State of Washington
Health Care Authority

2014 Washington State Health Care Authority Adult Medicaid Health Plan CAHPS® Report

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Introduction

The Washington State Health Care Authority (HCA) periodically assesses the perceptions and experiences of members enrolled in the Washington Medicaid managed care organizations (MCOs) as part of its process for evaluating the quality of health care services provided to adult members in the Washington Medicaid Program. Health Services Advisory Group, Inc. (HSAG) reported the results of the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Adult Medicaid Health Plan Survey for the Washington Medicaid Program on behalf of HCA through a subcontract with Acumentra Health, the State of Washington's External Quality Review Organization (EQRO).[1-1,1-2] The goal of the CAHPS Health Plan Survey is to provide performance feedback that is actionable and that will aid in improving overall member satisfaction.

This report presents the 2014 CAHPS results of adult members enrolled in the following Apple Health plans: Amerigroup Washington, Inc., Community Health Plan of Washington, Coordinated Care Corporation, Molina Healthcare of Washington, Inc., and United Health Care Community Plan. A sample of at least 1,350 adult members was selected from each participating MCO for inclusion in the CAHPS survey.[1-3] The surveys were completed in the spring of 2014. The standardized survey instrument selected was the CAHPS 5.0 Adult Medicaid Health Plan Survey with the Healthcare Effectiveness Data and Information Set (HEDIS®) supplemental item set.[1-4]

Report Overview

Results presented in this report include four global ratings: Rating of Health Plan, Rating of All Health Care, Rating of Personal Doctor, and Rating of Specialist Seen Most Often. Five composite measures are reported: Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Customer Service, and Shared Decision Making. Two individual item measures are reported: Coordination of Care and Health Promotion and Education. Additionally, the results of the 10 supplemental questions HCA selected for inclusion in the MCOs' CAHPS surveys are reported.

HSAG presents aggregate statewide results and plan-specific results and compares them to national Medicaid data, where applicable. The statewide Washington Medicaid Program aggregate results presented throughout this report are based on the combined results of the five participating MCOs.

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

1-2 The five MCOs contracted with various survey vendors to administer the CAHPS Adult Medicaid survey.

1-3 All of the MCOs elected to perform an oversample of their adult population. The final sample sizes for each MCO varied based on the percentage of oversample that was performed.

1-4 HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

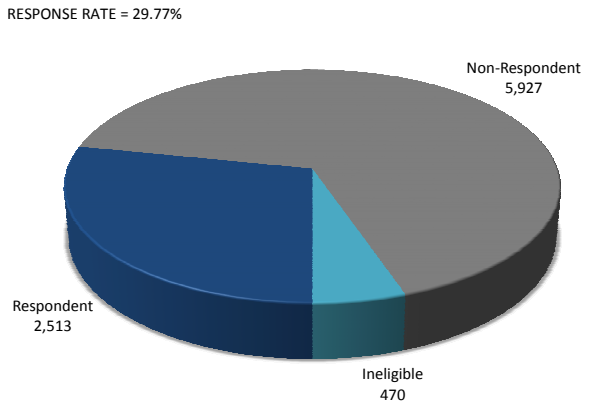
Key Findings

Survey Dispositions and Demographics

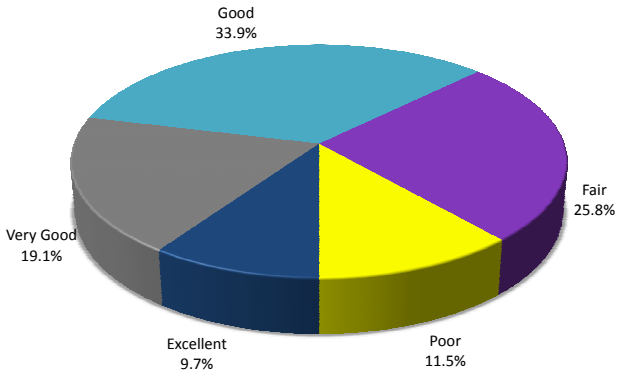
Table 1-1 provides an overview of the Washington Medicaid Program survey dispositions and adult member demographics.

