

2014 CHILD MEDICAID MEMBER SATISFACTION REPORT

February 2015

*This report was produced by Health Services Advisory Group, Inc. for the
New Hampshire Department of Health and Human Services.*



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1. Executive Summary

The State of New Hampshire requested administration of member satisfaction surveys to Medicaid members enrolled in New Hampshire Healthy Families Health Plan (NH Healthy Families) and Well Sense Health Plan (Well Sense). The New Hampshire Department of Health and Human Services (DHHS) contracted 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. It is important to note that in 2014 NH Healthy Families' and Well Sense's child Medicaid populations (i.e., child members enrolled in the two participating managed care organizations [MCOs]) were surveyed for the first time. The 2014 NH Healthy Families and Well Sense CAHPS results presented in the report represent a **baseline** assessment of parents'/caretakers' satisfaction with their child's NH Healthy Families and Well Sense health plan. Therefore, caution should be exercised when interpreting the results.

The standardized survey instrument selected was the CAHPS 5.0 Child Medicaid Health Plan Survey with the Healthcare Effectiveness Data and Information Set (HEDIS[®]) supplemental item set (without the children with chronic conditions [CCC] measurement set).¹⁻² The parents/caretakers of child members from the two MCOs completed the surveys from July to October 2014.

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

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

Performance Highlights

The Results Section of this report details the CAHPS results for NH Healthy Families, Well Sense, and the New Hampshire Medicaid Managed Care Program in aggregate (i.e., the two MCOs combined).

The following is a summary of the Child Medicaid CAHPS performance highlights. The performance highlights are categorized into four major types of analyses performed on the CAHPS data:

- ◆ National Committee for Quality Assurance (NCQA) Comparisons
- ◆ Plan Comparisons
- ◆ Priority Assignments
- ◆ Key Drivers of Satisfaction Priority Assignments

NCQA Comparisons

Three-point mean scores were calculated for each CAHPS global ratings (Rating of Health Plan, Rating of All Health Care, Rating of Personal Doctor, and Rating of Specialist Seen Most Often) and four composite measures (Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, and Customer Service) and compared to NCQA’s 2014 HEDIS Benchmarks were Thresholds for Accreditation three-point mean percentile distributions.^{1-3,1-4} The detailed results of this analysis are described in the Results Section beginning on page 2-6. Table 1-1 presents the list of measures that scored below the 50th percentile and at or above the 90th percentile for the New Hampshire Medicaid Managed Care Program and two MCOs.

Table 1-1 NCQA Comparisons Highlights		
NH Medicaid Program	NH Healthy Families Health Plan	Well Sense Health Plan
Below the 50th Percentile		
Rating of Health Plan	Rating of Health Plan	Rating of Health Plan
		Customer Service
		Rating of Specialist Seen Most Often
90th Percentile or Above		
Getting Care Quickly	Getting Care Quickly	How Well Doctors Communicate
How Well Doctors Communicate	Rating of All Health Care	Rating of Personal Doctor
Rating of Personal Doctor	Rating of Personal Doctor	

¹⁻³ National Committee for Quality Assurance. *HEDIS Benchmarks and Thresholds for Accreditation 2014*. Washington, DC: NCQA, January 30, 2014.

¹⁻⁴ NCQA does not publish benchmarks and thresholds for the Shared Decision Making composite measure, and Coordination of Care and Health Promotion and Education individual item measures; therefore, comparisons could not be performed for these CAHPS measures.

Plan Comparisons

In order to identify performance differences in member satisfaction between NH Health Families and Well Sense, case-mix adjusted results for each were compared to one another using standard statistical tests.¹⁻⁵ The results were case-mix adjusted for member general health status, respondent education level, and respondent age. These comparisons were performed on the four global ratings, five composite measures, and two individual item measures. The detailed results of the comparative analysis are described in the Results Section beginning on page 2-21.¹⁻⁶

The results of this comparative analysis revealed that NH Healthy Families and Well Sense did not score statistically better or worse than the comparative plan on any of the CAHPS measures.

Priority Assignments

The CAHPS 5.0 Child Medicaid Health Plan Survey analytic results were used to identify priority areas for quality improvement (QI) for the New Hampshire Medicaid Managed Care Program (i.e., the two MCOs combined). These priority areas are described in the Recommendations Section of this report beginning on page 3-2. The following are the priority areas identified for the New Hampshire Medicaid Managed Care Program:

- ◆ Rating of Health Plan
- ◆ Customer Service
- ◆ Getting Needed Care

¹⁻⁵ CAHPS results are known to vary due to differences in respondent age, respondent education level, and member health status. Therefore, the results were case-mix adjusted for differences in these demographic variables.

¹⁻⁶ Caution should be exercised when evaluating the statewide comparisons, given that the MCO differences may impact results.

Key Drivers of Satisfaction

Based on a comprehensive assessment of the New Hampshire Medicaid Managed Care Program CAHPS results, three potential priority areas for QI were identified: Rating of Health Plan, Customer Service, and Getting Needed Care. HSAG evaluated each of these areas to determine if particular CAHPS items (i.e., questions) strongly correlated with each priority area, which HSAG refers to as “key drivers.” Given that these individual items are driving members’ level of satisfaction with each of the priority areas, DHHS should consider determining whether or not potential QI activities could improve member satisfaction on each of the key drivers identified. Table 1-2 depicts the individual key drivers DHHS should consider focusing on for each of the three potential priority areas for QI. These key drivers are described in the Recommendations Section of this report beginning on page 3-3.

Table 1-2 Key Drivers of Satisfaction	
Rating of Health Plan	
	Respondents reported that when their child did not need care right away, they did not obtain an appointment for health care as soon as they thought they needed.
	Respondents reported that when they talked about their child starting or stopping a prescription medicine, a doctor or other health provider did not talk about the reasons they might not want their child to take a medicine.
	Respondents reported that their child’s personal doctor did not always seem informed and up-to-date about the care their child received from other doctors or health providers.
	Respondents reported that their child’s health plan’s customer service did not always give them the information or help they needed.
	Respondents reported that forms from their child’s health plan were often not easy to fill out.
Customer Service	
	Respondents reported that their child’s health plan’s customer service did not always give them the information or help they needed.
Getting Needed Care	
	Respondents reported that it was often not easy for their child to obtain appointments with specialists.

The following section presents the CAHPS results for NH Healthy Families, Well Sense, and the New Hampshire Medicaid Managed Care Program in aggregate (i.e., combined results for the two MCOs).

Survey Administration and Response Rates

Survey Administration

The standard NCQA HEDIS Specifications for Survey Measures require a sample size of 1,650 members for the CAHPS 5.0 Child Medicaid Health Plan Survey.²⁻¹ Members eligible for sampling included those who were enrolled in NH Healthy Families and Well Sense at the time the sample was drawn and who were continuously enrolled for at least five of the last six months of the measurement period (November 2013 through April 2014). Child members eligible for sampling included those who were 17 years of age or younger as of April 30, 2014.

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. All sampled members received an English version of the survey. A reminder postcard was sent to all non-respondents, followed by a second survey mailing and reminder postcard. The second phase, or telephone phase, consisted of Computer Assisted Telephone Interviewing (CATI) for sampled members who had not mailed in a completed survey. A maximum of three CATI calls was made to each non-respondent. Additional information on the survey protocol is included in the Reader's Guide Section beginning on page 4-3.

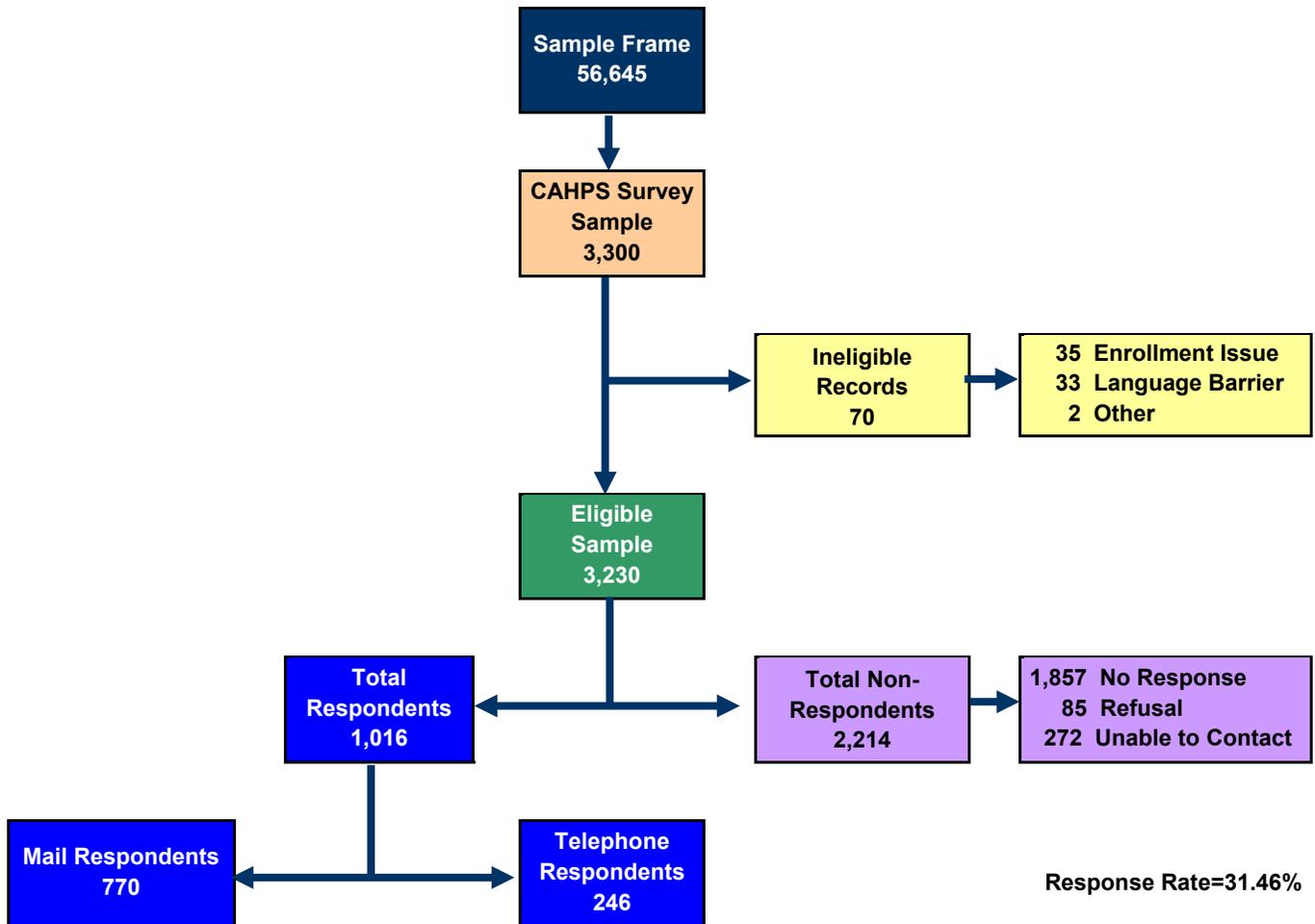
Response Rates

The New Hampshire CAHPS 5.0 Child Medicaid Health Plan Survey administration was designed to achieve the highest possible response rate. The CAHPS Survey response rate is the total number of completed surveys divided by all eligible members of the sample. A survey was assigned a disposition code of "completed" if at least one question was answered. Eligible members included the entire random sample 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.

