

FY 09–10 CHILD HEALTH PLAN *PLUS* MEMBER SATISFACTION REPORT

August 2010

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

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1. Executive Summary

The State of Colorado chose to administer member satisfaction surveys to members enrolled in the Child Health Plan *Plus* (CHP+) plan. The Colorado Department of Health Care Policy & Financing (the Department) contracts with Health Services Advisory Group, Inc. (HSAG) to administer and report the results of the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Surveys.¹⁻¹ The goal of the CAHPS Health Plan Surveys is to provide performance feedback that is actionable and will aid in improving overall member satisfaction.

The standardized survey instrument selected was the CAHPS 4.0H Child Medicaid Health Plan Survey (without the children with chronic conditions [CCC] measurement set). The parents or caretakers of child members from CHP+ completed the survey from February to May 2010.

Performance Highlights

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

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

NCQA Comparisons

Overall member satisfaction ratings for the four CAHPS global measures (Rating of Health Plan, Rating of All Health Care, Rating of Personal Doctor, and Rating of Specialist Seen Most Often) and five CAHPS composite measures (Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Customer Service, and Shared Decision Making) were compared to the NCQA National Distribution of 2009 Child Medicaid CAHPS Plan-level Results (which is referred to as NCQA national results throughout the rest of the document).^{1-2,1-3,1-4,1-5} This comparison resulted in plan ratings of one (★) to five (★★★★★) stars on these CAHPS measures, where one is the lowest possible rating and five is the highest possible rating. The detailed results of this comparative analysis are described in the Results Section beginning on page 2-5.

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

¹⁻² NCQA National Distribution of 2009 Child Medicaid CAHPS Plan-level Results. Prepared by NCQA for HSAG on December 9, 2009.

¹⁻³ The star assignments are determined by comparing the plan's three-point mean scores to the distribution of NCQA's 2009 national child Medicaid data.

¹⁻⁴ NCQA National Child Medicaid data for 2010 were not available at the time this report was prepared.

¹⁻⁵ National data do not exist for Coordination of Care and Health Promotion and Education individual measures.

Table 1-1 presents the highlights from this comparison.

Table 1-1 NCQA Comparisons Highlights	
Colorado CHP+	
★★	Rating of All Health Care
★★	Rating of Health Plan
★★	Getting Care Quickly
★★	Customer Service
★★★	Rating of Specialist Seen Most Often
★★★	Getting Needed Care
★★★	Shared Decision Making
★★★★	Rating of Personal Doctor
★★★★	How Well Doctors Communicate
★★★★★	80th Percentile or Above
★★★★	60th – 79th Percentiles
★★★	40th – 59th Percentiles
★★	20th – 39th Percentiles
★	Below 20th Percentile
NA	Not Applicable

Trend Analysis

In order to evaluate trends in member satisfaction, the 2010 Colorado CHP+ CAHPS Health Plan Survey results were compared to the 2009 CAHPS results. This year-to-year comparison was performed for the CHP+ population on the four global ratings, five composite measures, and two individual item measures. The detailed results of the trend analysis are described in the Results Section beginning on page 2-7.

- ◆ There was only one statistically significant result between the 2010 and 2009 scores. The How Well Doctors Communicate 2010 score was significantly higher than the 2009 score.

Plan Comparisons

In order to identify performance differences in member satisfaction, the case-mix adjusted results for the CHP+ population were compared to the Colorado Medicaid child population using standard statistical tests.^{1-6,1-7} These comparisons were performed on the four global ratings, five composite measures, and two individual item measures. The detailed results of the comparative analysis are described in the Results section beginning on page 2-12.

- ◆ Colorado CHP+ performed significantly lower than Colorado Medicaid for the Health Promotion and Education measure.

¹⁻⁶ In this report, Colorado Medicaid encompasses the following Child Medicaid plans: fee-for-service (FFS), Primary Care Physicians Program (PCPP), Denver Health Medical Plan (DHMP), and Rocky Mountain Health Plan (RMHP). For additional information, please see the FY 09-10 Child Medicaid Client Satisfaction Report.

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

- ◆ There were no statistically significant differences between the two populations for any of the other CAHPS measures.

Priority Assignments

The following are the high priorities for CHP+:

- ◆ Rating of Health Plan
- ◆ Rating of All Health Care
- ◆ Getting Care Quickly
- ◆ Customer Service

The Colorado CAHPS 4.0H Child Medicaid Health Plan Survey was administered in accordance with all NCQA specifications. Members eligible for sampling included those who were enrolled in CHP+ at the time the sample was drawn, and who were continuously enrolled in the plan for at least five of the last six months (July through December) of 2009. Members eligible for sampling included those who were 17 years of age or younger as of December 31, 2009.

Survey Administration and Response Rates

Survey Administration

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

The survey administration protocol was designed to achieve a high response rate from members, thus minimizing the potential effects of non-response bias. The survey process allowed members two methods by which they could complete the surveys. The first phase, or mail phase, consisted of a survey being mailed to the sampled members. For CHP+, those members who were identified as Spanish-speaking through administrative data were mailed a Spanish version of the survey. Members that were not identified as Spanish-speaking received an English version of the survey. The English and Spanish versions of the survey included a toll-free number that members could call to request a survey in another language (i.e., English or Spanish). A reminder postcard was sent to all non-respondents, followed by a second survey mailing and reminder postcard. The second phase, or telephone phase, consisted of Computer Assisted Telephone Interviewing (CATI) for sampled members who had not mailed in a completed survey. Up to six CATI calls were made to each non-respondent.²⁻³ Additional information on the survey protocol is included in the Reader's Guide section beginning on page 4-3.

Response Rates

The CAHPS 4.0H Child Medicaid Health Plan Survey administration was designed to 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

²⁻¹ HEDIS[®] is a registered trademark of the National Committee for Quality Assurance.