Table 1-1: Survey Dispositions and Demographics

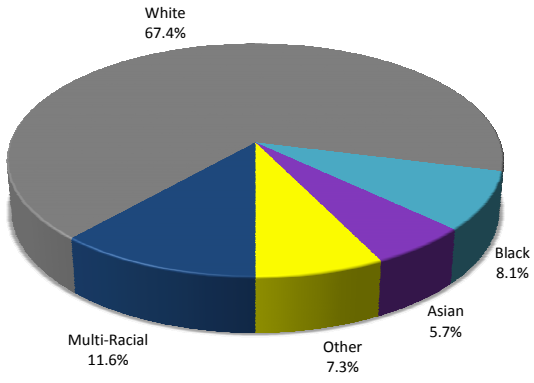
Survey Dispositions



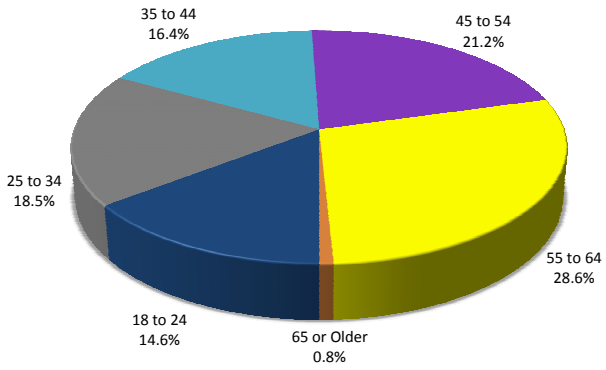
General Health Status



Race/Ethnicity



Age



Please note, percentages may not total 100.0% due to rounding.

National Comparisons

A three-point mean score was determined for the four CAHPS global ratings and four CAHPS composite measures. The resulting three-point mean scores were compared to National Committee for Quality Assurance (NCQA) 2014 HEDIS Benchmarks and Thresholds for Accreditation to derive the overall member satisfaction ratings (i.e., star ratings) for each CAHPS measure.[1-5,1-6] Table 1-2 provides highlights of the National Comparisons findings for the Washington Medicaid Program. The numbers presented below represent the three-point mean score for each measure, while the stars represent overall member satisfaction ratings when the three-point means were compared to NCQA HEDIS Benchmarks and Thresholds for Accreditation.[1-7]

Table 1-2: National Comparisons Washington Medicaid Program

Measure	National Comparisons
Global Rating	
Rating of Health Plan	★ 2.23
Rating of All Health Care	★ 2.25
Rating of Personal Doctor	★★ 2.46
Rating of Specialist Seen Most Often	★★★ 2.51
Composite Measure	
Getting Needed Care	★ 2.30
Getting Care Quickly	★★ 2.37
How Well Doctors Communicate	★★★★ 2.58
Customer Service	★ 2.46

Star Assignments Based on Percentiles
★★★★★ 90th or Above ★★★★ 75th-89th ★★★ 50th-74th ★★ 25th-49th ★ Below 25th

The National Comparisons results indicated the How Well Doctors Communicate composite measure scored at or between the 75th and 89th percentiles. The Rating of Specialist Seen Most Often global rating scored at or between the 50th and 74th percentiles. The Rating of Personal Doctor global rating and Getting Care Quickly composite measure scored at or between the 25th and 49th percentiles. The Rating of Health Plan and Rating of All Health Care global ratings, and

1-5 National Committee for Quality Assurance. *HEDIS® Benchmarks and Thresholds for Accreditation 2014*. Washington, DC: NCQA; January 30, 2014.

1-6 NCQA does not publish national benchmarks and thresholds for the Shared Decision Making composite measure, and the Coordination of Care and Health Promotion and Education individual item measures; therefore, these CAHPS measures were excluded from the National Comparisons analysis.