²⁻¹ National Committee for Quality Assurance. *HEDIS® 2014, Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA Publication, 2013.

A total of 1,016 completed surveys were returned on behalf of New Hampshire Medicaid Managed Care child members, including 525 NH Healthy Families and 491 Well Sense members. These completed surveys were used to calculate the New Hampshire Medicaid Managed Care Program results presented throughout this report. Figure 2-1 shows the distribution of survey dispositions and response rates for the New Hampshire Medicaid Managed Care Program.

Figure 2-1—Distribution of Surveys for New Hampshire Medicaid Managed Care Program (NH Healthy Families and Well Sense Combined)



The 2014 New Hampshire Child Medicaid Managed Care Program total response rate of 31.5 percent was 3.8 percentage points above the national child Medicaid response rate reported by NCQA for 2014, which was 27.7 percent.²⁻²

²⁻² National Committee for Quality Assurance. *HEDIS 2015 Survey Vendor Update Training*. October 23, 2014.

Table 2-1 depicts the sample distribution and response rates for the two MCOs and the statewide program aggregate.

Table 2-1 Sample Distribution and Response Rate					
Plan Name	Total Sample	Ineligible Records	Eligible Sample	Total Respondents	Response Rate
NH Medicaid Managed Care Program	3,300	70	3,230	1,016	31.46%
NH Healthy Families Health Plan	1,650	39	1,611	525	32.59%
Well Sense Health Plan	1,650	31	1,619	491	30.33%

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.²⁻³

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

Table 2-2 Child Demographics Age, Gender, Race/Ethnicity, and General Health Status			
	NH Medicaid Managed Care Program	NH Healthy Families Health Plan	Well Sense Health Plan
Age			
Less than 1	1.0%	0.8%	1.3%
1 to 3	15.0%	11.4%	19.0%
4 to 7	21.2%	17.8%	24.8%
8 to 12	31.0%	31.6%	30.4%
13 to 18*	31.7%	38.4%	24.6%
Gender			
Male	50.4%	51.7%	49.0%
Female	49.6%	48.3%	51.0%
Race/Ethnicity			
Multi-Racial	7.8%	6.9%	8.8%
White	83.6%	82.5%	84.9%
Black	1.8%	1.8%	1.7%
Asian	3.3%	3.8%	2.8%
Native American	0.1%	0.2%	0.0%
Other	3.3%	4.8%	1.7%
General Health Status			
Excellent	48.4%	47.3%	49.6%
Very Good	36.6%	35.6%	37.6%
Good	13.0%	14.7%	11.2%
Fair	1.9%	2.0%	1.7%
Poor	0.2%	0.4%	0.0%
<i>Please note: Percentages may not total 100% due to rounding.</i>			
<i>*Children are eligible for inclusion in the CAHPS survey if they are age 17 or younger as of April 30, 2014. Some children eligible for the CAHPS survey turned 18 between May 1, 2014 and the time of the survey administration.</i>			

²⁻³ Agency for Healthcare Research and Quality. *CAHPS Health Plan Survey and Reporting Kit 2008*. Rockville, MD: US Department of Health and Human Services, July 2008.

Table 2-3 depicts the self-reported age, level of education, and relationship to the child for the respondents who completed the CAHPS 5.0 Child Medicaid Health Plan Survey.

Table 2-3 Respondent Demographics Age, Education, and Relationship to Child			
	NH Medicaid Managed Care Program	NH Healthy Families Health Plan	Well Sense Health Plan
Age			
Under 18	5.9%	5.0%	6.9%
18 to 24	3.5%	2.6%	4.5%
25 to 34	28.8%	23.3%	34.6%
35 to 44	36.0%	39.6%	32.2%
45 to 54	18.9%	20.9%	16.6%
55 to 64	5.6%	7.4%	3.7%
65 or Older	1.3%	1.0%	1.5%
Education			
8th Grade or Less	0.9%	1.4%	0.4%
Some High School	6.5%	5.5%	7.6%
High School Graduate	32.4%	33.1%	31.7%
Some College	40.6%	40.6%	40.6%
College Graduate	19.6%	19.5%	19.7%
Relationship to Child			
Mother or Father	94.1%	93.8%	94.4%
Grandparent	3.5%	4.1%	2.9%
Other Relationship	1.4%	1.6%	1.1%
Legal Guardian	1.0%	0.4%	1.6%
<i>Please note: Percentages may not total 100% due to rounding.</i>			

NCQA Comparisons

In order to assess the overall performance of the New Hampshire Medicaid Managed Care Program, NH Healthy Families, and Well Sense, the four CAHPS global ratings and four CAHPS composite measures were scored on a three-point scale using the scoring methodology detailed in NCQA’s HEDIS Specifications for Survey Measures.²⁻⁴ The resulting three-point mean scores were compared to NCQA’s HEDIS Benchmarks and Thresholds for Accreditation three-point means for the 50th and 90th percentiles.²⁻⁵

Table 2-4 shows the three-point mean scores and NCQA national benchmarks and thresholds for the 50th and 90th percentiles on each of the four global ratings.

Table 2-4 NCQA Comparisons—Global Ratings				
Plan Name	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often
NH Medicaid Managed Care Program	2.412	2.573	2.708	2.614
NH Healthy Families Health Plan	2.402	2.594	2.717	2.655
Well Sense Health Plan	2.423	2.552	2.697	2.575
NCQA Benchmarks and Thresholds				
50th percentile	2.57	2.52	2.62	2.59
90th percentile	2.67	2.59	2.69	2.66

²⁻⁴ National Committee for Quality Assurance. *HEDIS® 2014, Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA Publication, 2013.

²⁻⁵ National Committee for Quality Assurance. *HEDIS Benchmarks and Thresholds for Accreditation 2014*. Washington, DC: NCQA, January 30, 2014.

Table 2-5 shows the three-point mean scores and NCQA national benchmarks and thresholds for the 50th and 90th percentiles for the four composite measures.²⁻⁶

Table 2-5 NCQA Comparisons—Composite Measures				
Plan Name	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service
NH Medicaid Managed Care Program	2.508	2.710	2.770	2.551
NH Healthy Families Health Plan	2.501	2.735	2.741	2.593
Well Sense Health Plan	2.514	2.684	2.802	2.510
NCQA Benchmarks and Thresholds				
50th percentile	2.46	2.61	2.68	2.53
90th percentile	2.57	2.69	2.75	2.63

NCQA does not provide benchmarks and thresholds for the Shared Decision Making composite measure, and Coordination of Care and Health Promotion and Education individual measures; therefore, comparisons could not be performed for these CAHPS measures.

²⁻⁶ National Committee for Quality Assurance. *HEDIS Benchmarks and Thresholds for Accreditation 2014*. Washington, DC: NCQA, January 30, 2014.

Summary of NCQA Comparisons Results

The following table summarizes the measures that were below the 50th percentile and at or above the 90th percentile.

Table 2-6 NCQA Comparisons Highlights		
NH Medicaid Program	NH Healthy Families Health Plan	Well Sense Health Plan
Below the 50th Percentile		
Rating of Health Plan	Rating of Health Plan	Rating of Health Plan
		Customer Service
		Rating of Specialist Seen Most Often
90th Percentile or Above		
Getting Care Quickly	Getting Care Quickly	How Well Doctors Communicate
How Well Doctors Communicate	Rating of All Health Care	Rating of Personal Doctor
Rating of Personal Doctor	Rating of Personal Doctor	

Rates and Proportions

For purposes of calculating the results, 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.²⁻⁷ 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 2014 Specifications for Survey Measures, Volume 3*.

The New Hampshire Medicaid Managed Care Program results were weighted. The results were weighted based on the total eligible population for each MCO's (i.e., NH Healthy Families' and Well Sense's) child population. The 2013 NCQA national data for the 90th and 50th percentiles are also presented for comparison. CAHPS scores with fewer than 100 respondents are denoted with a cross (+). Caution should be exercised when interpreting results for those measures with fewer than 100 respondents.

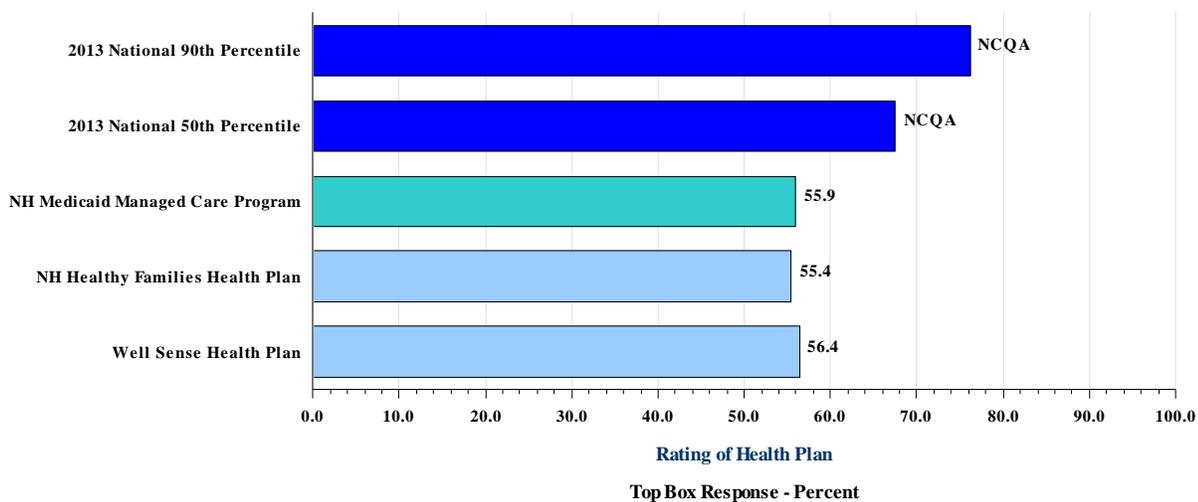
²⁻⁷ National Committee for Quality Assurance. *HEDIS® 2014, Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA Publication, 2013.

