemental item set. The CAHPS 5.0 Health Plan Surveys are a set of standardized surveys that assess patient perspectives on care. Originally, CAHPS was a five-year collaborative project sponsored by the Agency for Healthcare Research and Quality (AHRQ). The CAHPS questionnaires and consumer reports were developed under cooperative agreements among AHRQ, Harvard Medical School, RAND, and the Research Triangle Institute (RTI). In 1997, NCQA, in conjunction with AHRQ, created the CAHPS 2.0H Survey measure as part of NCQA's HEDIS.[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] In 2012, AHRQ released the CAHPS 5.0 Health Plan Surveys. Based on the CAHPS 5.0 versions, NCQA introduced new HEDIS versions of the Adult and Child Health Plan Surveys in August 2012, which are referred to as the CAHPS 5.0H Health Plan Surveys.[4-5]

The sampling and data collection procedures for the CAHPS 5.0 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.

[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.
[4-5] National Committee for Quality Assurance. *HEDIS® 2013, Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2012.

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

Table 4-1 lists the global ratings, composite measures, and individual item measures included in the CAHPS 5.0 Child Medicaid Health Plan Survey with the HEDIS supplemental item set.

Table 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, Colorado Choice, DHMP, Kaiser, and RMHP 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 2015. The members eligible for sampling included those who were age 17 or younger (as of December 31, 2015).

NCQA specifications require a sample size of 1,650 members for the CAHPS 5.0 Child Medicaid Health Plan Survey. For Colorado Access, Kaiser, and RMHP, a total random sample of 1,650 child members was selected from these plans. Colorado Choice and DHMP did not meet the minimum sample size criteria; therefore, 987 and 1,408 child members were selected from Colorado Choice's and DHMP's eligible population, respectively.

Survey Protocol

Table 4-2 shows the standard mixed mode (i.e., mail followed by telephone follow-up) CAHPS timeline used in the administration of the Colorado CAHPS 5.0 Child Medicaid Health Plan Surveys. The timeline is based on NCQA HEDIS Specifications for Survey Measures.[4-6]

Table 4-2—CAHPS 5.0 Mixed-Mode Methodology Survey Timeline

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

The CAHPS 5.0 Health Plan Survey process allowed members two methods by which they could complete a survey. 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. 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.[4-7]

[4-6] National Committee for Quality Assurance. *HEDIS® 2016, Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2015.

[4-7] 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.

NCQA specifications require that health plans provide a list of all eligible members for the sampling frame. Following these requirements, sampled members included those who met the following criteria:

- Were age 17 or younger as of December 31, 2015.
- Were currently enrolled in Colorado Access, Colorado Choice, DHMP, Kaiser, or RMHP.
- Had been continuously enrolled for at least five of the last six months of 2015.
- Had Medicaid as a 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). Prior to initiating CATI, HSAG employed the Telematch telephone number verification service to locate and/or update telephone numbers for all non-respondents. The survey samples were random samples with no more than one member being selected per household.

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

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 with the CHP+ plans. This section provides an overview of each analysis.

Response Rates

The administration of the CAHPS 5.0 Child Medicaid Health Plan Survey is comprehensive and is designed to achieve the highest possible response rate. NCQA defines the response rate as the total number of completed surveys divided by all eligible members of the sample.[4-8] A member's survey was assigned a disposition code of "completed" if at least three of the following five questions were answered: 3, 15, 27, 31, and 36. 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 4-4), 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 CAHPS Survey results was conducted using NCQA HEDIS Specifications for Survey Measures.[4-9] Per these specifications, no weighting or case-mix adjustment is performed on the results. NCQA also requires a minimum of 100 responses on each item in order to report the item as a valid CAHPS Survey result. However, for purposes of this report, 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® 2016, Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2015.

[4-9] Ibid.

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

Ratings of one (★) to five (★★★★★) stars were determined for 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.[4-10]

Table 4-3—Overall Child Medicaid Member Satisfaction Ratings Crosswalk

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

[4-10] National Committee for Quality Assurance. *HEDIS Benchmarks and Thresholds for Accreditation 2016*. Washington, DC: NCQA, January 21, 2016.