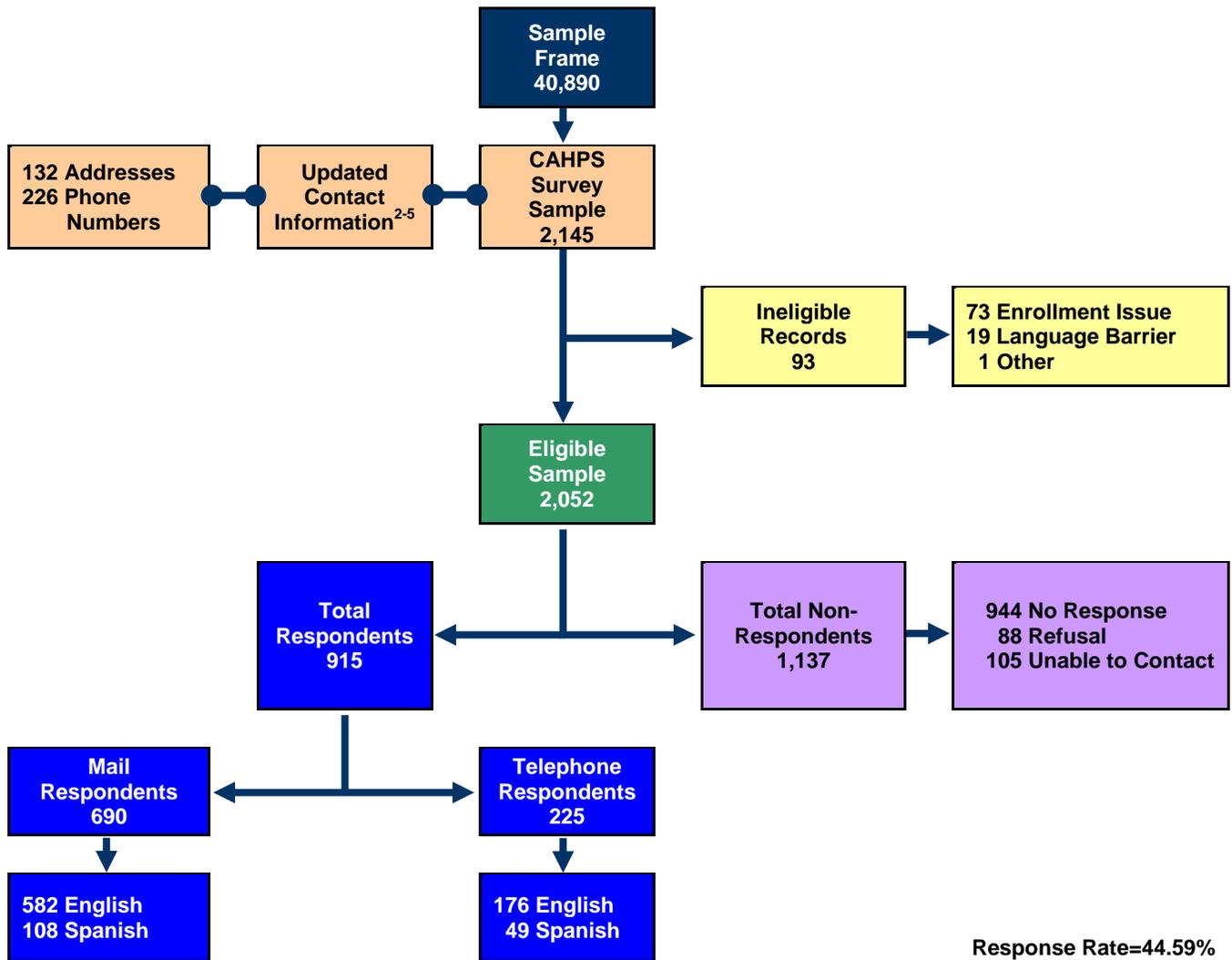
²⁻² National Committee for Quality Assurance. *HEDIS 2010, Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA Publication, 2009.

²⁻³ National Committee for Quality Assurance. *Quality Assurance Plan for HEDIS 2010 Survey Measures*. Washington, DC: NCQA Publication, 2009.

disposition code of “completed” if at least one question was answered. Eligible members included the entire random sample (including any oversample) minus ineligible members. Ineligible members met at least one of the following criteria: they were deceased, were invalid (did not meet the eligible population criteria), or had a language barrier.

A total of 915 completed surveys were returned on behalf of child CHP+ members. Figure 2-1 shows the individual distribution of survey dispositions and the response rate for CHP+. The response rate for the CHP+ population of 44.59 percent was 11.89 percentage points higher than the 2009 NCQA national child Medicaid response rate, which was 32.70 percent.²⁻⁴

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



²⁻⁴ National Committee for Quality Assurance. *HEDIS 2010 Survey Vendor Update Training*. October 22, 2009.

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

Child and Respondent Demographics

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

Table 2-1 shows the demographic characteristics of children for whom a parent/caretaker completed a CAHPS 4.0H Child Medicaid Health Plan Survey for CHP+. The Colorado Medicaid (FFS, PCPP, DHMP, and RMHP combined) child demographics are provided for comparison.²⁻⁷

Table 2-1 Child Demographics Age, Gender, Race/Ethnicity, and General Health Status		
	Colorado Medicaid (FFS, PCPP, DHMP, and RMHP)	Colorado CHP+
Age		
Less than 1	2.6%	1.5%
1 to 3	22.2%	13.7%
4 to 7	26.3%	22.7%
8 to 12	27.5%	34.1%
13 to 18	21.5%	27.9%
Gender		
Male	49.1%	45.8%
Female	50.9%	54.2%
Race/Ethnicity		
Multi-Racial	10.3%	10.6%
White	56.7%	63.5%
Black	8.0%	4.5%
Asian	2.6%	3.0%
Other	22.4%	18.4%
General Health Status		
Excellent	37.1%	38.9%
Very Good	36.9%	37.7%
Good	20.0%	18.1%
Fair	5.3%	4.8%
Poor	0.6%	0.4%
<i>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, 2009. Some children eligible for the CAHPS Survey turned age 18 between January 1, 2010, and the time of survey administration.</i>		

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

²⁻⁷ For additional information on the Colorado Medicaid results, please see the FY 09-10 Child Medicaid Client Satisfaction Report.

Table 2-2 shows the self-reported age, level of education, and relationship to the child for the respondents who completed the CAHPS 4.0H Child Medicaid Health Plan Survey for CHP+. The Colorado Medicaid (FFS, PCPP, DHMP, and RMHP combined) respondent demographics are provided for comparison.²⁻⁸

Table 2-2 Respondent Demographics Age, Education, and Relationship to Child		
	Colorado Medicaid (FFS, PCPP, DHMP, and RMHP)	Colorado CHP+
Respondent Age		
Under 18	6.5%	4.6%
18 to 24	10.8%	4.5%
25 to 34	31.8%	32.3%
35 to 44	26.8%	37.8%
45 to 54	14.3%	18.7%
55 to 64	6.8%	2.0%
65 or Older	3.0%	0.1%
Respondent Education		
8th Grade or Less	9.3%	9.8%
Some High School	16.4%	10.9%
High School Graduate	30.9%	27.6%
Some College	32.3%	36.5%
College Graduate	11.0%	15.2%
Relationship to Child		
Mother or Father	86.7%	98.6%
Grandparent	9.7%	0.7%
Legal Guardian	2.4%	0.7%
Other	1.2%	0.1%
<i>Please note: Percentages may not total 100% due to rounding.</i>		

²⁻⁸ For additional information on the Colorado Medicaid results, please see the FY 09-10 Child Medicaid Client Satisfaction Report.

NCQA Comparisons

In order to assess the overall performance of CHP+, each CAHPS measure was scored on a three-point scale using the scoring methodology detailed in NCQA’s HEDIS Specifications for Survey Measures.²⁻⁹ The resulting three-point mean scores were compared to the NCQA national results.^{2-10,2-11,2-12} Based on this comparison, plan ratings of one (★) to five (★★★★★) stars were determined for each CAHPS measure, where one is the lowest possible rating and five is the highest possible rating.

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

Table 2-3 shows the plan’s three-point mean scores and overall member satisfaction ratings on each of the four global ratings and five composite measures. National data do not exist for the Coordination of Care and Health Promotion and Education individual measures; therefore, overall member satisfaction ratings could not be determined.

²⁻⁹ National Committee for Quality Assurance. *HEDIS 2010, Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA Publication, 2009.

²⁻¹⁰ NCQA National Distribution of 2009 Child Medicaid CAHPS Plan-level Results. Prepared by NCQA for HSAG on December 9, 2009.

²⁻¹¹ The star assignments are determined by comparing the plan’s three-point mean scores to the distribution of NCQA’s 2009 national child Medicaid data.

²⁻¹² NCQA national child Medicaid data for 2010 were not available at the time this report was prepared.

