

## HCPF-ACC Member Experience – Phase 2 Member Interviews

---

### Final Report

#### Introduction

This is the second of a three-phase project conducted by TriWest Group (TriWest) to help the Department of Health Care Policy and Financing (the Department) integrate information regarding member experiences of the Accountable Care Collaborative (ACC) program into overall evaluation efforts. The project was made possible through funds provided by The Colorado Health Foundation and the Rose Community Foundation.

Phase 1 was aimed at exploring the core components of successful care coordination. Please see the [ACC Care Coordination Dyad Interviews Report](#)<sup>1</sup> for those findings, which have, in part, informed the development of the effort described here.

Phase 2 of the project builds on findings from dyad interviews and discussions with key ACC stakeholders (the Disability Leadership Community, Person and Family Centeredness Advisory Committee, and the Program Improvement Advisory Committee). TriWest conducted telephone interviews lasting approximately 30 minutes with ACC members regarding their experiences, challenges, and successes in accessing and receiving health care. The purpose of these interviews was two-fold: 1) to inform larger ACC evaluation efforts and specifically add members' perspectives to evaluation findings, and 2) to develop potential member survey questions that can be used in ongoing evaluation efforts.

#### Methods

##### Sampling

TriWest used a stratified random sampling approach to identify potential interviewees, aiming for an overall sample size of 50 to 70 members.

A sample of 1,400 was randomly drawn in several groupings, thus “stratifying” the sample. This was done to ensure that the final sample contained sufficient numbers of members with specific key characteristics represented in the sample. The key characteristics used to determine the strata were:

- Living in a rural versus urban area,
- Spanish versus English as a first language, and
- Risk stratification (high risk or other risk).<sup>2</sup>

---

<sup>1</sup> This report can be accessed at <https://www.colorado.gov/pacific/hcpf/research-data-and-grants>

<sup>2</sup> Risk stratifications are based on 3M's Aggregate Clinical Risk Groups (ACRG4). In the data provided to TriWest by HCPF, members were divided into two risk levels: 1) “High-risk” which included ACRG4 categories 3, 6 and 7

The random sample included only members with a least one Health First Colorado (Colorado's Medicaid Program) claim in the past 12 months and included both adult and pediatric claims. The final sample was stratified into eight separate groups:

Group Description	Random Sample Size
Rural Area, Spanish, High Risk	75 <sup>3</sup>
Rural Area, Spanish, Other Risk	75
Urban Area, Spanish, High Risk	75
Urban Area, Spanish, Other Risk	75
Rural Area, English, High Risk	275
Rural Area, English, Other Risk	275
Urban Area, English, High Risk	275
Urban Area, English, Other Risk	275

## Interview Protocol

### Recruitment of Respondents

Following the sampling protocol described above, TriWest staff conducted 88 semi-structured interviews, each lasting approximately 20 to 30 minutes. Prior to calling potential respondents, a flyer was sent to all members not previously identified as Spanish speaking. The flyer informed them of the upcoming interview calls, explained the project, and provided a toll-free number to call with questions, request they not be contacted, or reach out actively to complete an interview. TriWest offered \$10 grocery store gift cards to members in appreciation for their time and participation.

### Conducting and Documenting

Several steps were taken to improve interviewer reliability. Interviewers were TriWest staff and independent consultants who have conducted TriWest interviews in the past. These interviewers were trained by project leads and met regularly during the interview process to refine question wording, timing, and potential follow up/probative questions, as well as to agree on consistent interview administration. Because of the length of the interviews and because they were conducted via telephone, interviewers were able to take adequate notes.

---

(Significant Acute, Dominant Chronic and Malignancies and Catastrophes) and, 2) "Other risk" which included ACRG4 categories 1, 2, 4 and 5 (Healthy and Non Users, Pregnancy/Delivery, Minor Chronic and Moderate Chronic).

<sup>3</sup> This number assumes an approximate 10% Spanish speaking population, and over-samples to account for a likely lower response rate.

The telephone calls were not recorded.

### Collection of Demographic Information

Consumers were asked a brief series of demographic questions at the conclusion of the interview. Demographic questions were limited to avoid inadvertent identification of the interview participants.