Global Ratings

Rating of Health Plan

Parents/caretakers of child members were asked to rate their child’s health plan on a scale of 0 to 10, with 0 being the “worst health plan possible” and 10 being the “best health plan possible.” Top-level responses were defined as those responses with a rating of 9 or 10. Figure 2-2 shows the 2013 NCQA national data for the 90th and 50th percentiles, and the 2014 Rating of Health Plan question summary rates for NH Healthy Families, Well Sense, and the New Hampshire Medicaid Managed Care Program.^{2-8,2-9,2-10}

Figure 2-2—Rating of Health Plan



²⁻⁸ The 2014 NH Medicaid Managed Care Program scores presented in this section are derived from the combined results of the two participating MCOs: NH Healthy Families and Well Sense.

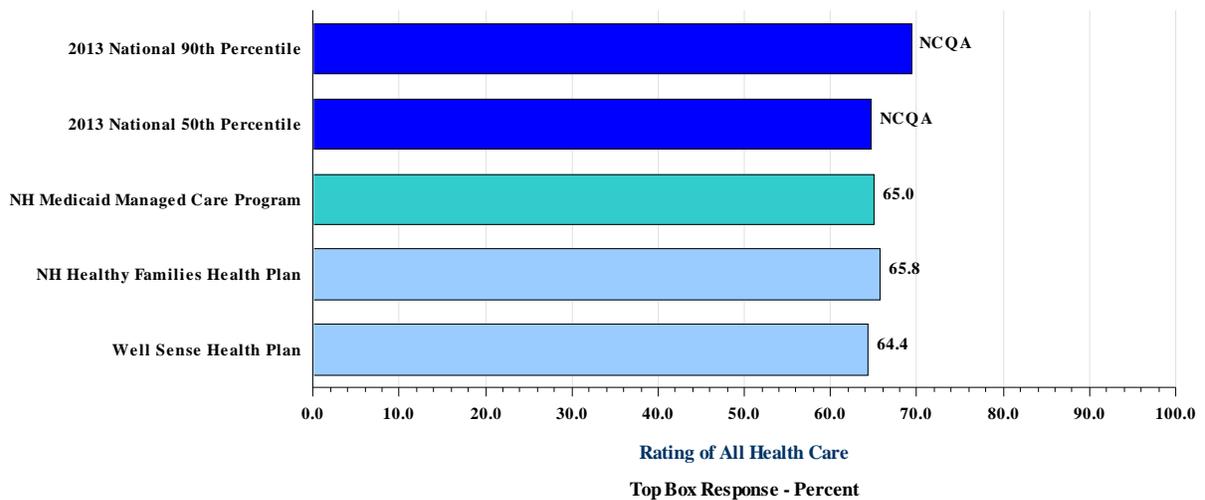
²⁻⁹ NCQA national data were not available for 2014 at the time this report was prepared; therefore, 2013 NCQA national data are presented in this section.

²⁻¹⁰ The source for the NCQA national data contained in this publication is Quality Compass[®] 2013 data and is used with the permission of the National Committee for Quality Assurance (NCQA). Quality Compass 2013 includes certain CAHPS data. Any data display, analysis, interpretation, or conclusion based on these data is solely that of the authors, and NCQA specifically disclaims responsibility for any such display, analysis, interpretation, or conclusion. Quality Compass[®] is a registered trademark of NCQA. CAHPS[®] is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Rating of All Health Care

Parents/caretakers of child members were asked to rate all of their child’s health care on a scale of 0 to 10, with 0 being the “worst health care possible” and 10 being the “best health care possible.” Top-level responses were defined as those responses with a rating of 9 or 10. Figure 2-3 shows the 2013 NCQA national data for the 90th and 50th percentiles, and the 2014 Rating of All Health Care question summary rates for NH Healthy Families, Well Sense, and the New Hampshire Medicaid Managed Care Program.

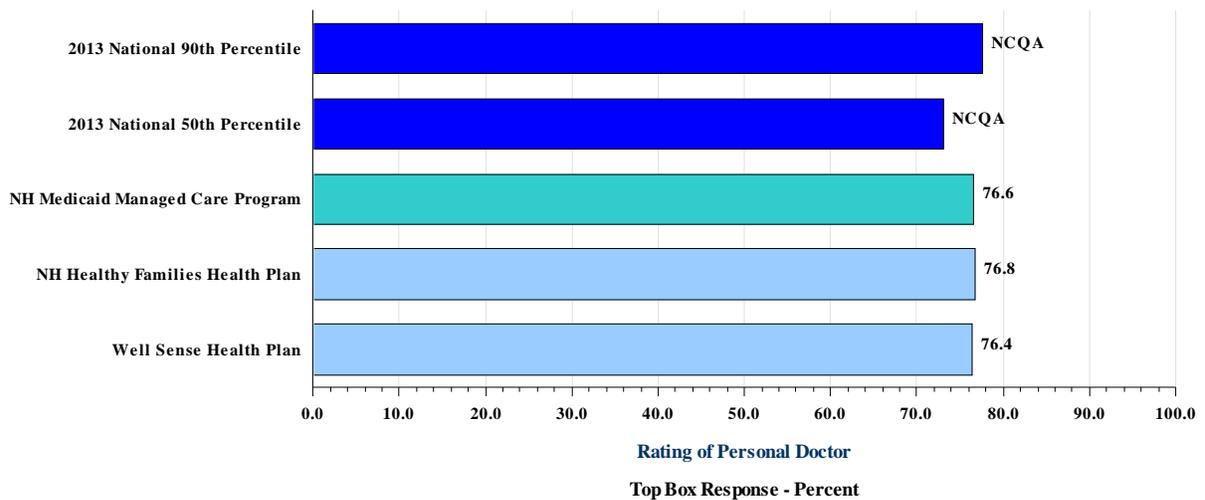
Figure 2-3—Rating of All Health Care



Rating of Personal Doctor

Parents/caretakers of child members were asked to rate their child’s personal doctor on a scale of 0 to 10, with 0 being the “worst personal doctor possible” and 10 being the “best personal doctor possible.” Top-level responses were defined as those responses with a rating of 9 or 10. Figure 2-4 shows the 2013 NCQA national data for the 90th and 50th percentiles, and the 2014 Rating of Personal Doctor question summary rates for NH Healthy Families, Well Sense, and the New Hampshire Medicaid Managed Care Program.

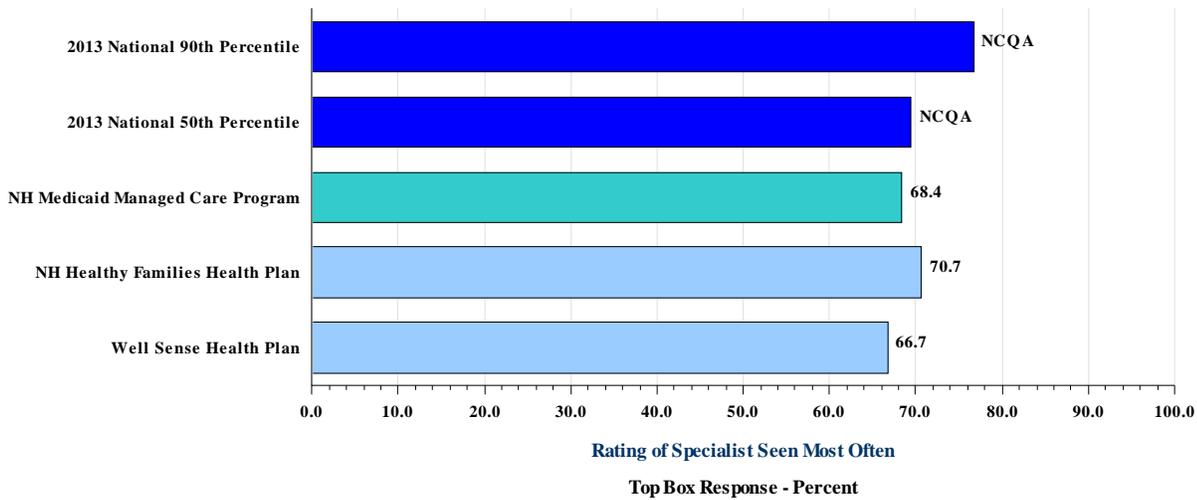
Figure 2-4—Rating of Personal Doctor



Rating of Specialist Seen Most Often

Parents/caretakers of child members were asked to rate the specialist their child saw most often on a scale of 0 to 10, with 0 being the “worst specialist possible” and 10 being the “best specialist possible.” Top-level responses were defined as those responses with a rating of 9 or 10. Figure 2-5 shows the 2013 NCQA national data for the 90th and 50th percentiles, and the 2014 Rating of Specialist Seen Most Often question summary rates for NH Healthy Families, Well Sense, and the New Hampshire Medicaid Managed Care Program.

Figure 2-5—Rating of Specialist Seen Most Often

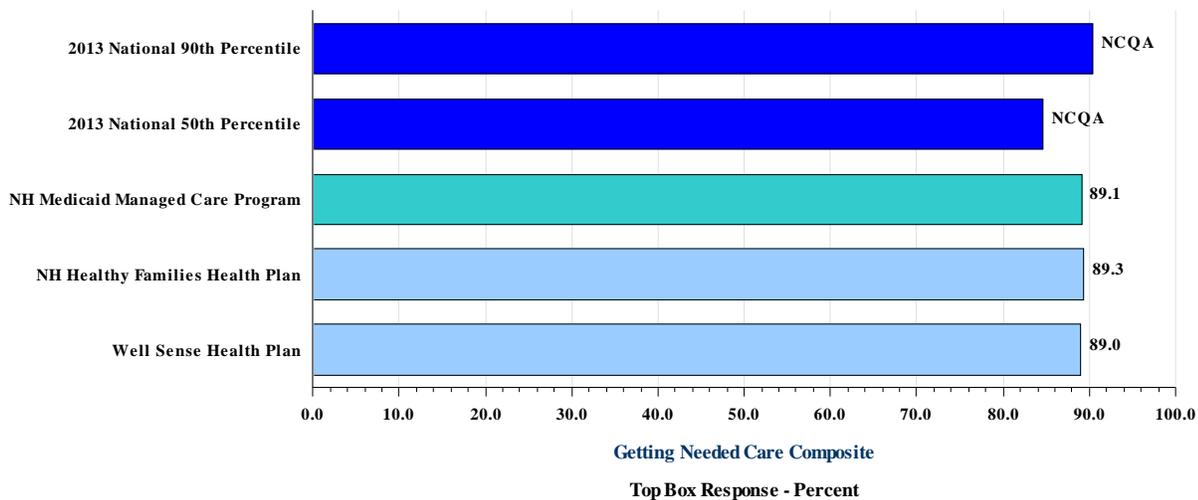


Composite Measures

Getting Needed Care

Parents/caretakers of child members were asked two questions to assess how often it was easy to get needed care for their child. For each of these questions (Questions 14 and 28), a top-level response was defined as a response of “Usually” or “Always.” Figure 2-6 shows the 2013 NCQA national data for the 90th and 50th percentiles, and the 2014 Getting Needed Care global proportions for NH Healthy Families, Well Sense, and the New Hampshire Medicaid Managed Care Program.