Table 2-3 NCQA Comparisons Overall Member Satisfaction Ratings		
Colorado CHP+	Three-Point Mean	Star Rating
Global Rating		
Rating of Personal Doctor	2.623	★★★★
Rating of Specialist Seen Most Often	2.557	★★★
Rating of All Health Care	2.444	★★
Rating of Health Plan	2.463	★★
Composite Measure		
Getting Needed Care	2.371	★★★
Getting Care Quickly	2.530	★★
How Well Doctors Communicate	2.692	★★★★
Customer Service	2.351	★★
Shared Decision Making	2.589	★★★
Individual Measure		
Coordination of Care	2.276	NB
Health Promotion and Education	1.920	NB
<i>Please note: A minimum of 100 responses to each measure is required in order to report the measure as a CAHPS Survey Result. Measures that do not meet the minimum number of responses are denoted as Not Applicable (NA). Measures that NCQA did not provide national distributions for are denoted as No Benchmark (NB).</i>		

Summary of NCQA Comparison Results

The NCQA comparisons revealed the following summary results:

- ◆ CHP+ scored at or between the 60th and 79th percentiles nationally on two CAHPS measures: Rating of Personal Doctor and How Well Doctors Communicate.
- ◆ CHP+ scored at or between the 40th and 59th percentiles nationally on three CAHPS measures: Rating of Specialist Seen Most Often, Getting Needed Care, and Shared Decision Making.
- ◆ CHP+ scored at or between the 20th and 39th percentiles nationally on four CAHPS measures: Rating of All Health Care, Rating of Health Plan, Getting Care Quickly, and Customer Service.
- ◆ CHP+ did not score at or above the 80th percentile or below the 20th percentile on any CAHPS measures.

Trend Analysis

In 2009, Colorado CHP+ had 730 completed CAHPS Child Medicaid Health Plan Surveys. These completed surveys were used to calculate the 2009 CAHPS results presented in this section for trending purposes.²⁻¹³

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.²⁻¹⁴ The scoring of the global ratings, composite measures, and individual item measures involved assigning top-level responses a score of one, with all other responses receiving a score of zero. After applying this scoring methodology, the percentage of top-level responses was calculated in order to determine the question summary rates and global proportions. For additional details, please refer to the *NCQA HEDIS Specifications for Survey Measures, Volume 3*.

The 2010 CHP+ CAHPS scores were compared to corresponding 2009 scores to determine whether there were statistically significant differences. Figure 2-2 through Figure 2-4 show the results of this trend analysis. Statistically significant differences are noted with directional triangles. Scores that were statistically higher in 2010 than in 2009 are noted with upward (▲) triangles. Scores that were statistically lower in 2010 than in 2009 are noted with downward (▼) triangles. Scores in 2010 that were not statistically different from scores in 2009 are not noted with triangles. Please note, a minimum of 100 responses to each CAHPS measure is required in order to report the measure as a CAHPS Survey result. Measures that do not meet the minimum number of responses are denoted as Not Applicable (NA).

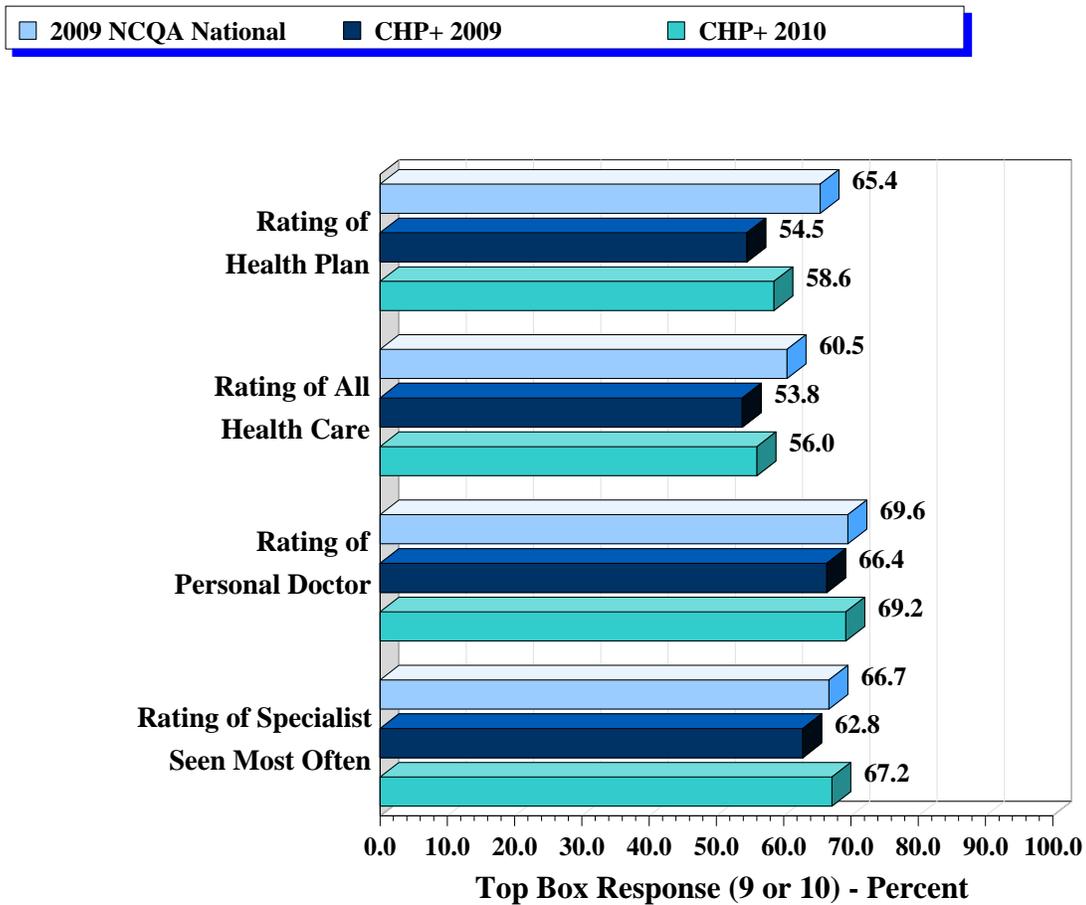
²⁻¹³ For detailed information on the 2009 CHP+ CAHPS results, please refer to the 2009 CHP+ Member Satisfaction Report.

²⁻¹⁴ National Committee for Quality Assurance. *HEDIS 2010, Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA Publication, 2009.

Global Ratings

Figure 2-2 depicts the 2009 and 2010 CHP+ top-box question summary rates for each of the global ratings and the 2009 NCQA National Child Medicaid average using responses of 9 or 10 for top-box scoring.²⁻¹⁵