Trend Analysis

In order to evaluate trends in Colorado CHP+ member satisfaction, HSAG performed a stepwise three-year trend analysis. The first step compared the 2016 CAHPS results to the 2015 CAHPS results. If the initial 2016 and 2015 trend analysis did not yield any significant differences, then an additional trend analysis was performed between 2016 and 2014 results. For 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.[4-11] The scoring of the global ratings, composite measures, and individual item measures involved assigning top-level responses a score of one, with all other responses receiving a score of zero. After applying this scoring methodology, the percentage of top-level responses was calculated in order to determine the question summary rates and global proportions. For additional details, please refer to the *NCQA HEDIS 2016 Specifications for Survey Measures, Volume 3*.

The 2016 Colorado CHP+ and plan-level CAHPS scores were compared to the corresponding 2015 scores, where appropriate, to determine whether there were statistically significant differences. If there were no statistically significant differences from 2016 to 2015, then 2016 scores were compared to 2014 scores. A difference is considered significant if the two-sided *p*-value of the *t*-test is less than 0.05. Scores that were statistically higher in 2016 than in 2015 are noted with black upward (▲) triangles. Scores that were statistically lower in 2016 than in 2015 are noted with black downward (▼) triangles. Scores that were statistically higher in 2016 than in 2014 are noted with red upward (▲) triangles. Scores that were statistically lower in 2016 than in 2014 are noted with red downward (▼) triangles. Scores in 2016 that were not statistically different from scores in 2015 or in 2014 are not noted with triangles.

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.

Weighting

For purposes of the trend analysis, HSAG calculated a weighted score for the Colorado CHP+ program. The 2014, 2015, and 2016 CAHPS scores for Colorado CHP+ were weighted based on each of the plan's total eligible CHP+ population for the corresponding year.

The weighted score was:

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

[4-11] National Committee for Quality Assurance. *HEDIS® 2016, Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA Publication, 2015.

Plan Comparisons

Plan comparisons were performed to identify member satisfaction differences that were statistically different than the CHP+ program average. 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 for the Colorado CHP+ plans were case-mix adjusted for member general health status, respondent education level, and respondent age.

Two types of hypothesis tests were applied to the child CAHPS comparative results. First, a global *F* test was calculated, which determined whether the difference between the health plans' scores was significant.

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

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

The *F* statistic, as calculated above, had an *F* distribution with ($P-1$, q) degrees of freedom, where *q* was equal to *n*/*P* (i.e., the average number of respondents in a plan). Due to these qualities, this *F* test produced *p* values that were slightly larger than they should have been; therefore, finding significant differences between health plans was less likely. An alpha-level of 0.05 was used. 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 Colorado CHP+ health plans. The equation for the differences was as follows:

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

In this equation, Σ^{*} was the sum of all health plans except health plan *p*.

The variance of Δ_{p} was:

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

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

For the plan comparisons, no threshold number of responses was required for the results to be reported. Measures with less than 100 responses are denoted with a cross (+). Caution should be used when evaluating rates derived from fewer than 100 respondents.

Limitations and Cautions

The findings presented in the 2016 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 adjust 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.

Quality Improvement References

The CAHPS surveys were originally developed to meet the needs of consumers for usable, relevant information on quality of care from the members' perspectives. However, they also play an important role as a QI tool for health care organizations, which can use the standardized data and results to identify relative strengths and weaknesses in their performance, determine where they need to improve, and track their progress over time. The following references offer guidance on possible approaches to CAHPS-related QI activities.[4-12]

AHRQ Health Care Innovations Exchange Web site. *Expanding Interpreter Role to Include Advocacy and Care Coordination Improves Efficiency and Leads to High Patient and Provider Satisfaction*. Available at: https://innovations.ahrq.gov/profiles/expanding-interpreter-role-include-advocacy-and-care-coordination-improves-efficiency-and. Accessed on: July 11, 2016.

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[4-12] Agency for Healthcare Research and Quality. *CAHPS User Resources: Quality Improvement Resources*. Available at: http://www.ahrq.gov/cahps/quality-improvement/index.html. Accessed on: July 11, 2016.

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5. Survey Instrument

The survey instrument selected for the 2016 Colorado CHP+ Member Satisfaction Survey was the CAHPS 5.0 Child Medicaid Health Plan Survey with the HEDIS supplemental item set without CCC measurement set. This section provides a copy of the survey instrument.