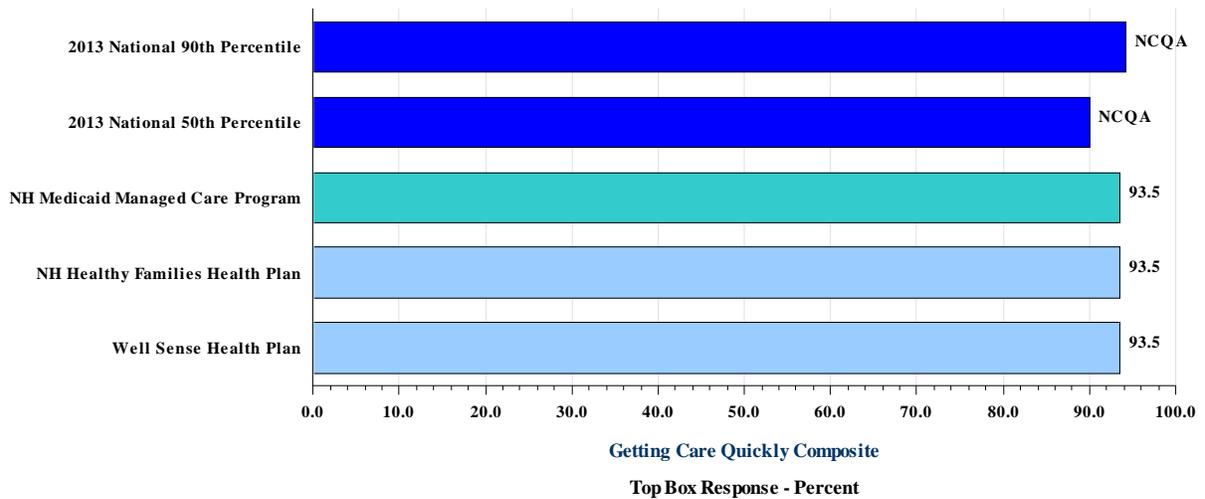
Figure 2-6—Getting Needed Care



Getting Care Quickly

Parents/caretakers of child members were asked two questions to assess how often their child received care quickly. For each of these questions (Questions 4 and 6), a top-level response was defined as a response of “Usually” or “Always.” Figure 2-7 shows the 2013 NCQA national data for the 90th and 50th percentiles, and the 2014 Getting Care Quickly global proportions for NH Healthy Families, Well Sense, and the New Hampshire Medicaid Managed Care Program.

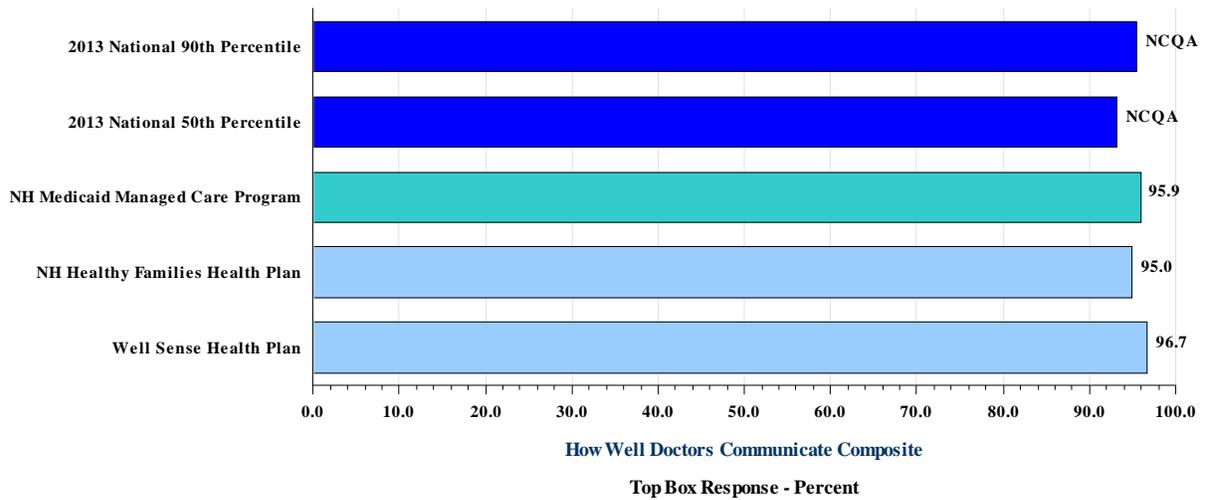
Figure 2-7—Getting Care Quickly



How Well Doctors Communicate

Parents/caretakers of child members were asked four questions to assess how often their child’s doctors communicated well. For each of these questions (Questions 17, 18, 19, and 22), a top-level response was defined as a response of “Usually” or “Always.” Figure 2-8 shows the 2013 NCQA national data for the 90th and 50th percentiles, and the 2014 How Well Doctors Communicate global proportions for NH Healthy Families, Well Sense, and the New Hampshire Medicaid Managed Care Program.

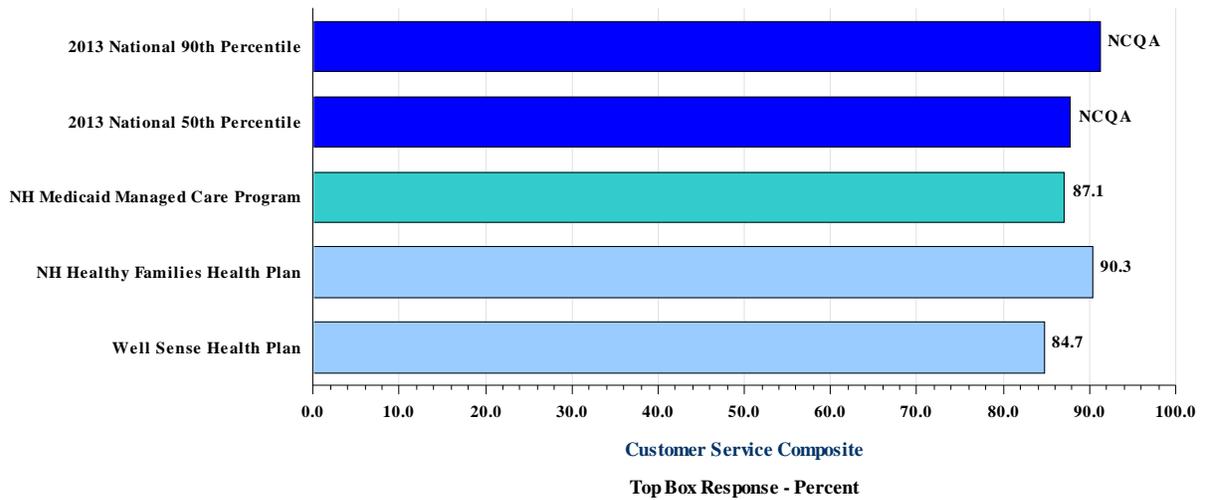
Figure 2-8—How Well Doctors Communicate



Customer Service

Parents/caretakers of child members were asked two questions to assess how often they were satisfied with their child’s MCO’s customer service. For each of these questions (Questions 32 and 33), a top-level response was defined as a response of “Usually” or “Always.” Figure 2-9 shows the 2013 NCQA national data for the 90th and 50th percentiles, and the 2014 Customer Service global proportions for NH Healthy Families, Well Sense, and the New Hampshire Medicaid Managed Care Program.

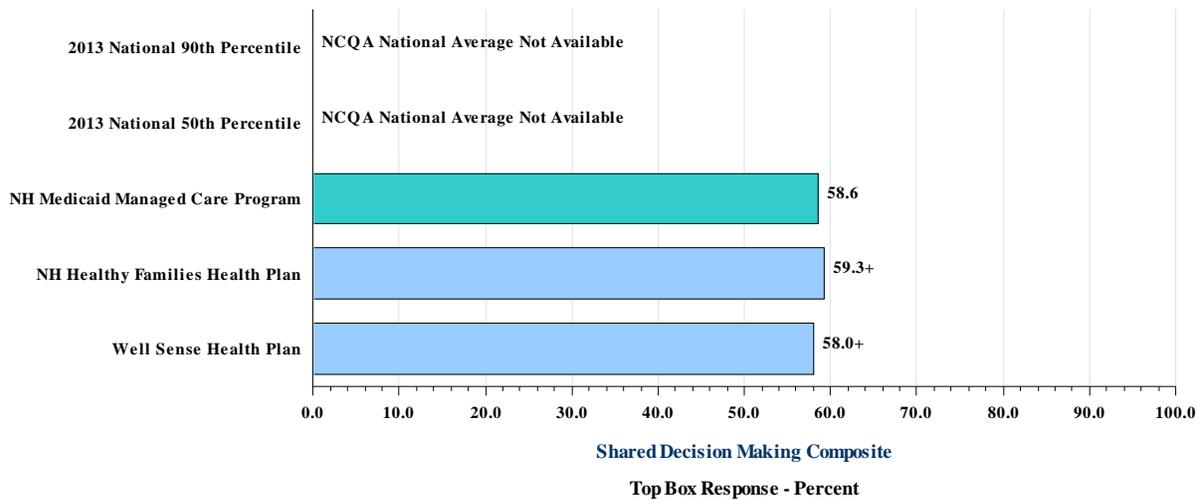
Figure 2-9—Customer Service



Shared Decision Making

Parents/caretakers of child members were asked three questions to assess if their child’s doctors involved them in decision making when discussing starting or stopping a prescription medication. For each of these questions (Questions 10, 11, and 12), a top-level response was defined as a response of “A lot” or “Yes.” Figure 2-10 shows the 2014 Shared Decision Making global proportions for NH Healthy Families, Well Sense, and the New Hampshire Medicaid Managed Care Program.²⁻¹¹