Figure 2-2—Trend Analysis: Global Ratings



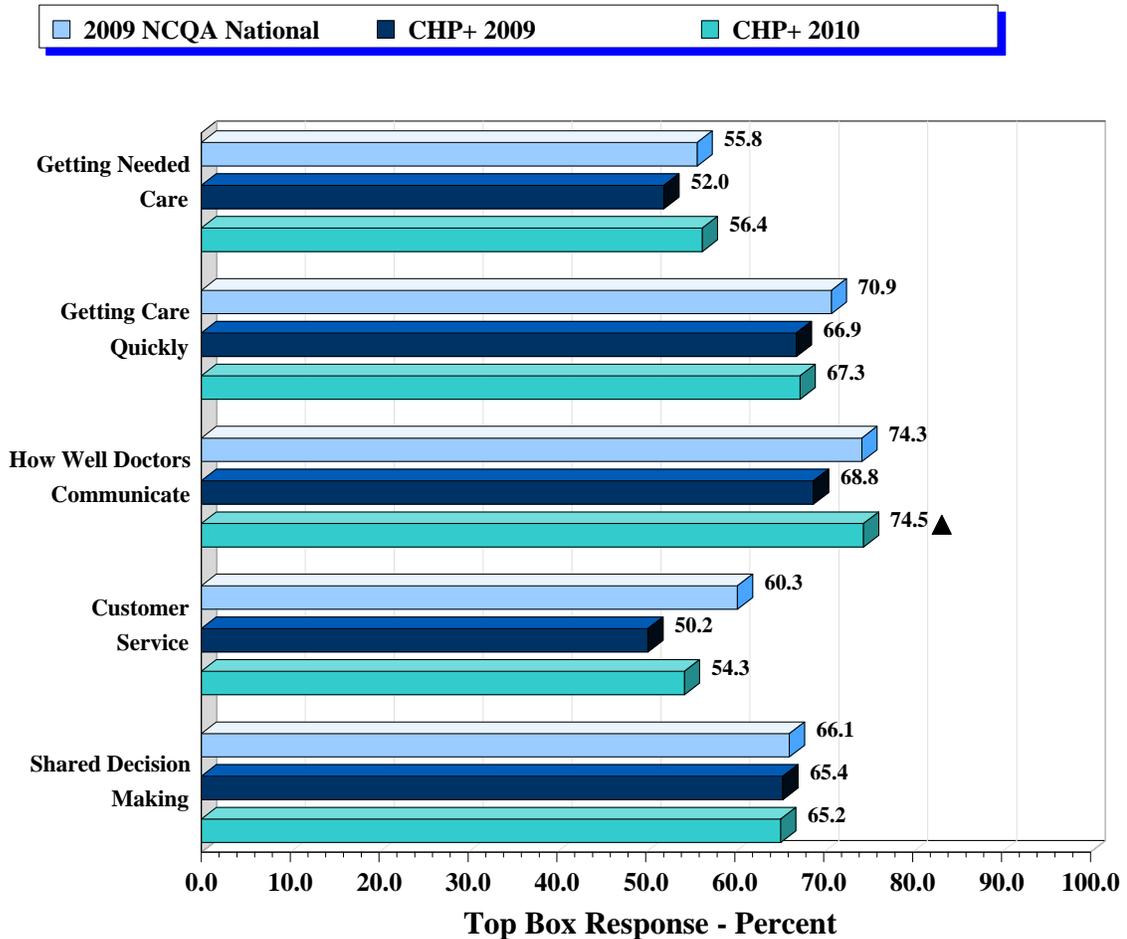
Statistical Significance Note: ▲ indicates the 2010 score is significantly higher than the 2009 score
▼ indicates the 2010 score is significantly lower than the 2009 score

²⁻¹⁵ NCQA national averages were not available for 2010 at the time this report was prepared; therefore, 2009 NCQA national averages are presented in this section.

Composite Measures

Figure 2-3 depicts the 2009 and 2010 CHP+ top-box global proportions for each of the composite measures and the 2009 NCQA National Child Medicaid average using responses of “Always” or “Definitely Yes” for top-box scoring.

Figure 2-3—Trend Analysis: Composite Measures

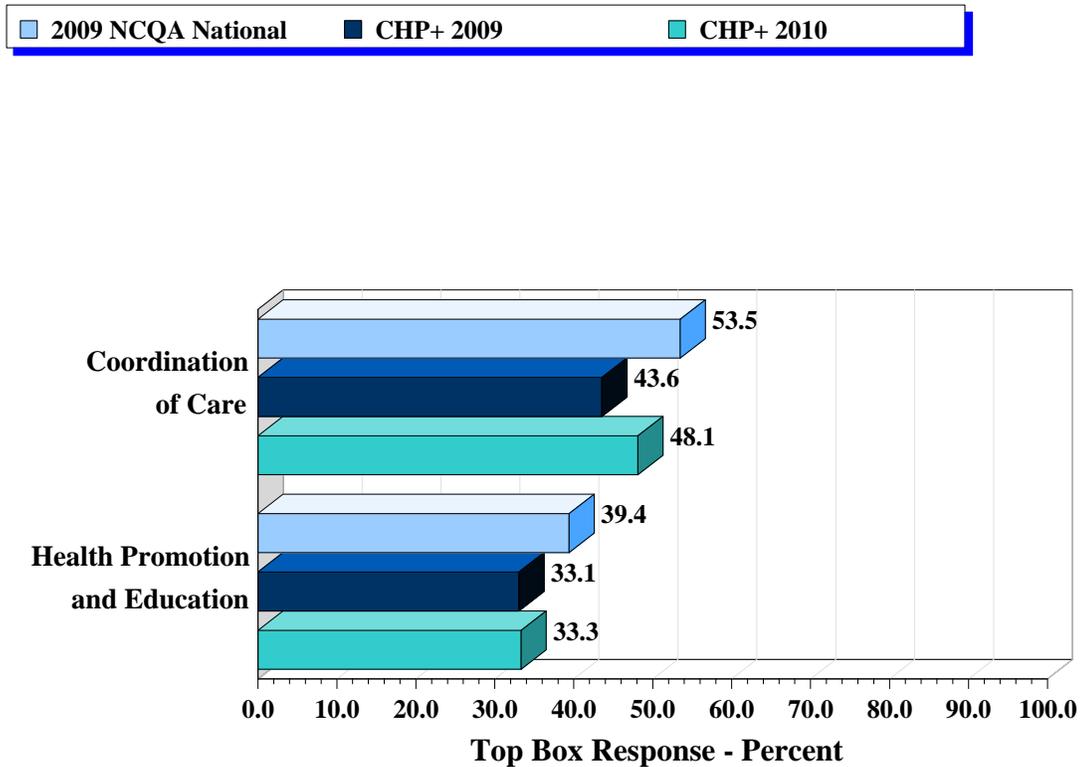


Statistical Significance Note: ▲ indicates the 2010 score is significantly higher than the 2009 score
▼ indicates the 2010 score is significantly lower than the 2009 score

Individual Item Measures

Figure 2-4 depicts the 2009 and 2010 CHP+ top-box question summary rates for each of the individual item measures and the 2009 NCQA National average using responses of “Always” for top-box scoring.

Figure 2-4—Trend Analysis: Individual Item Measures



Statistical Significance Note: ▲ indicates the 2010 score is significantly higher than the 2009 score
▼ indicates the 2010 score is significantly lower than the 2009 score

Summary of Trend Analysis Results

The trend analysis revealed the following summary results:

- ◆ CHP+ scored significantly higher in 2010 than in 2009 on one CAHPS measure, How Well Doctors Communicate.
- ◆ CHP+ did not score significantly lower in 2010 than in 2009 on any CAHPS measures.

Plan Comparisons

In order to identify performance differences in member satisfaction, the results for Colorado Medicaid (FFS, PCPP, DHMP, and RMHP combined) and CHP+ were compared to one another using standard tests for statistical significance.^{2-16,2-17} For purposes of this analysis, results were case-mix adjusted. Case-mix refers to the characteristics of respondents used in adjusting the results for comparability among health plans. Results were case-mix adjusted for member general health status, respondent educational level, and respondent age.²⁻¹⁸ Given that differences in case-mix can result in differences in ratings between plans that are not due to differences in quality, the data were adjusted to account for disparities in these characteristics. The case-mix adjustment was performed using standard regression techniques (i.e., covariance adjustment).

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

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

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

²⁻¹⁶ Caution should be exercised when evaluating plan comparisons, given that population and plan differences may impact CAHPS results.

²⁻¹⁷ The Colorado Medicaid results were calculated using the data of the four health plans from the FY 09-10 Child Medicaid Client Satisfaction Report. For more detailed information, please refer to the FY 09-10 Child Medicaid Client Satisfaction Report.

²⁻¹⁸ Agency for Healthcare Research and Quality. *CAHPS Health Plan Survey and Reporting Kit 2008*. Rockville, MD: US Department of Health and Human Services, July 2008.