COLORADO
Department of Health Care Policy & Financing

DataStat

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

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

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

SURVEY INSTRUCTIONS

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

Correct Mark ●

Incorrect Marks 

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

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

START HERE

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

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

○ Yes ➔ ***Go to Question 3***
○ No

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

_____

YOUR CHILD'S HEALTH CARE IN THE LAST 6 MONTHS

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

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

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

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

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

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

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

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

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

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

- ○ None ➔ ***Go to Question 15***
- ○ 1 time
- ○ 2
- ○ 3
- ○ 4
- ○ 5 to 9
- ○ 10 or more times

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

- ○ Yes
- ○ No

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

- ○ Yes
- ○ No ➔ ***Go to Question 13***

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

- ○ Yes
- ○ No

11. Did you and a doctor or other health provider talk about the reasons you might not want your child to take a medicine?

- ○ Yes
- ○ No

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

- ○ Yes
- ○ No

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

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

Worst Health Care Possible — Best Health Care Possible

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

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

YOUR CHILD'S PERSONAL DOCTOR

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

- ○ Yes
- ○ No ➔ ***Go to Question 27***

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

- ○ None ➔ ***Go to Question 26***
- ○ 1 time
- ○ 2
- ○ 3
- ○ 4
- ○ 5 to 9
- ○ 10 or more times

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

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

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

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

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

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

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

- ○ Yes
- ○ No ➔ ***Go to Question 22***

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

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

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

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

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

- ○ Yes
- ○ No

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

- ○ Yes
- ○ No ➔ ***Go to Question 26***

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

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

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

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

Worst Personal Doctor Possible — Best Personal Doctor Possible

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.

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

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

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

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

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

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

- ○ None ➔ ***Go to Question 31***
- ○ 1 specialist
- ○ 2
- ○ 3
- ○ 4
- ○ 5 or more specialists

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

○	○	○	○	○	○	○	○	○	○	○
0	1	2	3	4	5	6	7	8	9	10
Worst Specialist Possible										Best Specialist Possible

YOUR CHILD'S HEALTH PLAN

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

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

- ○ Yes
- ○ 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?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ 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?

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

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

- ○ Yes
- ○ 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?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ 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?

○	○	○	○	○	○	○	○	○	○	○
0	1	2	3	4	5	6	7	8	9	10
Worst Health Plan Possible										Best Health Plan Possible

ABOUT YOUR CHILD AND YOU

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

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

38. In general, how would you rate your child's overall <u>mental or emotional</u> health?

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

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

- ○ Less than 1 year old

☐☐ YEARS OLD (write in)

40. Is your child male or female?

- ○ Male
- ○ Female

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

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

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

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

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

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

44. Are you male or female?

- ○ Male
- ○ Female

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

- ○ 8th grade or less
- ○ Some high school, but did not graduate
- ○ High school graduate or GED
- ○ Some college or 2-year degree
- ○ 4-year college graduate
- ○ More than 4-year college degree

46. How are you related to the child?

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

47. Did someone help you complete this survey?

- ○ Yes ➔ ***Go to Question 48***
- ○ No ➔ ***Go to Question 48a***

48. How did that person help you? Mark one or more.

- ○ Read the questions to me
- ○ Wrote down the answers I gave
- ○ Answered the questions for me
- ○ Translated the questions into my language
- ○ Helped in some other way

ADDITIONAL QUESTIONS

48a. In the last 6 months, not counting the times your child needed health care right away, how many days did you usually have to wait between making an appointment and your child actually seeing a health provider?

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

48b. In the last 6 months, how often was it easy to get appointments for your child with specialists?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always
- ○ My child did not see a specialist in the last 6 months

48c. In the last 6 months, how often were you able to get the care your child needed from his or her doctor or other health provider during evenings, weekends, or holidays?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always
- ○ My child did not need care from his or her doctor or other health provider during evenings, weekends, or holidays in the last 6 months

48d. In the last 6 months, did you and your child's doctor or other health provider talk about the kinds of behaviors that are normal for your child at this age?

- ○ Yes
- ○ No
- ○ My child did not see a doctor or other health provider in the last 6 months ➔ ***Go to Question 48f***

48e. In the last 6 months, did you and your child's doctor or other health provider talk about whether there are any problems in your household that might affect your child?

- ○ Yes
- ○ No
- ○ My child did not see a doctor or other health provider in the last 6 months

48f. What is your preferred method of contact regarding your child's health care?

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

THANK YOU

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

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

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