Figure 2-10—Shared Decision Making



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

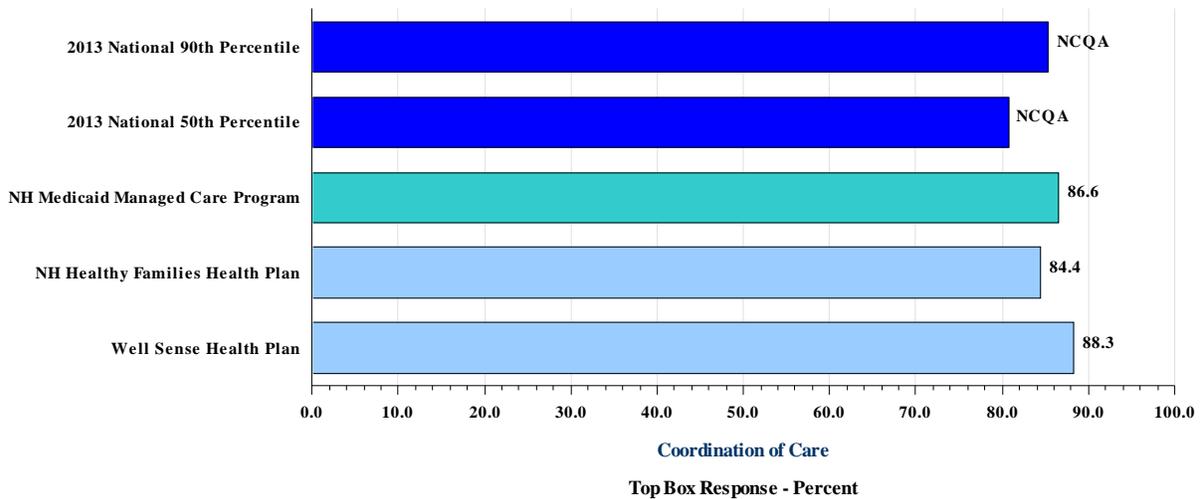
²⁻¹¹ As a result of the transition to the CAHPS 5.0 Child Medicaid Health Plan Survey and changes to the Shared Decision Making composite measure, 2013 NCQA national data are not available for this CAHPS measure.

Individual Item Measures

Coordination of Care

Parents/caretakers of child members were asked a question to assess how often their child’s personal doctor seemed informed and up-to-date about care their child had received from another doctor. For this question (Question 25), a top-level response was defined as a response of “Usually” or “Always.” Figure 2-11 shows the 2013 NCQA national data for the 90th and 50th percentiles, and the 2014 Coordination of Care question summary rates for NH Healthy Families, Well Sense, and the New Hampshire Medicaid Managed Care Program.

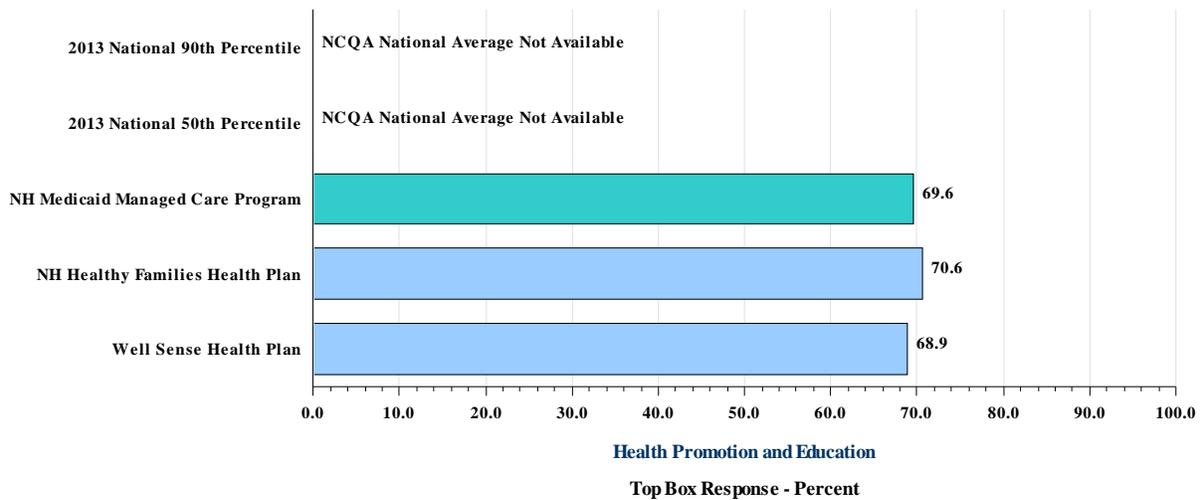
Figure 2-11—Coordination of Care



Health Promotion and Education

Parents/caretakers of child members were asked a question to assess if their child’s doctor talked with them about specific things they could do to prevent illness in their child. For this question (Question 8), a top-level response was defined as a response of “Yes.” Figure 2-12 shows the 2014 Health Promotion and Education question summary rates for NH Healthy Families, Well Sense, and the New Hampshire Medicaid Managed Care Program.²⁻¹²

Figure 2-12—Health Promotion and Education



²⁻¹² As a result of the transition to the CAHPS 5.0 Child Medicaid Health Plan Survey and changes to the Health Promotion and Education individual item measure, 2013 NCQA national data are not available for this CAHPS measure.

Plan Comparisons

In order to identify performance differences in member satisfaction between the two participating MCOs, the results of each were compared to one another using standard tests for statistical significance.²⁻¹³ For purposes of this comparison, results were case-mix adjusted. Case-mix refers to the characteristics of respondents used in adjusting the results for comparability among the MCOs. Results were case-mix adjusted for member general health status, respondent-educational level, and respondent age.²⁻¹⁴ Given that differences in case-mix can result in differences in ratings between the two MCOs 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). For additional information, please refer to the Reader's Guide Section beginning on page 4-8.

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 2014 Specifications for Survey Measures, Volume 3*.

Statistically significant differences are noted in the tables by arrows. If the plan performed statistically *better* than the comparative plan, this is denoted with an upward (↑) arrow. Conversely, if the plan performed statistically *worse* than the comparative plan, this is denoted with a downward (↓) arrow. If the plans' scores are not statistically different, this is denoted with a horizontal (↔) arrow.

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

²⁻¹³ Caution should be exercised when evaluating the plan comparisons, given that the MCOs' differences may impact CAHPS results.

²⁻¹⁴ Agency for Healthcare Research and Quality. *CAHPS Health Plan Survey and Reporting Kit 2008*. Rockville, MD: US Department of Health and Human Services, July 2008.

Table 2-7 Plan Comparisons		
	NH Healthy Families Health Plan	Well Sense Health Plan
Global Rating		
Rating of Health Plan	55.4% ↔	56.3% ↔
Rating of All Health Care	65.3% ↔	64.9% ↔
Rating of Personal Doctor	76.6% ↔	76.6% ↔
Rating of Specialist Seen Most Often	71.2% ↔	66.2% ↔
Composite Measure		
Getting Needed Care	89.3% ↔	89.0% ↔
Getting Care Quickly	93.6% ↔	93.4% ↔
How Well Doctors Communicate	94.9% ↔	96.8% ↔
Customer Service	90.2% ↔	84.7% ↔
Shared Decision Making	59.3% ⁺ ↔	58.1% ⁺ ↔
Individual Item Measure		
Coordination of Care	84.7% ↔	88.1% ↔
Health Promotion and Education	70.6% ↔	68.9% ↔
<p>↑ Indicates the plan's score is statistically better than the comparative plan. ↔ Indicates the plan's score is not statistically different than the comparative plan. ↓ Indicates the plan's score is statistically worse than the comparative plan.</p> <p>Please note: Scores with fewer than 100 respondents are denoted with a cross (+). If there are fewer than 100 respondents for a measure, caution should be exercised when interpreting the results.</p>		

Summary of Plan Comparisons Results

The Plan Comparisons revealed that there were no statistically significant differences between NH Healthy Families' and Well Sense's scores on any of the CAHPS measures.

Supplemental Items

DHHS elected to add six supplemental items to the standard CAHPS 5.0 Child Medicaid Health Plan Survey. Table 2-8 details the survey language and response options for each of the supplemental items. Table 2-9 through Table 2-14 show the results for each supplemental item. For these supplemental items, the number and percentage of responses for each item are presented for NH Healthy Families and Well Sense.

Table 2-8 Supplemental Items		
Question		Response Options
Q25a.	In the last 6 months, did anyone from your child’s health plan, doctor’s office, or clinic help coordinate your child’s care among these doctors or other health providers?	Yes No
Q25b.	In the last 6 months, who helped to coordinate your child’s care? Mark one or more.	Someone from your child’s health plan Someone from your child’s doctor’s office or clinic Someone from another organization A friend or family member You
Q25c.	How satisfied are you with the help you received to coordinate your child’s care in the last 6 months?	Very dissatisfied Dissatisfied Neither dissatisfied nor satisfied Satisfied Very satisfied
Q32a.	Were any of the following a reason you did not get the information or help you needed from customer service at your child’s health plan? Mark one or more.	You had to call several times before you could speak with someone The information customer service gave you was not correct Customer service did not have the information you needed You waited too long for someone to call you back No one called you back Some other reason

Table 2-8 Supplemental Items	
Question	Response Options
Q36a. Some health plans help with transportation for your child to get to doctors' offices or clinics. This help can be a shuttle bus, tokens or vouchers for a bus or taxi, or payments for mileage. In the last 6 months, did you phone your child's health plan to get help with transportation for your child?	Yes No
Q36b. In the last 6 months, when you phoned your child's health plan to get help with transportation, how often did you get it?	Never Sometimes Usually Always

Care Coordination Among Doctors or Other Health Providers

Parents/caretakers of child members were asked if anyone from their child’s health plan, personal doctor’s office, or clinic helped coordinate their child’s care among doctors or other health providers (Question 25a). Table 2-9 displays the responses for this question.

Table 2-9 Received Help Coordinating Care Among Doctors or Other Health Providers				
Plan Name	Yes		No	
	N	%	N	%
NH Healthy Families Health Plan	75	57.3%	56	42.7%
Well Sense Health Plan	77	53.5%	67	46.5%

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

Parents/caretakers of child members were asked who helped coordinate their child’s care among these doctors or other health providers (Question 25b). Table 2-10 displays the responses for this question.