1-7 For purposes of the National Comparisons, the calculated three-point mean scores were not case mix-adjusted.

the Getting Needed Care and Customer Service composite measures scored below the 25th percentile.

Rates and Proportions

Top-box question summary rates were calculated for each global rating and individual item measure, and top-box global proportions were calculated for each composite measure. The top-box rates (i.e., rates of satisfaction) for each CAHPS measure were compared to 2013 NCQA adult Medicaid national averages, where applicable.[1-8] The results of these comparisons revealed that the Washington Medicaid Program scored below the NCQA national average on all nine comparable CAHPS measures.

Statewide Comparisons

HSAG calculated three-point means for each global rating, composite measure, and individual item measure. HSAG compared the MCO results to the Washington Medicaid Program average to determine if plan results were statistically significantly different than the Washington Medicaid Program average. Table 1-3 through Table 1-5 present the findings of the Statewide Comparisons for the global ratings, composite measures, and individual item measures, respectively.

Table 1-3: Statewide Comparisons—Global Ratings

Plan Name	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often
Amerigroup Washington, Inc.	↔	↔	↔	↔
Community Health Plan of Washington	↔	↓	↔	↓
Coordinated Care Corporation	↔	↔	↔	↔
Molina Healthcare of Washington, Inc.	↑	↔	↔	↔
United Health Care Community Plan	↔	↑	↔	↔

↑ *Indicates the plan's score is statistically better than the Washington Medicaid Program average.*
↔ *Indicates the plan's score is not statistically different than the Washington Medicaid Program average.*
↓ *Indicates the plan's score is statistically worse than the Washington Medicaid Program average.*

1-8 As a result of the transition from the CAHPS 4.0 to CAHPS 5.0 survey and changes to the Shared Decision Making composite measure and Health Promotion and Education individual item, 2013 NCQA national averages are not available for these CAHPS measures. Thus, comparisons could not be performed.

Table 1-4: Statewide Comparisons—Composite Measures					
Plan Name	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service	Shared Decision Making
Amerigroup Washington, Inc.	↔	↔	↔	↔	↔
Community Health Plan of Washington	↓	↓	↔	↓	↔
Coordinated Care Corporation	↔	↔	↔	↔	↔
Molina Healthcare of Washington, Inc.	↔	↔	↔	↔	↔
United Health Care Community Plan	↑	↑	↔	↔	↔

↑ *Indicates the plan's score is statistically better than the Washington Medicaid Program average.*
↔ *Indicates the plan's score is not statistically different than the Washington Medicaid Program average.*
↓ *Indicates the plan's score is statistically worse than the Washington Medicaid Program average.*

Table 1-5: Statewide Comparisons—Individual Item Measures		
Plan Name	Coordination of Care	Health Promotion and Education
Amerigroup Washington, Inc.	↔	↔
Community Health Plan of Washington	↔	↔
Coordinated Care Corporation	↔	↔
Molina Healthcare of Washington, Inc.	↔	↑
United Health Care Community Plan	↔	↔

↑ *Indicates the plan's score is statistically better than the Washington Medicaid Program average.*
↔ *Indicates the plan's score is not statistically different than the Washington Medicaid Program average.*
↓ *Indicates the plan's score is statistically worse than the Washington Medicaid Program average.*

The results from the Statewide Comparisons revealed the following summary results:

- Amerigroup Washington, Inc. and Coordinated Care Corporation did not score statistically *better* or *worse* than the Washington Medicaid Program average on any of the measures.
- Community Health Plan of Washington scored statistically *worse* than the Washington Medicaid Program average on five measures.
- Molina Healthcare of Washington, Inc. scored statistically *better* than the Washington Medicaid Program average on two measures.
- United Health Care Community Plan scored statistically *better* than the Washington Medicaid Program average on three measures.

2014 CAHPS Performance Measures

The CAHPS 5.0 Adult Medicaid Health Plan Survey with the HEDIS supplemental item set includes 57 core questions that yield 11 measures. 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 (e.g., "Coordination of Care").