### Interviewee Characteristics

Member Characteristics	Number of Interviewees	Percent of all Respondents	Percent of ACC Population	Percent of Health First Colorado Population
<b>Total Number of Interviews</b>	<b>88</b>	<b>100%</b>		
<b>Geographic Areas</b>				
Rural	45	51%	15%	15%
Urban	43	49%	85%	85%
<b>Demographics</b>				
Female	47	53%	55%	56%
Male	41	47%	45%	44%
English Language <sup>4</sup>	50	74%	88%	87%
Spanish Language <sup>5</sup>	17	25%	11%	11%
Adult Patient	46	52%	47%	52%
Parent of Child Patient	42	48%	53%	48%
<b>Race and Ethnicity</b>				
African American	5	6%	7%	7%
Alaskan Native	0	--	--	--
Asian American	1	1%	3%	2%
Caucasian/White (Non-Hispanic)	37	42%	35%	35%
Hispanic	41	47%	31%	30%
Native American	1	1%	2%	2%
Native Hawaiian/Pacific Islander	0	--	--	--
Other or Unknown	2	2%	23%	24%

<sup>4</sup> Interviews were conducted in English although English may not have been the member's first or primary language.

<sup>5</sup> Interviews were conducted in Spanish. Members were previously identified as Spanish-speaking.

Member Characteristics	Number of Interviewees	Percent of all Respondents	Percent of ACC Population	Percent of Health First Colorado Population
<b>Total Number of Interviews</b>	<b>88</b>	<b>100%</b>		
<b>Health First Colorado Risk Stratification</b>				
High Risk	47	53%	16%	--
Other Risk	41	47%	84%	

Respondents were fairly evenly represented across the groups targeted by the sampling strategy, evenly divided across members living in rural versus urban areas of the state, and high risk versus other risk levels. For three quarters (75%) of members, English was their first language, compared to 25% for whom Spanish was their first language. The original study goal was to have at least 10% of interviews conducted with Spanish-speaking respondents. However, response rates for this population were much higher than expected.

The study population was designed (through random selection) to mirror that of the overall Accountable Care Collaborative population, with the exception of the purposeful stratification of the sample to ensure greater balance across geography (urban vs. rural), language, and risk level. There were some proportional race and ethnicity differences between the study population and the larger Accountable Care Collaborative population, largely due to a much smaller number of “other” or “unknown” responses in the survey population.

Interviewees were evenly divided between adult members and parents/guardians of child members. Most parents interviewed were biological parents, with four (5%) foster care parents, all of whom were providing kinship foster care (relatives cared for the children).

## Interview Findings

### Utilization of Services

The interview sample was drawn from members with at least one Health First Colorado (Colorado’s Medicaid program) claim in the past 12 months, and all respondents reported at least one visit to a healthcare provider in the past year. One person interviewed was no longer covered by Health First Colorado after losing coverage due to a change in employment.

Members reported most frequently seeking medical care from a primary care clinic and seeing a primary care medical provider (PCMP). However, four members did report that they had not been able to find a primary care provider that would accept new Medicaid patients. One additional member had recently lost her primary care provider (the doctor left the practice) and

had struggled to find a replacement. These members (without a current primary care provider) most often sought care in either an urgent care clinic or emergency department.

There was considerable variation in healthcare utilization reports across members. Just under half (40%) reported usually visiting a healthcare provider one to two times per year, with exceptions for sporadic illnesses or if they needed to see a specialist for a particular condition. One quarter (25%) reported seeking healthcare quarterly and 20 percent reported monthly visits to a healthcare provider. The remaining members (6%) either reported receiving care more often than monthly or did not answer the question. As would be expected, those members classified in a higher risk category by Health First Colorado tended to report more frequent utilization of healthcare services. Of those classified as "high risk", 33% reported monthly or more than monthly visits to healthcare providers compared to only 13% of those classified as "other risk" reporting monthly or more than monthly visits.. Utilization did not differ across rural or urban areas or for Spanish versus English speaking members.

In addition to reporting utilization of PCMPs, members also reported regular utilization of specialists, including dental providers, allergists, cardiologists, nephrologist, and surgeons. One rural member described challenges accessing specialists because of the need to travel long distances. Five members (6%) reported regular behavioral health visits in addition to primary care.