Table 2-4 Plan Comparisons		
	Colorado Medicaid (FFS, PCPP, DHMP, and RMHP)	Colorado CHP+
Global Rating		
Rating of Personal Doctor	71.8% ↔	69.1% ↔
Rating of Specialist Seen Most Often	68.6% ↔	66.3% ↔
Rating of All Health Care	59.4% ↔	56.1% ↔
Rating of Health Plan	62.5% ↔	58.8% ↔
Composite Measure		
Getting Needed Care	53.4% ↔	56.1% ↔
Getting Care Quickly	68.4% ↔	67.0% ↔
How Well Doctors Communicate	76.1% ↔	74.1% ↔
Customer Service	53.5% ↔	54.4% ↔
Shared Decision Making	69.6% ↔	64.7% ↔
Individual Measure		
Coordination of Care	54.3% ↔	48.2% ↔
Health Promotion and Education	39.6% ↑	33.2% ↓
<i>Please note: A minimum of 100 responses to each measure is required in order to report the measure as a CAHPS Survey Result. Measures that do not meet the minimum number of responses are denoted as Not Applicable (NA). All plans' results, including results from plans with fewer than 100 respondents, are included in the derivation of the Colorado Medicaid average.</i>		

Summary of Plan Comparisons Results

The plan comparisons revealed the following statistically significant results:

- ◆ There were no significant differences between CHP+ and Colorado Medicaid on 10 of the CAHPS measures: Rating of Personal Doctor, Rating of Specialist Seen Most Often, Rating of All Health Care, Rating of Health Plan, Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Customer Service, Shared Decision Making, and Coordination of Care.
- ◆ CHP+ scored significantly lower than Colorado Medicaid on one CAHPS measure, Health Promotion and Education.

General Recommendations

For fiscal year (FY) 2010-2011, HSAG recommends the continued administration of the CAHPS 4.0H Child Medicaid Health Plan Survey without the CCC measurement set. During this year, HSAG will be surveying five reporting units for the CHP+ population, instead of a statewide CHP+ aggregate. The five plans that will be surveyed are: Colorado Access, Denver Health Medical Plan, Rocky Mountain Health Plan, Kaiser, and the State Network.

Plan-Specific Recommendations

This section presents Child Medicaid CAHPS recommendations for CHP+. The recommendations are grouped into four main categories for quality improvement (QI): top, high, moderate, and low priority. The priority of the recommendations is based on the combined results of the NCQA comparisons and trend analysis.

The priorities presented in this section should be viewed as potential suggestions for QI. Additional sources of QI information, such as other HEDIS results, should be incorporated into a comprehensive QI plan. A number of resources are available to assist state Medicaid agencies and health plans with the implementation of CAHPS-based QI initiatives.³⁻¹ A comprehensive list of these resources is included in the Reader's Guide Section, beginning on page 4-9.

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

³⁻¹ AHRQ Web site. The CAHPS Improvement Guide. Available at: <http://www.caahps.ahrq.gov/qiguide/default.aspx>. Accessed on: July 1, 2010.

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
NA/NB	NA/—	Moderate
★★★★	▼	Moderate
★★★★	—	Moderate
★★★★★	▼	Moderate
★★★★★	▲	Low
★★★★★	—	Low
★★★★★	▲	Low

*Please note:
Global ratings, composite measures, or individual item measures that do not meet the minimum number of responses are denoted as Not Applicable (NA). Measures that NCQA did not provide benchmarks for are denoted as No Benchmark (NB). 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.*

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
CHP+	★★	—	High

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

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 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, function 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.

Health Plan Experiences

Quality initiative efforts should focus on the overall experience a member has with the health plan. This includes effectively managing paperwork to ensure a complete and timely process. It is also important for health plans to monitor the relevance and comprehensiveness of information that is distributed to its members. Furthermore, providing high-quality customer service can help improve members’ perceptions of their health plan.

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
CHP+	★★	—	High

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

Access to Care

Health plans should identify potential barriers that prevent patients from receiving appropriate access to care. Access to care issues include obtaining the care that the patient and/or physician deem necessary, obtaining timely urgent care, locating a personal doctor, or receiving adequate assistance when calling a physician office. It is important to reduce any hindrances a patient might encounter while seeking care.

Health Care Experiences

To improve patients' health care experience, health plans should eliminate any unnecessary challenges a patient might encounter when receiving health care and to ensure that patients receive adequate time with a clinician so that questions and concerns may be appropriately addressed. This includes providing patients with ample information that is easy to understand. In addition, providing care in a timely fashion will help increase patients' satisfaction with their health care experience.

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
CHP+	★★★★	—	Moderate

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

Physician and Patient Communication

Increased communication levels between physicians and patients are important. Indicators of good communication include providing clear explanations, listening carefully, and treating patients with courtesy and respect.

Wait Times

Physicians should attempt to decrease the time between the point that care is needed and when it is received by eliminating barriers that may prohibit patients from receiving prompt, adequate care. This can be achieved by identifying and resolving bottlenecks and redundancies in the patient flow process. Collaborating with other departments can also improve patient flow. Furthermore, physicians can identify areas in the process where physician workload can be redistributed to eliminate excess wait times.

Rating of Specialist Seen Most Often

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

Table 3-5 Priority Assignments Rating of Specialist Seen Most Often			
Plan	NCQA Comparisons (Star Ratings)	Trend Analysis	Priority Assignment
CHP+	★★★	—	Moderate

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

Specialist Availability

Increasing the availability of specialists will allow patients to receive timely care. One method that can be used to improve the perceived ability to access care is to develop a scheduling model that allows for appointment-flexibility for those patients who need to see a specialist.

Referral Process

Streamlining the referral process allows members to more readily obtain the care they need. The first step to a streamlined referral process is having effective communication mechanisms between primary care physicians (PCPs) and specialists to determine which clinical conditions require a referral. Furthermore, by involving the patient in the referral process, he/she is made more aware of the necessary information needed for the provider or upcoming appointment. Next, it is helpful for providers to have access to a standardized referral form to ensure that all necessary information is being collected from the parties involved (e.g., plans, patients, and providers).

Telemedicine

Telemedicine models allows for the use of electronic communication and information technologies to provide specialty services to patients in varying locations. Telemedicine such as live, interactive video conferencing allows providers to offer care from a remote location. Physician specialists located in urban settings can diagnose and treat patients in communities where there is a shortage of specialists. Telemedicine consultation models allow for the local provider to both present the patient at the beginning of the consult and to participate in a case conference with the specialist at the end of the teleconference visit. This allows for the local provider to be more involved in the consultation process and more informed about the care the patient is receiving.

Composite Measures

Getting Needed Care

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

Table 3-6 Priority Assignments Getting Needed Care Composite			
Plan	NCQA Comparisons (Star Ratings)	Trend Analysis	Priority Assignment
CHP+	★★★	—	Moderate

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

Provider Directories

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

Appropriate Health Care Providers

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

Referral Expert

A referral expert can be either a person and/or computer that is responsible for tracking and managing each health plan’s referral requirements. Referral experts can decrease the time and energy lost from getting referral approvals. Reducing, or eliminating, delays for referrals, tests, and procedures can increase patient satisfaction. Also, referral experts can save costs associated with phone and paper-based approval processes, and costs that result from grievances and complaints.