Table 2-10 Who Helped Coordinate Care		
Response/Plan Name	Yes	
Someone from their Child’s Health Plan	N	%
NH Healthy Families Health Plan	15	10.9%
Well Sense Health Plan	14	11.1%
Someone from their Child’s Doctor’s Office or Clinic	N	%
NH Healthy Families Health Plan	66	48.2%
Well Sense Health Plan	61	48.4%
Someone from Another Organization	N	%
NH Healthy Families Health Plan	8	5.8%
Well Sense Health Plan	7	5.6%
A Friend or Family Member	N	%
NH Healthy Families Health Plan	10	7.3%
Well Sense Health Plan	11	8.7%
You (i.e., Parent/Caretaker)	N	%
NH Healthy Families Health Plan	40	29.2%
Well Sense Health Plan	43	34.1%

Please note: Respondents may have marked more than one response option; therefore, percentages will not total 100%.

Parents/caretakers of child members were asked how satisfied they were with the help they received to coordinate their child’s care among doctors or other health providers in the last 6 months (Question 25c). Table 2-11 displays the responses for this question.

Table 2-11 Satisfied with Help Coordinating Care										
Plan Name	Very dissatisfied		Dissatisfied		Neutral		Satisfied		Very satisfied	
	N	%	N	%	N	%	N	%	N	%
NH Healthy Families Health Plan	1	1.4%	2	2.7%	1	1.4%	25	33.8%	45	60.8%
Well Sense Health Plan	2	2.7%	0	0.0%	2	2.7%	30	40.0%	41	54.7%

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

Access to Customer Service

Parents/caretakers of child members were asked about the reason(s) they did not get the information or help needed from customer service at their child’s health plan (Question 32a). Table 2-12 displays the responses for this question.¹⁵

Table 2-12 Access to Customer Service		
Response/Plan Name	Yes	
Respondent Had to Call Several Times Before Speaking with Someone	N	%
NH Healthy Families Health Plan	16	21.1%
Well Sense Health Plan	9	10.5%
Information Customer Service Gave was Not Correct	N	%
NH Healthy Families Health Plan	6	7.9%
Well Sense Health Plan	9	10.5%
Customer Service Did Not Have the Information Member Needed	N	%
NH Healthy Families Health Plan	8	10.5%
Well Sense Health Plan	13	15.1%
Respondent Waited too Long for Someone to Call Back	N	%
NH Healthy Families Health Plan	5	6.6%
Well Sense Health Plan	10	11.6%
No One Called Back	N	%
NH Healthy Families Health Plan	5	6.6%
Well Sense Health Plan	8	9.3%
Some Other Reason	N	%
NH Healthy Families Health Plan	22	28.9%
Well Sense Health Plan	24	27.9%
<i>Please note: Respondents may have marked more than one response option; therefore, percentages will not total 100%.</i>		

²⁻¹⁵ Please note, the results presented in Table 2-12 represent the proportions of members that had valid responses to the preceding gateway questions (i.e., Questions 31 and 32) and, as a result, were asked to select one of more applicable response options describing the reasons they did not get the information or help needed from their health plan’s customer service. In some instances, a member could have not selected any of the possible response options listed for this supplemental question.

Transportation

Parents/caretakers of child members were asked if they phoned their child’s health plan to get help with transportation for their child (Question 36a). Table 2-13 displays the responses for this question.

Table 2-13 Needed Help with Transportation				
Plan Name	Yes		No	
	N	%	N	%
NH Healthy Families Health Plan	9	1.8%	492	98.2%
Well Sense Health Plan	10	2.2%	455	97.8%
<i>Please note: Percentages may not total 100% due to rounding.</i>				

Parents/caretakers of child members were asked to assess, when they phoned their child’s health plan to get help with transportation, how often they received help (Question 36b). Table 2-14 displays the responses for this question.

Table 2-14 Access to Transportation								
Plan Name	Never		Sometimes		Usually		Always	
	N	%	N	%	N	%	N	%
NH Healthy Families Health Plan	2	22.2%	1	11.1%	2	22.2%	4	44.4%
Well Sense Health Plan	3	30.0%	1	10.0%	0	0.0%	6	60.0%
<i>Please note: Percentages may not total 100% due to rounding.</i>								

3. Recommendations

The Recommendations Section presents QI recommendations based on two types of independent analyses:

- ◆ Comparisons to NCQA's national benchmarks and thresholds
- ◆ Identification of key drivers of satisfaction

NCQA comparisons were used to provide recommendations through the determination of priority assignments. The key drivers of satisfaction analysis further focuses the recommendations by providing a more granular evaluation of those specific items that are driving satisfaction.

Priority Assignments

This section defines QI priority assignments for each global rating and composite measure. The priority assignments are grouped into four main categories for QI: top, high, moderate, and low priority. The priority assignments are based on the results of the comparisons to NCQA benchmarks and thresholds percentile distributions.³⁻¹

Table 3-1 shows how the priority assignments are determined on each CAHPS measure for the New Hampshire Medicaid Managed Care Program.

Table 3-1 Derivation of Priority Assignments on each CAHPS Measure	
NCQA Percentiles	Priority Assignment
Below the 25th percentile	Top
At or between the 25th and 49th percentiles	High
At or between the 50th and 74th percentiles	Moderate
At or between the 75th and 89th percentiles	Low
At or above the 90th percentile	Low

Table 3-2 shows the priority assignments for the New Hampshire Medicaid Managed Care Program.

Table 3-2 New Hampshire Medicaid Managed Care Program Priority Assignments	
Measure	Priority Assignment
Rating of Health Plan	Top
Customer Service	Moderate
Getting Needed Care	Moderate
Rating of Specialist Seen Most Often	Moderate
Rating of All Health Care	Low
Getting Care Quickly	Low
How Well Doctors Communicate	Low
Rating of Personal Doctor	Low

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

Key Drivers of Satisfaction Priority Assignments

For the New Hampshire Medicaid Managed Care Program, a key drivers of satisfaction analysis was performed. The purpose of the key drivers of satisfaction analysis is to help decision makers identify specific aspects of care that are most likely to benefit from QI activities. The analysis provides information on: (1) how well the program is performing on the survey item (question), and (2) how important that item is to overall satisfaction.

The key drivers of satisfaction analysis focuses on the top priorities. However, if less than three top priorities were identified, additional priorities are identified (up to three) by determining which measures had the lowest percentile scores through a comparison of each global rating's and composite measures' three-point mean to NCQA national benchmarks and thresholds. Table 3-3 displays the priority areas identified for analysis and the priority assignment for the New Hampshire Medicaid Managed Care Program.

Table 3-3 Key Drivers of Satisfaction—Priority Areas	
Priority Areas	Priority Assignment
Rating of Health Plan	Top
Customer Service	Moderate
Getting Needed Care	Moderate

The New Hampshire Medicaid Managed Care Program’s performance on a survey item was measured by calculating a problem score, in which a negative experience with care was defined as a problem and assigned a “1,” and a positive experience (i.e., non-negative) was assigned a “0.” The higher the problem score, the lower the member satisfaction with the aspect of service measured by that question. The problem score can range from 0 to 1. For additional information on the assignment of problem scores, please refer to the Reader’s Guide Section beginning on page 4-10.

For each item evaluated, the relationship between the item’s problem score and performance on the priority area was calculated using a Pearson product moment correlation. Items were then prioritized based on their overall problem score and their correlation to the priority area. Key drivers of satisfaction were defined as those items that (1) have a problem score that was greater than the program’s median problem score for all items examined, and (2) have a correlation that is greater than the program’s median correlation for all items examined.

Table 3-4 depicts those items identified for each of the priority areas as being key drivers of satisfaction for the New Hampshire Medicaid Managed Care Program.

Table 3-4 Key Drivers of Satisfaction	
Rating of Health Plan	
	Respondents reported that when their child did not need care right away, they did not obtain an appointment for health care as soon as they thought they needed.
	Respondents reported that when they talked about their child starting or stopping a prescription medicine, a doctor or other health provider did not talk about the reasons they might not want their child to take a medicine.
	Respondents reported that their child’s personal doctor did not always seem informed and up-to-date about the care their child received from other doctors or health providers.
	Respondents reported that their child’s health plan’s customer service did not always give them the information or help they needed.
	Respondents reported that forms from their child’s health plan were often not easy to fill out.
Customer Service	
	Respondents reported that their child’s health plan’s customer service did not always give them the information or help they needed.
Getting Needed Care	
	Respondents reported that it was often not easy for their child to obtain appointments with specialists.

Recommendations for Quality Improvement

Based on the results of the key drivers of satisfaction analysis, the following are general recommendations based on the most up-to-date information in the CAHPS literature. The New Hampshire Medicaid Managed Care Program and plans should evaluate these general recommendations in the context of its own operational and QI activities. For additional information, please refer to the QI references beginning on page 4-12.

Rating of Health Plan

Alternatives to One-on-One Visits

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

Health Plan Operations

It is important for health plans to view their organization as a collection of microsystems (such as providers, administrators, and other staff that provide services to members) that provide the health plan's health care "products." Health care microsystems include: a team of health providers, patient/population to whom care is provided, environment that provides information to providers and patients, support staff, equipment, and office environment. The goal of the microsystems approach is to focus on small, replicable, functional service systems that enable health plan staff to provide high-quality, patient-centered care. The first step to this approach is to define a measurable collection of activities. Once the microsystems are identified, new processes that improve care should be tested and implemented. Effective processes can then be rolled out throughout the health plan.

Online Patient Portal

A secure online patient portal allows members easy access to a wide array of health plan and health care information and services that are particular to their needs and interests. To help increase members' satisfaction with their health plan, health plans should consider establishing an online patient portal or integrating online tools and services into their current Web-based systems that focus on patient-centered care. Online health information and services that can be made available to

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

Promote Quality Improvement Initiatives

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

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

Customer Service

Service Recovery

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

Employee Training and Empowerment

Employees who have the necessary skills and tools to appropriately communicate with members and answer their questions and/or complete their requests are more likely to provide exceptional customer service. Therefore, it is important for health programs, plans, and providers to ensure that

staff have adequate training on all pertinent business processes. Furthermore, staff members should feel empowered to resolve most issues a member might have. This will eliminate transferring members to multiple employees and will help to resolve a complaint in a more timely manner.

Call Centers

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

Creating an Effective Customer Service Training Program

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

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

The key to ensuring that employees carry out the skills they learned in training is to not only provide motivation, but implement a support structure when they are back on the job so that they are held responsible. It is advised that all employees sign a commitment statement to affirm the course of action agreed upon. Programs and health plans should ensure leadership are involved in the training process to help establish camaraderie between managers and employees and to help employees realize the impact of their role in making change.