Reasons given for emergency department (ED) and urgent care use were all centered on accessibility of primary care. Members reported ED and urgent care visits most often when their PCMP clinic was closed. A few (15%) reported utilization because they could not get an appointment right away. However, those members generally reported being unable to get a same-day appointment leading to the decision to seek out an ED or urgent care clinic. Only one reported an ED visit after being offered a same day appointment.

There were four patients in the sample who reported current exclusive use of ED and urgent care facilities because they have been unable to find a local provider taking new Health First Colorado patients.

### **Overall Satisfaction with Healthcare**

Overall, most members interviewed (89%) expressed satisfaction with their current healthcare services. Nearly a third (32%) reported feeling "very satisfied." In particular, satisfied members reported that they like and trust their PCMP and they believe their health needs (or their child's health needs) are being addressed. Members praised the ability to get appointments quickly,

"I want to just say Medicaid has been fantastic. I have not had any problems. They have not given me a hard time. So I'm just very, very grateful."

with most reporting the ability for same-day appointments or clinics that accept walk-in patients.

Those members who reported not being satisfied with services identified difficulty in finding providers taking new Health First Colorado patients or finding a good quality provider locally. This was particularly true of members living in rural areas. One respondent pointed out that she felt that her status of “being on Medicaid” led to doctors making judgments about her and treating her differently than when she had private insurance. Several other respondents reported being unhappy with long waits in the clinic, even when arriving on time for an appointment.

Turnover within practices caused issues for a small number of members, who reported recently losing a well-liked doctor. More frequently, members were dissatisfied with large practices where a larger number of providers meant little consistency in which doctor they saw during each visit.

### **Barriers to Access and Suggested Program Improvements**

Across all members, the most common barrier to receiving quality healthcare was communication with providers, both inside and outside the exam room. Outside the exam room, members suggested better direct lines of communication with doctors, with some expressing frustration at being unable to reach a doctor directly with healthcare questions.

Some also suggested better communication with providers within the exam room. Members reported that, after waiting for long periods of time in the exam room, the provider did not spend enough time with them to have all of their questions answered. Parents, in particular, expressed a desire for more general information about their child’s development and ways to keep them healthy.

Spanish-speaking members universally reported access to a translator for appointments and did not see language issues as a communication barrier in the clinic. However, these members were more likely to report difficulty in understanding provider instructions and/or the benefits available to them, and often reported receiving mailed information in English that required a friend or family member to translate.

One person mentioned the difficulty in having to take time off work for a medical appointment and that it is a hardship to have to wait a long time (sometimes as much as an hour) in the waiting room or exam room when missing work.

Very few members in general discussed either satisfaction with or suggestions to improve pharmacy benefits. Although two members, both living in rural areas, reported their

pharmacies were prone to running out of the medications they take regularly, leading to long waits for prescription refills (up to two weeks) or requiring them to make frequent (and often long) trips to obtain refills for a smaller amount of medication.

Choosing a provider and finding the right provider were important factors in member satisfaction. Not all members were as concerned with the lack of options or no options, but recognized that they needed to do some work to find the right provider for them. As one member stated: “I am very satisfied, you know Medicaid is great. But I just need to do a better job of picking my doctors [sic], like research them before I go to see them.”

Across all interviewees, trust in their provider (and clinic staff as a whole) was strongly related to member satisfaction with care, to perceptions of efficacy in making healthcare decisions, and to the likelihood of follow medical directives. Patients who did not have good relationships with providers were less likely to follow medical advice and were more likely to report that their health had gotten worse or stayed the same (rather than improving) over the past year.

For one dissatisfied member, the perception of stigma of being on Health First Colorado was a significant factor.

“I’m not really happy, I would say dissatisfied. I think I am being judged because I have a daughter on Medicaid and they treat you like you are stupid because you are on a government subsidy. This is temporary for us because this is a transition time in our work life. My biggest challenge has been respect and the attitude from the medical staff. I would like the doctor [sic] to actually listen to what the mother says, it would be an improvement.”