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
CHP+	★★	—	High

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

Open Access Scheduling

A scheduling model that allows appointment-flexibility for those patients making same-day appointments is one method that can be used to improve the perceived ability to access care. Instead of booking appointments weeks or months in advance, an open access scheduling model including 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

It is important to simplify patient flow in order to decrease wait times. Identifying and resolving bottlenecks and redundancies in this process is one method that may be used to achieve these results. Patient flow can also be streamlined by identifying areas in the process where physician workloads can be redistributed to other staff (e.g., collection of patient’s health history can be assigned to a physician assistant).

Electronic Communication

Electronic forms of communication between patient and provider can help alleviate the demand for in-person visits. Electronic communication can provide prompt care to patients that may not require a physician’s appointment and can provide physicians with more availability to see patients that require an in-person assessment. This form of communication can also be used when scheduling appointments, providing prescription refills, answering patient questions, educating patients on health topics, and disseminating lab results. It should be noted that the 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
CHP	★★★★	▲	Low

In order to improve members' satisfaction under the How Well Doctors Communicate measure, QI activities should focus on skills training, communication tools, and educational materials.

Skills Training for Clinicians and Physicians

Specialized workshops for clinicians and physicians can enhance their communication skills with patients. The seminars can include sessions for communicating with various cultures and challenging patients. In addition, the training can provide methods to effectively communicate a patient's history, how to be empathetic, and how to effectively communicate various treatment options to a patient.

Communication Tools for Patients

Providing patients with a pre-structured question list will help them to ask all pertinent questions when they speak with their provider. Administering surveys after the patient visit can also be a useful tool to ensure that their next visit meets all expectations. Furthermore, providing patients with a copy of their medical record can improve communication between patients and providers.

Educational Materials

Physicians may provide educational literature to patients before, during, and after a visit. Patients will be able to educate themselves on a medical condition specific to their needs. An automatic program could be used to send patients information relative to their appointment.

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
CHP+	★★	—	High

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

Tools to Further Identify Challenges

Health plans can create an individualized survey based on key areas that are noted for improvement and develop questions that will identify specific customer service challenges that need to be addressed. Furthermore, a focus group can provide insight into additional problems not able to be captured through a survey. One method that could be used is to appoint a staff member to conduct a walkthrough of the process a member would go through in contacting customer service. This will assist in identifying potential areas for QI.

Service Recovery

Service recovery can range from a wide range of events from listening to a patient who is upset to handing out incentives to patients who have had to wait longer than a specified time for a doctor’s visit. Service recovery can also include events such as making amends for issues that were patient created.

Customer Service Performance Measures

Health plans should evaluate and modify internal customer service performance measures. New measures should be communicated with staff members. By tracking and reporting progress internally and modifying measures as needed, customer service performance may be improved.

Employee Training and Empowerment

It is important to ensure customer service staff have adequate training on all pertinent business processes; furthermore, staff members should feel empowered to resolve any issues a member might have. This will eliminate transferring members to various employees and will help to resolve a complaint in a timely manner.

Shared Decision Making

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

Table 3-10 Priority Assignments Shared Decision Making Composite			
Plan	NCQA Comparisons (Star Ratings)	Trend Analysis	Priority Assignment
CHP+	★★★	—	Moderate

In order to improve member satisfaction scores under the Shared Decision Making measure, QI activities should focus on skills training for physicians, promoting shared decision making, and ensuring patients spend enough time with their physician.

Skills Training for Physicians

Implementing a shared decision making model requires physician recognition that patients have the ability to make choices that affect their health care. Therefore, a key to a successful shared decision making model is ensuring that physicians are properly trained. Training should focus on providing skills to facilitate the shared decision making process; ensuring that physicians understand the importance of taking into consideration each patient’s values, preferences, and needs; and improving communication skills. Effective and efficient training methods include seminars and workshops.

Physician Encouragement of Shared Decision Making

Patients may become more involved in the management of their health care if physicians promote shared decision making. Physicians will be able to better encourage their patients to participate if the health plan provides physicians with literature that conveys the importance of the shared decision making model.

Adequate Time Spent With Physicians

Shared decision making is more likely to occur when a physician has enough time scheduled for an appointment. It is important that neither the physician nor the patient feel rushed during an appointment. Pre-structured question lists may be provided to patients in order to assist them in asking all necessary questions so the appointment is as efficient and effective as possible.

Individual Item Measures

Coordination of Care

Table 3-11 shows the priority assignments for the Coordination of Care measure.

Table 3-11 Priority Assignments Coordination of Care			
Plan	NCQA Comparisons (Star Ratings)	Trend Analysis	Priority Assignment
CHP+	NB	—	Moderate

In order to improve member satisfaction scores under the Coordination of Care measure, QI activities should focus on communication tools, planned visits, and coordination between physicians.

Communication Tools for Patients

Providing patients with a copy of their medical record can improve communication between patients and providers. Administering surveys after the patient visit can also be a useful tool to ensure that their next visit meets all expectations. Patients can complete a questionnaire that asks about their perceptions of care received to date, functional and clinical health status, and health risk status. Providers can use this information to deliver a treatment plan that is appropriate for each patient.

Planned Visit Management

By identifying patients with chronic conditions that have routine appointments, a system could be implemented to ensure that these patients have the necessary tests done before an appointment.

Coordination Between Physicians

A referral agreement can improve the flow of information among the PCP, specialist, and patient. PCPs and specialists should develop guidelines to identify which clinical conditions the PCPs should manage and which should be referred to specialists.

Health Promotion and Education

Table 3-12 shows the priority assignments for the Health Promotion and Education measure.

Table 3-12 Priority Assignments Health Promotion and Education			
Plan	NCQA Comparisons (Star Ratings)	Trend Analysis	Priority Assignment
CHP+	NB	—	Moderate

In order to improve member satisfaction scores under the Health Promotion and Education measure, QI activities should focus on group visits, support groups, and educational materials.

Group Visits

Where appropriate, group visits are an efficient way for patients to have face-to-face contact with their physician, get educational content, and learn from experiences of other patients. Additionally, this method does not interrupt a physician’s time throughout the day. These groups provide social and psychological support for participants to help motivate them to follow their treatment plan and take more responsibility for their own health. Benefits of this method include reduced health care costs, greater patient and physician satisfaction, patient empowerment, and greater patient compliance.

Support Groups

Trained professionals can moderate support groups and educate patients in self-care training. An ample amount of literature and guidebooks are available that can serve as a text for self-care programs. The guidebooks can also be used as a relevant source for support group meetings.

Educational Materials

Physicians can facilitate patient education by providing patients access to pertinent and specific information, either via the Internet or in print. There are several products available where patients can independently research information about their own health care.

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 3-13 provides a summary of the responsible parties for various aspects of care.³⁻²

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

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

Those measures identified for CHP+ that exhibited low performance suggest that additional analysis may be required to identify what is truly causing low performance in these areas. Methods that could be used include:

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

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

³⁻² Edgman-Levitan S, et al. *The CAHPS® Improvement Guide: Practical Strategies for Improving the Patient Care Experience*. Department of Health Care Policy Harvard Medical School, October 2003.