Getting Needed Care

Appropriate Health Care Providers

Health plans should ensure that patients are receiving care from physicians most appropriate to treat their condition. Tracking patients to ascertain they are receiving effective, necessary care from those appropriate health care providers is imperative to assessing quality of care. Health plans should actively attempt to match patients with appropriate health care providers and engage providers in their efforts to ensure appointments are scheduled for patients to receive care in a timely manner. These efforts can lead to improvements in quality, timeliness, and patients' overall access to care.

Interactive Workshops

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

“Max-Packing”

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

Referral Process

Streamlining the referral process, allows health plan members to more readily obtain the care they need. A referral expert can assist with this process and expedite the time from physician referral to the patient receiving needed care. A referral expert can be either a person and/or electronic system that is responsible for tracking and managing each health plan's referral requirements. An electronic referral system, such as a Web-based system, can improve the communication mechanisms between primary care physicians (PCPs) and specialists to determine which clinical conditions require a referral. This may be determined by referral frequency. An electronic referral process also allows providers to have access to a standardized referral form to ensure that all necessary information is collected from the parties involved (e.g., plans, patients, and providers) in a timely manner.

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 levels. Table 3-5 provides a summary of the responsible parties for various aspects of care.³⁻²

Table 3-5—Accountability for Areas of Care			
Domain	Composite	Who Is Accountable?	
		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 plans can still play a major role in influencing the performance of provider groups through intervention and incentive programs.

Those measures identified for the New Hampshire Medicaid Managed Care Program 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:

- ◆ 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 HyperText Markup Language [HTML] output of detailed CAHPS survey results).
- ◆ 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, Shaller D, McInnes K, et al. *The CAHPS® Improvement Guide: Practical Strategies for Improving the Patient Care Experience*. Department of Health Care Policy Harvard Medical School, October 2003.

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 standard CAHPS 5.0 Child Medicaid Health Plan Survey with the HEDIS supplemental item set. The CAHPS 5.0 Health Plan Surveys are a set of standardized surveys that assess patient perspectives on care. Originally, CAHPS was a five-year collaborative project sponsored by the Agency for Healthcare Research and Quality (AHRQ). The CAHPS questionnaires and consumer reports were developed under cooperative agreements among AHRQ, Harvard Medical School, RAND, and the Research Triangle Institute (RTI). In 1997, NCQA, in conjunction with AHRQ, created the CAHPS 2.0H Survey measure as part of NCQA's HEDIS.⁴⁻¹ In 2002, AHRQ convened the CAHPS Instrument Panel to re-evaluate and update the CAHPS Health Plan Surveys and to improve the state-of-the-art methods for assessing members' experiences with care.⁴⁻² The result of this re-evaluation and update process was the development of the CAHPS 3.0H Health Plan Surveys. The goal of the CAHPS 3.0H Health Plan Surveys was to effectively and efficiently obtain information from the person receiving care. In 2006, AHRQ released the CAHPS 4.0 Health Plan Surveys. Based on the CAHPS 4.0 versions, NCQA introduced new HEDIS versions of the Adult Health Plan Survey in 2007 and the Child Health Plan Survey in 2009, which are referred to as the CAHPS 4.0H Health Plan Surveys.^{4-3,4-4} In 2012, AHRQ released the CAHPS 5.0 Health Plan Surveys. Based on the CAHPS 5.0 versions, NCQA introduced new HEDIS versions of the Adult and Child Health Plan Surveys in August 2012, which are referred to as the CAHPS 5.0H Health Plan Surveys.⁴⁻⁵

The sampling and data collection procedures for the CAHPS 5.0 Health Plan Survey were 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 data.

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

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

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

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

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

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

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

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

Sampling Procedures

The members eligible for sampling included those who were NH Healthy Families or Well Sense members at the time the sample was drawn and who were continuously enrolled for at least five of the last six months of the measurement period (November 1, 2013 through April 30, 2014). The members eligible for sampling included those who were age 17 or younger (as of April 30, 2014).

A random sample of 1,650 child members was selected from each MCO’s eligible populations. Oversampling was not performed on the child population.

Survey Protocol

The CAHPS 5.0 Health Plan Survey process allowed members two methods by which they could complete a survey. The first phase, or mail phase, consisted of a survey being mailed to all sampled members. For NH Healthy Families and Well Sense all sampled members received an English version of the survey. 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 three CATI calls was made to each non-respondent. It has been shown that the addition of the telephone phase aids in the reduction of non-response bias by increasing the number of respondents who are more demographically representative of a plan's population.⁴⁻⁶

HSAG was provided a list of all eligible members for the sampling frame. HSAG sampled members who met the following criteria:

- ◆ Were age 17 or younger as of April 30, 2014.
- ◆ Were currently enrolled in NH Healthy Families or Well Sense.
- ◆ Had been continuously enrolled for at least five of the last six months of the measurement period (November 1, 2013 through April 30, 2014).
- ◆ Had Medicaid as a payer.

HSAG inspected a sample of the file records to check for any apparent problems with the files, such as missing address elements. The sample of records from each population was passed through the United States Postal Service's National Change of Address (NCOA) system to obtain new addresses for members who had moved (if they had given the Postal Service a new address). Prior to initiating CATI, HSAG employed the Telematch telephone number verification service to locate and/or update telephone numbers for all non-respondents. The survey samples were samples with no more than one member being selected per household.

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

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 standard mixed mode (i.e., mail followed by telephone follow-up) CAHPS timeline used in the administration of the New Hampshire CAHPS 5.0 Child Medicaid Health Plan Surveys. This timeline is based on NCQA HEDIS Specifications for Survey Measures.^{4,7}

Table 4-2—CAHPS 5.0 Mixed-Mode Methodology Survey Timeline	
Task	Timeline
Send first questionnaire with cover letter to the parent/caretaker of child member.	0 days
Send a postcard reminder to non-respondents four to 10 days after mailing the first questionnaire.	4 – 10 days
Send a second questionnaire (and letter) to non-respondents approximately 35 days after mailing the first questionnaire.	35 days
Send a second postcard reminder to non-respondents four to 10 days after mailing the second questionnaire.	39 – 45 days
Initiate CATI interviews for non-respondents approximately 21 days after mailing the second questionnaire.	56 days
Initiate systematic contact for all non-respondents such that at least three telephone calls are attempted at different times of the day, on different days of the week, and in different weeks.	56 – 70 days
Telephone follow-up sequence completed (i.e., completed interviews obtained or maximum calls reached for all non-respondents) approximately 14 days after initiation.	70 days

⁴⁻⁷ National Committee for Quality Assurance. *HEDIS® 2014, Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA Publication, 2013.

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. This section provides an overview of each analysis.

Response Rates

The administration of the CAHPS 5.0 Child Medicaid Health Plan Survey is comprehensive and is designed to achieve the highest possible response rate. The response rate is defined as the total number of completed surveys divided by all eligible members of the sample.⁴⁻⁸ A 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 minus ineligible members. Ineligible members of the sample met one or more of the following criteria: were deceased, were invalid (did not meet criteria described on page 4-3), or had a language barrier.

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

Child and Respondent Demographics

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

⁴⁻⁸ National Committee for Quality Assurance. *HEDIS® 2014, Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA Publication, 2013.

NCQA Comparisons

An analysis of the CAHPS Survey results was conducted using NCQA HEDIS Specifications for Survey Measures.⁴⁻⁹ Per these specifications, no weighting or case-mix adjustment is performed on the results. NCQA also requires a minimum of 100 responses on each item in order to report the item as a valid CAHPS Survey result. However, for purposes of this report, results are reported for a CAHPS measure even when the NCQA minimum reporting threshold of 100 respondents was not met. Therefore, caution should be exercised when interpreting results for those measures with fewer than 100 responses.

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 published NCQA HEDIS Benchmarks and Thresholds for Accreditation for the 50th and 90th percentiles. NCQA does not publish benchmarks and thresholds for the Shared Decision Making composite measure, and Coordination of Care and Health Promotion and Education individual item measures; therefore, comparisons could not be performed for these CAHPS measures. For detailed information on the derivation of three-point mean scores, please refer to *NCQA HEDIS 2014 Specifications for Survey Measures, Volume 3*.

⁴⁻⁹ National Committee for Quality Assurance. *HEDIS® 2014, Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA Publication, 2013.

Table 4-3 shows the benchmarks and thresholds used to derive the overall member satisfaction ratings on each CAHPS measure.⁴⁻¹⁰

Table 4-3—Overall Child Medicaid Member Satisfaction Ratings Crosswalk				
Measure	90th Percentile	75th Percentile	50th Percentile	25th Percentile
Rating of Health Plan	2.67	2.62	2.57	2.51
Rating of All Health Care	2.59	2.57	2.52	2.49
Rating of Personal Doctor	2.69	2.65	2.62	2.58
Rating of Specialist Seen Most Often	2.66	2.62	2.59	2.53
Getting Needed Care	2.57	2.52	2.46	2.38
Getting Care Quickly	2.69	2.66	2.61	2.54
How Well Doctors Communicate	2.75	2.72	2.68	2.63
Customer Service	2.63	2.58	2.53	2.50

⁴⁻¹⁰ National Committee for Quality Assurance. *HEDIS Benchmarks and Thresholds for Accreditation 2014*. Washington, DC: NCQA, January 30, 2014.

Rates and Proportions

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 following the 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 2014 Specifications for Survey Measures, Volume 3*.

Weighting

A weighted New Hampshire Medicaid Managed Care Program rate was calculated. Results were weighted based on the total eligible population for each health plan (i.e., NH Healthy Families and Well Sense). The New Hampshire Medicaid Managed Care Program aggregate includes the results of the MCOs (i.e., NH Healthy Families and Well Sense combined).

Plan Comparisons

Plan comparisons were performed to identify member satisfaction differences that were statistically different between NH Healthy Families and Well Sense. Given that differences in case-mix can result in differences in ratings between the MCOs that are not due to differences in quality, the data were adjusted to account for disparities in these characteristics. Case-mix refers to the characteristics of members and respondents used in adjusting the results for comparability among the MCOs. Results for the MCOs were case-mix adjusted for member general health status, respondent education level, and respondent age. One type of hypothesis test was applied to the child CAHPS comparative results. The *t*-test determined whether there were statistically significant differences between the two MCOs.