Other members suggested better communication around benefits and eligibility. Some said that they received a significant amount of paperwork and that the need to reenroll can be confusing. Others reported simply not knowing enough about their benefits, including one respondent who was frustrated that Health First Colorado does not pay for urgent care.

Some rural members reported that travel could be a barrier to accessing services, particularly in finding specialty care. Some members said that one factor in not following up on referrals to specialists was the need to drive significant distances for an appointment.

### **Perceptions of the Healthcare Team**

Overall, members did not seem to think of their healthcare providers as working together as part of a team. When asked about the concept, the majority of members named only their PCMP. A smaller number (just under half of members) did also include nurses and other staff at their PCMP clinic as being on their “team.” However, without prompting, very few members

offered suggestions of other healthcare professionals that might also make up the team. Only four mentioned specialists, including behavioral health providers, and only one named their pharmacist. Three mentioned their dentist as being part of their team. A handful of respondents (11%) also included family members.

Nine members (10%) reported not feeling as though they have a healthcare team at all, even after a list of potential individuals was provided. This was either because they currently do not have a PCMP (five of the nine) or because they do not feel any level of engagement with their providers. As one member put it, “I think it is really just me, with some help from the RN. I don’t think the doctor [sic] is really all the way [sic] on the team.” This member also cited problems with his provider being very rushed during appointments and not having enough time to talk about all of his health concerns.

Interestingly, most respondents (62, 70%) did not initially name themselves to their healthcare team, although this seemed more a matter of automatically assuming that they were included rather than a belief that they did not play an active role in their health care. All but two members who reported having a healthcare team felt they were working together well. However, two did specifically state that while the “team” seemed to communicate well with each other, they did not always do so with the patient.

A total of six members (7%) reported either having a **care coordinator**, or described an individual (besides a family member) helping them to coordinate appointments, medications, referral follow-ups, etc. In three additional cases, individuals had case managers in other government agencies that also filled an informal role of healthcare coordinator (WIC and Colorado Coalition for the Homeless). None of the members with an identified care coordinator received services through a delegated provider.

“I like all the personal treatment. They are fair with everything. They treat me with respect. If I need a translator, they get one for me.”

Five of the six members with care coordinators reported being either “satisfied” or “very satisfied” with their healthcare. For the one member who reported being dissatisfied, the care coordinator had begun working with him recently and had attended some appointments with a provider with whom the member was having difficulty. Later in the interview, the respondent reported that things were getting better. Another member expressed some difficulties regarding responsiveness from a coordinator, believing that a large caseload made it hard for the coordinator to follow through with him.

## Factors in Decision Making

Overwhelmingly, members reported that trust in their providers was the most important factor in making decisions about their healthcare. When members felt that providers genuinely cared about their well-being (or their child's well being) and listened to their concerns, they were more likely to closely follow medical advice.

"I listen to what they are saying and if they are caring and concerned, then I pay attention and do [what they say to do]. But if they seem dismissive of me, I don't do it."

There was no variation in this finding across members in rural versus urban areas or in English versus Spanish-speaking members. Parents were more likely to report they take the lead in making decisions and often spoke in terms of advocacy for their children. One parent said, "I am an advocate for him. I make sure his issues are taken seriously."

Respondents who were specifically prompted about money as a factor in decision-making generally reported that it was not a factor and that Health First Colorado coverage insured they received necessary care without having to worry about cost.

"Medicaid has allowed me to take care of health issues I wouldn't be able to afford even if I were back at work."

Travel sometimes did play a factor in decisions, with some rural members reporting not always following up with specialists or not visiting the clinic as often as instructed because of either the distance needed to travel or a lack of available transportation when needed.

## Member Engagement and Empowerment

Members reported feeling as though they have a fair amount of control in making their own healthcare decisions or in making decisions on behalf of their children. Nearly all either emphatically stated, "I make decisions," or indicated that they, together with their provider, made healthcare decisions. The following are some examples of different ways that members characterized their role in healthcare decision-making:

- "I make decisions. But I listen to the doctor's advice."
- "I am my child's advocate. I make decisions to keep her healthy."
- "I like that my doctor gives me options of what I can do. I get to pick."
- "I would say both [the provider and I], we do it together. There are things I want to push for and then might back off. We're new, so she is trying to get to know us."
- "My doctors take the lead. I listen to them."