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

Survey Administration

Survey Overview

The survey instrument selected was the CAHPS 4.0H Child Medicaid Health Plan Survey (without the CCC measurement set). The CAHPS 4.0H Health Plan Surveys are a set of standardized surveys that assess patient perspectives on care. Originally, CAHPS was a five-year collaborative project sponsored by the Agency for Healthcare Research and Quality (AHRQ). The CAHPS questionnaires and consumer reports were developed under cooperative agreements among AHRQ, Harvard Medical School, RAND, and the Research Triangle Institute (RTI). In 1997, NCQA, in conjunction with AHRQ, created the CAHPS 2.0H Survey measure as part of NCQA's HEDIS.⁴⁻¹ In 2002, AHRQ convened the CAHPS Instrument Panel to re-evaluate and update the CAHPS Health Plan Surveys and to improve the state-of-the-art methods for assessing members' experiences with care.⁴⁻² The result of this re-evaluation and update process was the development of the CAHPS 3.0H Health Plan Surveys. The goal of the CAHPS 3.0H Health Plan Surveys was to effectively and efficiently obtain information from the person receiving care. In 2006, AHRQ released the CAHPS 4.0 Health Plan Surveys. Based on the CAHPS 4.0 versions, NCQA introduced new HEDIS versions of the Adult Health Plan Survey in 2007, which are referred to as the CAHPS 4.0H Health Plan Surveys.⁴⁻³ NCQA released the CAHPS 4.0H Child Medicaid Health Plan Survey in 2009.⁴⁻⁴

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

⁴⁻¹ National Committee for Quality Assurance. *HEDIS® 2002, Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA Publication, 2001.

⁴⁻² National Committee for Quality Assurance. *HEDIS® 2003, Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA Publication, 2002.

⁴⁻³ National Committee for Quality Assurance. *HEDIS® 2007, Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA Publication, 2006.

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

The CAHPS 4.0H Child Medicaid Health Plan Survey includes 47 core questions that yield 11 measures of satisfaction. These measures include four global rating questions, five composite measures, and two individual item measures. The global measures (also referred to as global ratings) reflect overall satisfaction with the health plan, health care, personal doctors, and specialists. The composite measures are sets of questions grouped together to address different aspects of care (e.g., “Getting Needed Care” or “Getting Care Quickly”). The individual item measures are individual questions that look at a specific area of care (i.e., “Coordination of Care” and “Health Promotion and Education”).

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

Table 4-1—CAHPS Measures		
Global Ratings	Composite Measures	Individual Item Measures
Rating of Health Plan	Getting Needed Care	Coordination of Care
Rating of All Health Care	Getting Care Quickly	Health Promotion and Education
Rating of Personal Doctor	How Well Doctors Communicate	
Rating of Specialist Seen Most Often	Customer Service	
	Shared Decision Making	

Sampling Procedures

The members eligible for sampling included those who were CHP+ members at the time the sample was drawn, and who were continuously enrolled for at least five of the last six months (July through December) of 2009. The members eligible for sampling included those who were age 17 or younger (as of December 31, 2009).

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

Survey Protocol

The CAHPS 4.0H Health Plan Survey process allowed for two methods by which members could complete the surveys. The first phase, or mail phase, consisted of a survey being mailed to all sampled members. For CHP+, those members who were identified as Spanish-speaking through administrative data were mailed a Spanish version of the survey. Members that were not identified as Spanish-speaking received an English version of the survey. The English and Spanish versions of the survey included a toll-free number that members could call to request a survey in another language (i.e., English or Spanish). A reminder postcard was sent to all non-respondents, followed by a second survey mailing and reminder postcard. The second phase, or telephone phase, consisted of CATI of sampled members who had not mailed in a completed survey. A series of up to six CATI calls was made to each non-respondent.⁴⁻⁵ It has been shown that the addition of the telephone phase aids in the reduction of non-response bias by increasing the number of respondents who are more demographically representative of a plan's population.⁴⁻⁶

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

- ◆ Were age 17 or younger as of December 31, 2009.
- ◆ Were currently enrolled in CHP+.
- ◆ Had been continuously enrolled for at least five of the last six months of 2009.
- ◆ Had Medicaid as the primary payer.

HSAG inspected a sample of the file records to check for any apparent problems with the files, such as missing address elements. A random sample of records from each population was passed through the United States Postal Service's National Change of Address (NCOA) system to obtain new addresses for members who had moved (if they had given the Postal Service a new address). Following NCQA requirements, the survey samples were random samples with no more than one member being selected per household.

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

⁴⁻⁵ National Committee for Quality Assurance. *Quality Assurance Plan for HEDIS 2010 Survey Measures*. Washington, DC: NCQA Publication, 2009.

⁴⁻⁶ Fowler FJ Jr., Gallagher PM, Stringfellow VL, et al. "Using Telephone Interviews to Reduce Nonresponse Bias to Mail Surveys of Health Plan Members." *Medical Care*. 2002; 40(3): 190-200.

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

Table 4-2—CAHPS 4.0H Survey Timeline	
Task	Timeline
Send first questionnaire with cover letter to the respondent.	0 days
Send a postcard reminder to non-respondents four to 10 days after mailing the first questionnaire.	4 – 10 days
Send a second questionnaire (and letter) to non-respondents approximately 35 days after mailing the first questionnaire.	35 days
Send a second postcard reminder to non-respondents four to 10 days after mailing the second questionnaire.	39 – 45 days
Initiate CATI interviews for non-respondents approximately 21 days after mailing the second questionnaire.	56 days
Initiate systematic contact for all non-respondents such that at least six telephone calls are attempted at different times of the day, on different days of the week, and in different weeks.	56 – 70 days
Telephone follow-up sequence completed (i.e., completed interviews obtained or maximum calls reached for all non-respondents) approximately 14 days after initiation.	70 days

⁴⁻⁷ National Committee for Quality Assurance. *HEDIS 2010, Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA Publication, 2009.

Methodology

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

Response Rates

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

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

Child and Respondent Demographics

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

NCQA Comparisons

An analysis of the CHP+ CAHPS 4.0H Child Medicaid Health Plan Survey results was conducted using NCQA HEDIS Specifications for Survey Measures. Per these specifications, no weighting or case-mix adjustment is performed on the results. NCQA also requires a minimum of 100 responses on each item in order to report the item as a valid CAHPS Survey result.

⁴⁻⁸ National Committee for Quality Assurance. *HEDIS 2010, Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA Publication, 2009.

In order to perform the NCQA comparisons, a three-point mean score was determined for each CAHPS measure. The resulting three-point mean scores were compared to the NCQA national results to derive the overall member satisfaction ratings (i.e., star ratings) for the global ratings and composite measures. For detailed information on the derivation of three-point mean scores, please refer to *NCQA HEDIS 2010 Specifications for Survey Measures, Volume 3*.

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

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

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

Table 4-3—Overall Member Satisfaction Ratings Crosswalk				
Measure	80th Percentile	60th Percentile	40th Percentile	20th Percentile
Rating of Health Plan	2.632	2.584	2.549	2.437
Rating of All Health Care	2.548	2.521	2.472	2.427
Rating of Personal Doctor	2.643	2.619	2.587	2.551
Rating of Specialist Seen Most Often	2.617	2.584	2.532	2.479
Getting Needed Care	2.471	2.394	2.337	2.234
Getting Care Quickly	2.666	2.624	2.590	2.487
How Well Doctors Communicate	2.711	2.683	2.651	2.600
Customer Service	2.491	2.447	2.373	2.323
Shared Decision Making	2.630	2.597	2.560	2.519

Trend Analysis

In order to evaluate trends in Colorado CHP+ member satisfaction, HSAG performed a trend analysis. The 2010 CAHPS results were compared to the 2009 CAHPS 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.⁴⁻⁹ The scoring of the global ratings, composite measures, and individual item measures involved assigning top-level responses a score of one, with all other responses receiving a score of zero. After applying this scoring methodology, the percentage of top-level responses was calculated in order to determine the question summary rates and global proportions. For additional detail, please refer to the *NCQA HEDIS 2010 Specifications for Survey Measures, Volume 3*.