The source of demographic data (i.e., member and respondent characteristics) used to perform the case-mix adjustment are responses to questions included in the CAHPS survey instrument that ask about the child member's general health status, respondent's highest level of education completed, and respondent's age. This method of case-mix adjustment adheres to the standard regression methodology established by AHRQ and used in ARHQ's standard CAHPS macro program.

⁴⁻¹¹ National Committee for Quality Assurance. *HEDIS® 2014, Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA Publication, 2013.

Key Drivers of Satisfaction Analysis

In order to determine potential items for QI efforts, a key drivers of satisfaction analysis was performed at the program level. The purpose of the key drivers of satisfaction analysis is to help decision makers identify specific aspects of care that will most benefit from QI activities. The analysis provides information on:

- ◆ How well the program is performing on the survey item.
- ◆ How *important* that item is to overall satisfaction.

Table 4-4 depicts the CAHPS 5.0 Child Medicaid Health Plan Survey items that were analyzed for each global rating and composite measure in the key drivers of satisfaction analysis.

Table 4-4—Correlation Matrix								
Question Number	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service
Q4	✓	✓	✓	✓	✓	✓		
Q6	✓	✓	✓	✓	✓	✓		
Q8	✓	✓	✓	✓			✓	
Q9	✓	✓	✓	✓	✓		✓	
Q10	✓	✓	✓	✓	✓		✓	
Q11	✓	✓	✓	✓			✓	
Q12	✓	✓	✓	✓	✓		✓	
Q14	✓	✓	✓	✓	✓	✓		✓
Q17	✓	✓	✓				✓	
Q18	✓	✓	✓				✓	
Q19	✓	✓	✓				✓	
Q21	✓	✓	✓				✓	
Q22	✓	✓	✓		✓		✓	
Q23	✓	✓	✓					
Q25	✓	✓	✓				✓	
Q28	✓	✓		✓	✓	✓		
Q32	✓	✓						✓
Q33	✓	✓						✓
Q35	✓	✓						✓

A checkmark (✓) indicates that the question was used in the key drivers of satisfaction analysis for the specified global rating or composite measure.

The program’s perceived performance on a survey question is measured by calculating a *problem score*, in which a negative experience with care is defined as a problem and assigned a “1,” and a positive experience is assigned a “0.” The higher the problem score, the lower the member satisfaction with the aspect of service measured by that question. The problem score can range from 0 to 1.

Table 4-5 depicts the problem score assignments for the different response categories.

Table 4-5—Assignment of Problem Scores		
Never/Sometimes/Usually/Always Format		
<i>Response Category</i>	<i>Classification</i>	<i>Code</i>
Never	Problem	1
Sometimes	Problem	1
Usually	Not a problem	0
Always	Not a problem	0
No Answer	Not classified	Missing
Not At All/A Little/Some/A Lot Format		
<i>Response Category</i>	<i>Classification</i>	<i>Code</i>
Not At All	Problem	1
A Little	Problem	1
Some	Not a problem	0
A Lot	Not a problem	0
No Answer	Not classified	Missing
No/Yes Format		
<i>Response Category</i>	<i>Classification</i>	<i>Code</i>
No	Problem	1
Yes	Not a problem	0
No Answer	Not classified	Missing

A mean problem score above the median problem score is considered to be “high.” A correlation above the median correlation is considered to be “high.” Key drivers are those items for which the problem score and correlation are both above their respective medians. The median, rather than the mean, is used to ensure that extreme problem scores and correlations do not have disproportionate influence in prioritizing individual questions.

Correlation

The relationship between the problem score of a question and priority items was calculated using the Pearson product moment correlation. This conversion modifies the distributions of both variables so that they conform to the standard normal distribution and can be compared.

The correlation can range from -1 to 1, with negative values indicating a negative relationship between overall satisfaction and a particular survey item. However, the correlation analysis conducted is not focused on the direction of the correlation, but rather on the degree of correlation. Therefore, the absolute value of r is used in the analysis, and the range for r is 0 to 1. An r of zero

indicates no relationship between the response to a question and satisfaction. As r increases, the importance of the question to the respondent's satisfaction increases.

Limitations and Cautions

The findings presented in the 2014 New Hampshire Child Medicaid Member Satisfaction 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 member general health status, respondent education, and respondent age, it was not possible to adjust for differences in child member and respondent characteristics that were not measured. These characteristics include income, employment, or any other characteristics that may not be under the plans' control.

Non-Response Bias

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

Causal Inferences

Although this report examines whether the parents or caretakers of child members of the plans report differences in satisfaction with various aspects of their child's health care experiences, these differences may not be completely attributable to the health plan. These analyses identify whether parents or caretakers of child members enrolled in NH Healthy Families and Well Sense give different ratings of satisfaction with their child's health plan. The survey by itself does not necessarily reveal the exact cause of these differences.

Baseline Results

It is important to note that in 2014 the NH Healthy Families' and Well Sense's child Medicaid populations were surveyed for the first time. The 2014 CAHPS survey results presented in the report represent an initial **baseline** assessment of parent's/caretakers' satisfaction with their child's health plan; therefore, caution should be exercised when interpreting the results.

Quality Improvement References

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

AHRQ Health Care Innovations Exchange Web site. *Expanding Interpreter Role to Include Advocacy and Care Coordination Improves Efficiency and Leads to High Patient and Provider Satisfaction*. Available at: <https://innovations.ahrq.gov/profiles/expanding-interpreter-role-include-advocacy-and-care-coordination-improves-efficiency-and>. Accessed on: December 1, 2014.

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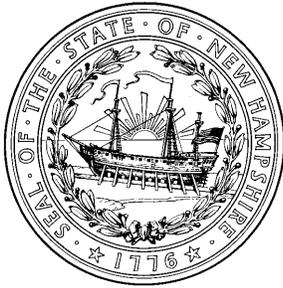
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5. Survey Instrument

The survey instrument selected for the 2014 New Hampshire Child Medicaid Member Satisfaction Survey was the CAHPS 5.0 Child Medicaid Health Plan Survey with the HEDIS supplemental item set. This section provides a copy of the survey instrument.



Your privacy is protected. All information that would let someone identify you or your family will be kept private. The research staff 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 the survey so we don't have to send you reminders.

If you want to know more about this study, please call 1-800-839-8241.

SURVEY INSTRUCTIONS

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

Correct Mark 

Incorrect Marks   

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

- Yes → *Go to Question 1*
- No

↓ **START HERE** ↓

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

1. Our records show that your child is now in [HEALTH PLAN NAME/STATE MEDICAID PROGRAM NAME]. Is that right?
 - Yes → *Go to Question 3*
 - No

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



**YOUR CHILD'S HEALTH CARE
IN THE LAST 6 MONTHS**

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

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

- Yes
- No → *Go to Question 5*

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

- Never
- Sometimes
- Usually
- Always

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

- Yes
- No → *Go to Question 7*

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

- Never
- Sometimes
- Usually
- Always

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

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

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

- Yes
- No

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

- Yes
- No → *Go to Question 13*

10. When you talked about your child starting or stopping a prescription medicine, how much did a doctor or other health provider talk about the reasons you might want your child to take a medicine?

- Not at all
- A little
- Some
- A lot

11. When you talked about your child starting or stopping a prescription medicine, how much did a doctor or other health provider talk about the reasons you might not want your child to take a medicine?

- Not at all
- A little
- Some
- A lot



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

- Yes
- No

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

-
- 0 1 2 3 4 5 6 7 8 9 10
- Worst Health Care Possible Best Health Care Possible

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

- Never
- Sometimes
- Usually
- Always

YOUR CHILD'S PERSONAL DOCTOR

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

- Yes
- No → *Go to Question 27*

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

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

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

- Never
- Sometimes
- Usually
- Always

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

- Never
- Sometimes
- Usually
- Always

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

- Never
- Sometimes
- Usually
- Always

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

- Yes
- No → *Go to Question 22*

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

- Never
- Sometimes
- Usually
- Always

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

- Never
- Sometimes
- Usually
- Always



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

- Yes
- No

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

- Yes
- No → *Go to Question 26*

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

- Never
- Sometimes
- Usually
- Always

25a. In the last 6 months, did anyone from your child's health plan, doctor's office, or clinic help coordinate your child's care among these doctors or other health providers?

- Yes
- No → *Go to Question 26*

25b. In the last 6 months, who helped to coordinate your child's care? Mark one or more.

- Someone from your child's health plan
- Someone from your child's doctor's office or clinic
- Someone from another organization
- A friend or family member
- You

25c. How satisfied are you with the help you received to coordinate your child's care in the last 6 months?

- Very dissatisfied
- Dissatisfied
- Neither dissatisfied nor satisfied
- Satisfied
- Very satisfied

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

- | | | | | | | | | | | |
|--------------------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-------------------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Worst Personal Doctor Possible | | | | | | Best Personal Doctor Possible | | | | |

GETTING HEALTH CARE FROM SPECIALISTS

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

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

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

- Yes
- No → *Go to Question 31*

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

- Never
- Sometimes
- Usually
- Always



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

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

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

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

YOUR CHILD'S HEALTH PLAN

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

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

- Yes
- No → **Go to Question 34**

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

- Never
- Sometimes
- Usually
- Always

32a. Were any of the following a reason you did not get the information or help you needed from customer service at your child's health plan? Mark one or more.

- You had to call several times before you could speak with someone
- The information customer service gave you was not correct
- Customer service did not have the information you needed
- You waited too long for someone to call you back
- No one called you back
- Some other reason

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

- Never
- Sometimes
- Usually
- Always

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

- Yes
- No → **Go to Question 36**

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

- Never
- Sometimes
- Usually
- Always

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

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



36a. Some health plans help with transportation for your child to get to doctors' offices or clinics. This help can be a shuttle bus, tokens or vouchers for a bus or taxi, or payments for mileage. In the last 6 months, did you phone your child's health plan to get help with transportation for your child?

- Yes
- No → *Go to Question 37*

36b. In the last 6 months, when you phoned your child's health plan to get help with transportation, how often did you get it?

- Never
- Sometimes
- Usually
- Always

ABOUT YOUR CHILD AND YOU

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

- Excellent
- Very good
- Good
- Fair
- Poor

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

- Excellent
- Very good
- Good
- Fair
- Poor

39. What is your child's age?

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

40. Is your child male or female?

- Male
- Female

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

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

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

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

43. What is your age?

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

44. Are you male or female?

- Male
- Female

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

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



46. How are you related to the child?

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

47. Did someone help you complete this survey?

- Yes → **Go to Question 48**
- No → **Thank you. Please return the completed survey in the postage-paid envelope.**

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

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

THANK YOU

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

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

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