Six members described sharing in decision making with a spouse or other family member. This included two interviews that were conducted with children of elderly members who have taken

on a caregiver role. These adult children indicated they worked with their parents' providers to make decisions on their behalf.

## Improving Member Engagement

Health First Colorado participants were asked what would be helpful to them to stay or become more actively involved in their healthcare. Just over one-quarter (28%) of the 88 respondents offered suggestions for things they needed to either maintain or improve their current level of engagement in their healthcare. The low number of suggestions to improve is likely due to a combination of two factors: 1) most respondents were satisfied with the level of care received through Health First Colorado, and 2) members seemed reluctant to discuss any lack of engagement or active involvement in their own healthcare.

Seven general suggestions were provided:

- Five members said that they would like more or better information about medications or health conditions. Parents in particular expressed a desire to have more information about their child's overall health and things that can help them to stay healthy.
- Some expressed confusion around benefits available to them in Health First Colorado. Specifically, five members said that they would like more information about the benefits available to them.
- Five members said they do not have a care coordinator but either could benefit from one or said that they would like to see more and better communication across their healthcare team.
- Some members expressed frustration at being able to directly ask providers questions, either on the phone or by having more time to ask questions during an appointment, with three reporting that better and more direct communication with their providers would improve their engagement.
- Several members (3) said they wished providers listened to their input regarding their own healthcare needs or the needs of their child.
- Three members said they have been unable to find a provider and need further assistance.
- Three members expressed a desire for shorter wait times for both scheduling appointments and waiting to see a provider once they got to the clinic for their appointment.

## Summary and Recommendations for Next Steps

The members interviewed for this report reported, overall, being generally satisfied with their current health care. In particular, members tended to report good relationships with their providers and that they trusted the medical advice and directions received. Also, most respondents interviewed reported that the state of their health (or their child's health) had

either improved or stayed the same over the past year.

Two main areas of improvement were discussed: better access to providers and better communication with providers. Some members reported difficulty in finding a provider accepting new Health First Colorado members. Others reported difficulty in scheduling appointments in a timely manner, needing to wait too long until an appointment was available, and/or difficulty in getting a same day appointment for more urgent matters.

Members also reported wanting more and better communication with their providers. In some cases, members perceived providers being “rushed” during appointments, which prevented them from getting all questions or concerns addressed. Other members expressed a desire for more detailed information about their health conditions and about how to stay healthy and/or to keep their children healthy.

### **Next Steps**

The next step in this process is to work with stakeholders to design questions for a pilot Member Survey. Based on findings here, we have identified four main areas for survey questions:

1. Frequency and types of medical visits
2. Reasons for and frequency of ED and Urgent Care utilization
3. Gaps in access (particularly around specialty care)
4. Provider characteristics that foster a trusting relationship
5. Types of information and support that would increase member engagement in their health care

Appendix A of this document contains some sample questions, but additional questions will be developed in close consultation with the Department and with Health First Colorado stakeholders.

## Appendix A: Potential Survey Questions

### Recommendations for consumer survey

- How often do you see a Primary Care Provider (regular doctor)?
  - Less than once per year
  - 1-2 times per year
  - Once every 3 months
  - Once a month
  - More than once a month
- How often do you see a Specialist (allergist, cardiologist, nutritionist, psychiatrist, etc.)?
  - Less than once per year
  - 1-2 times per year
  - Once every 3 months
  - Once a month
  - More than once a month
- How often do you go to Urgent Care for services?
  - Less than once a year
  - 1-2 times per year
  - More than 1-2 times per year
- How often do you go to an Emergency Department for services?
  - Less than once a year
  - 1-2 times per year
  - More than 1-2 times per year
- When you go to an Urgent Care for services, why do you go there instead of your primary care office?
  - Primary care office is closed
  - Urgent Care is quicker
  - Urgent Care location is better for me
  - Urgent Care is less expensive
- When you go to an Emergency Department for services, why do you go there instead of your primary care office?
  - Primary care office is closed
  - Emergency Department is quicker
  - Emergency Department location is better for me
  - Emergency Department is less expensive