The 2010 CHP+ CAHPS scores were compared to the corresponding 2009 scores to determine whether there were statistically significant differences. A difference was considered significant if the two-sided *p* value of the *t* test was less than 0.05. Scores that were statistically higher in 2010 than in 2009 are noted with upward (▲) triangles. Scores that were statistically lower in 2010 than in 2009 are noted with downward (▼) triangles. Scores in 2010 that were not statistically different from scores in 2009 are not noted with triangles. Per NCQA specifications, measures that did not meet the minimum number of 100 responses required by NCQA are denoted as NA.

Plan Comparisons

A comparison was performed to identify member satisfaction differences between CHP+ and Colorado Medicaid (FFS, PCPP, DHMP, and RMHP combined).⁴⁻¹⁰ 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 detail, please refer to the *NCQA HEDIS 2010 Specifications for Survey Measures, Volume 3*.

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

⁴⁻⁹ National Committee for Quality Assurance. *HEDIS 2010, Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA Publication, 2009.

⁴⁻¹⁰ For additional information on the FFS, PCPP, DHMP, and RMHP child CAHPS results, please see the FY 09-10 Child Medicaid Client Satisfaction Report.

⁴⁻¹¹ National Committee for Quality Assurance. *HEDIS 2010, Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA Publication, 2009.

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

Limitations and Cautions

The findings presented in the 2010 Colorado CHP+ CAHPS report are subject to some limitations in the survey design, analysis, and interpretation. These limitations should be considered carefully when interpreting or generalizing the findings. These limitations are discussed below.

Case-Mix Adjustment

While data for the plan comparisons have been adjusted for differences in survey-reported general health status, age, and education, it was not possible to account for differences in member and respondent characteristics that were not measured. These characteristics include income, employment, or any other characteristics that may not be under the plan's control.

Non-response Bias

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

Causal Inferences

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

Quality Improvement References

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

AHRQ Web site. The CAHPS Improvement Guide. Available at: <http://www.cahps.ahrq.gov/qiguide/default.aspx>. Accessed on: July 1, 2010.

Backer LA. Strategies for better patient flow and cycle time. *Family Practice Management*. 2002; 9(6): 45-50. Available at: <http://www.aafp.org/fpm/20020600/45stra.html>. Accessed on: July 1, 2010.

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

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

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

Edgman-Levitan S, Shaller D, McInnes K, Joyce R, Coltin K, Cleary P. *The CAHPS® Improvement Guide: Practical Strategies for Improving the Patient Care Experience*. Department of Health Care Policy, Harvard Medical School; 2003. Available at: <http://www.cahps.ahrq.gov/qiguide/default.aspx?print=1>. Accessed on: July 1, 2010.

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

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

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

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

⁴⁻¹² AHRQ Website. *CAHPS User Resources: Quality Improvement Resources*. Available at: https://www.cahps.ahrq.gov/content/resources/QI/RES_QI_Intro.asp?p=103&s=31. Accessed on: July 1, 2010.

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

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

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

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

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

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

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

Murray M. Reducing waits and delays in the referral process. *Family Practice Management*. 2002; 9(3): 39-42. Available at: <http://www.aafp.org/fpm/20020300/39redu.html>. Accessed on: July 1, 2010.

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

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

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

Wasson JM, Godfrey M, Nelson E, et al. Microsystems in health care: Part 4. Planning patient-centered care. *Joint Commission Journal on Quality and Safety*. 2003; 29(5): 227-237. Available at: <http://howyourhealth.com/html/CARE.pdf>. Accessed on: July 1, 2010.

5. Survey Instrument

The survey instrument selected for the 2010 Colorado CHP+ Member Satisfaction Survey was the CAHPS 4.0H Child Medicaid Health Plan Survey. This section provides a copy of the survey instrument.

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

SURVEY INSTRUCTIONS

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

Yes **→If Yes, Go to Question 1**

No

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

You may notice a number on the cover of this survey. This number is ONLY used to let us know if you returned your survey so we don't have to send you reminders.

If you want to know more about this study, please call 1-800-914-2283.

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

1. Our records show that your child is now in Child Health Plan Plus. Is that right?

¹ Yes → If Yes, Go to Question 3

² No

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

YOUR CHILD'S HEALTH CARE IN THE LAST 6 MONTHS

These questions ask about your child's health care. Do 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?

¹ Yes

² No → If 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 you thought he or she needed?

¹ Never

² Sometimes

³ Usually

⁴ Always

5. In the last 6 months, not counting the times your child needed care right away, did you make any appointments for your child's health care at a doctor's office or clinic?

¹ Yes

² No → If No, Go to Question 7

6. In the last 6 months, **not** counting the times your child needed care right away, how often did you get an appointment for health care at a doctor's office or clinic as soon as you thought your child needed?

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

7. In the last 6 months, **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?

⁰ None →If None, Go to Question 13

- ¹ 1
- ² 2
- ³ 3
- ⁴ 4
- ⁵ 5 to 9
- ⁶ 10 or more

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

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

9. Choices for your child's treatment or health care can include choices about medicine, surgery, or other treatment. In the last 6 months, did your child's doctor or other health provider tell you there was more than one choice for your child's treatment or health care?

- ¹ Yes
- ² No →If No, Go to Question 12

10. In the last 6 months, did your child's doctor or other health provider talk with you about the pros and cons of each choice for your child's treatment or health care?

- ¹ Definitely yes
- ² Somewhat yes
- ³ Somewhat no
- ⁴ Definitely no

11. In the last 6 months, when there was more than one choice for your child's treatment or health care, did your child's doctor or other health provider ask you which choice you thought was best for your child?

- ¹ Definitely yes
- ² Somewhat yes
- ³ Somewhat no
- ⁴ Definitely no

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

- 0 Worst health care possible
- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10 Best health care possible

YOUR CHILD'S PERSONAL DOCTOR

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

Does your child have a personal doctor?

- Yes
- No → If No, Go to Question 25

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

None → If None, Go to Question 24

- 1
- 2
- 3
- 4
- 5 to 9
- 10 or more

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

- Never
- Sometimes
- Usually
- Always

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

- Never
- Sometimes
- Usually
- Always

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

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

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

- ¹ Yes
- ² No → If No, Go to Question 20

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

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

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

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

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

- ¹ Yes
- ² No

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

- ¹ Yes
- ² No → If No, Go to Question 24

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

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

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

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

GETTING HEALTH CARE FROM SPECIALISTS

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

25. Specialists are doctors like surgeons, heart doctors, allergy doctors, skin doctors, and other doctors who specialize in one area of health care. In the last 6 months, did you try to make any appointments for your child to see a specialist?

- ¹ Yes
² No → If No, Go to Question 29

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

- ¹ Never
² Sometimes
³ Usually
⁴ Always

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

- ⁰ None → If None, Go to Question 29
¹ 1 specialist
² 2
³ 3
⁴ 4
⁵ 5 or more specialists

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

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

YOUR CHILD'S HEALTH PLAN

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

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

- Yes
 No → If No, Go to Question 31

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

- Never
 Sometimes
 Usually
 Always

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

- Yes
 No → If No, Go to Question 34

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

- 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 → If No, Go to Question 36

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

- 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 Worst health plan possible
 1
 2
 3
 4
 5
 6
 7
 8
 9
 10 Best health plan possible

ABOUT YOUR CHILD AND YOU

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

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

38. What is your child's age?

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

39. Is your child male or female?

- ¹ Male
- ² Female

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

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

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

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

42. What is your age?

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

43. Are you male or female?

- ¹ Male
- ² Female

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

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

45. How are you related to the child?

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

46. Did someone help you complete this survey?

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

47. How did that person help you?

Check all that apply.

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

THANK YOU

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

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

CD Contents

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

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