Table 2-1 lists the measures included in the CAHPS 5.0 Adult Medicaid Health Plan Survey with the HEDIS supplemental item set.

Table 2-1: 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	

How CAHPS Results Were Collected

NCQA developed specific HEDIS methodology to ensure the collection of CAHPS data is consistent throughout all plans to allow for comparison. In accordance with NCQA guidelines, the sampling procedures and survey protocol were adhered to as described below.[2-1]

Sampling Procedures

The MCOs contracted with separate survey vendors to perform sampling. Members were sampled who met the following criteria:

- Were 18 years of age or older as of December 31, 2013.
- Were currently enrolled in an MCO.
- Had been continuously enrolled in the plan for at least five of the last six months (July through December) of 2013.
- Had Medicaid as a payer.

Next, a simple random sample of members was selected for inclusion in the survey. No more than one member per household was selected as part of the random survey samples. A sample of at least 1,350 adult members was selected from each MCO. Additionally, each MCO elected to oversample their population. NCQA protocol allows oversampling in increments of 5 percent. Table 3-1, on page 3-1, provides an overview of the total sample sizes for each plan and the Washington Medicaid Program in aggregate.

Survey Protocol

The survey administration protocol employed by Molina Healthcare of Washington, Inc. was a standard Internet mixed-mode methodology, which allowed members the option to complete the survey via the Internet. The survey administration protocol employed by the other MCOs also allowed for two methods by which members could complete a survey.[2-2] The first, or mail phase, consisted of sampled members receiving a survey via mail. Non-respondents received a reminder postcard, followed by a second survey mailing and reminder postcard. The second phase, or telephone phase, consisted of Computer Assisted Telephone Interviewing (CATI) of members who did not mail in a completed survey. At least three CATI calls to each non-respondent were

[2-1] Please note, HSAG did not conduct the sampling and survey administration for the MCOs. The MCOs contracted with various survey vendors to perform the sampling and survey administration. Following the survey administration, the MCOs/their survey vendors provided HSAG with the collected CAHPS survey data for purposes of analysis and reporting.

[2-2] Amerigroup Washington, Inc. and Community Health Plan of Washington utilized an enhanced mixed-mode survey methodology pre-approved by NCQA.

attempted.[2-3] 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.[2-4]

Table 2-2 shows the standard mixed-mode (i.e., mail followed by telephone follow-up) CAHPS timeline used in the administration of the CAHPS surveys.[2-5]

Table 2-2: CAHPS 5.0 Mixed-Mode Methodology Survey Timeline

Task	Timeline
Send first questionnaire with cover letter to the adult 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

2-3 National Committee for Quality Assurance. *Quality Assurance Plan for HEDIS 2014 Survey Measures.* Washington, DC: NCQA; 2013.

2-4 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.

2-5 The timeline utilized by Molina Healthcare of Washington, Inc. may have varied given the difference in the mixed-mode methodology used for survey administration (i.e., mixed mail and Internet).

How CAHPS Results Were Calculated and Displayed

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, HSAG performed a number of analyses to comprehensively assess member satisfaction. In addition to individual plan results, HSAG calculated a Washington Medicaid Program average. HSAG combined results from the five participating MCOs to form the Washington Medicaid Program average. This section provides an overview of each analysis.

Who Responded to the Survey

The administration of the CAHPS survey is comprehensive and is designed to achieve the highest possible response rate. NCQA defines the response rate as the total number of completed surveys divided by all eligible members of the sample.[2-6] HSAG considered a survey 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 criteria), were mentally or physically incapacitated, or had a language barrier.

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

Demographics of Adult Members

The demographics analysis evaluated demographic information of adult members. HCA should exercise caution when extrapolating the CAHPS results to the entire population if the respondent population differs significantly from the actual population of the plan.

National Comparisons

For the National Comparisons analysis, HSAG scored the four global ratings and four composite measures on a three-point scale using an NCQA-approved scoring methodology. HSAG compared the Washington Medicaid Program's and plans' resulting three-point mean scores to published NCQA HEDIS Benchmarks and Thresholds for Accreditation.[2-7] NCQA does not publish national benchmarks and thresholds for Shared Decision Making, Coordination of Care, and Health Promotion and Education; therefore, these CAHPS measures were excluded from the National Comparisons analysis. Based on this comparison, ratings of one (★) to five (★★★★★)

[2-6] National Committee for Quality Assurance. *HEDIS® 2014, Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA; 2013.

[2-7] For detailed information on the derivation of three-point mean scores, please refer to *HEDIS® 2014, Volume 3: Specifications for Survey Measures.*

stars were determined for each CAHPS measure, where one is the lowest possible rating (i.e., Poor) and five is the highest possible rating (i.e., Excellent).

Table 2-3 shows the percentiles that were used to determine the overall member satisfaction ratings (i.e., star ratings) for each CAHPS measure.

Table 2-3: Star Ratings

Stars	Percentiles
★★★★★ Excellent	At or above the 90th percentile
★★★★ Very Good	At or between the 75th and 89th percentiles
★★★ Good	At or between the 50th and 74th percentiles
★★ Fair	At or between the 25th and 49th percentiles
★ Poor	Below the 25th percentile

Table 2-4 shows the NCQA HEDIS Benchmarks and Thresholds for Accreditation used to derive the overall adult Medicaid member satisfaction ratings (i.e., star ratings) on each CAHPS measure.[2-8] Please refer to pages 3-5 and 3-6 in the Results section for the NCQA comparisons and corresponding star ratings.

Table 2-4: Overall Adult Medicaid Member Satisfaction Ratings Crosswalk

Measure	90th Percentile	75th Percentile	50th Percentile	25th Percentile
Rating of Health Plan	2.54	2.46	2.40	2.32
Rating of All Health Care	2.42	2.38	2.32	2.27
Rating of Personal Doctor	2.57	2.53	2.50	2.43
Rating of Specialist Seen Most Often	2.59	2.56	2.51	2.48
Getting Needed Care	2.46	2.41	2.37	2.31
Getting Care Quickly	2.49	2.45	2.41	2.37
How Well Doctors Communicate	2.64	2.58	2.54	2.48
Customer Service	2.61	2.58	2.54	2.48

2-8 National Committee for Quality Assurance. *HEDIS® Benchmarks and Thresholds for Accreditation 2014*. Washington, DC: NCQA; January 30, 2014.

Rates and Proportions

For purposes of the Rates and Proportions analysis, HSAG calculated question summary rates for each global rating and individual item measure, and global proportions for each composite measure following NCQA HEDIS Specifications for Survey Measures.[2-9] The scoring of the global ratings, composite measures, and individual item measures involved assigning top-box responses a score of one, with all other responses receiving a score of zero. For the global ratings, composite measures, and individual item measures, a "top-box" response was defined as follows:

- "9" or "10" for the global ratings,
- "Usually" or "Always" for the Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, and Customer Service composite measures,
- "A lot" or "Yes" for the Shared Decision Making composite measure,
- "Usually" or "Always" for the Coordination of Care individual item measure,
- "Yes" for the Health Promotion and Education individual item measure.

Weighting

A weighted Washington Medicaid Program aggregate top-box rate was calculated. The top-box results for the program aggregate were weighted based on the total eligible population for each MCO's adult population. This weighting was performed for purposes of calculating a program aggregate rate that most accurately represents the overall Washington Medicaid population. As previously noted, the Washington Medicaid Program results were derived from the combined results of the five participating MCOs.

Statewide Comparisons

In order to identify performance differences in member satisfaction between the five MCOs, HSAG calculated case-mix adjusted three-point mean scores for each CAHPS measure. The three-point means were case-mix adjusted for general health status, education level, and age of the respondent.[2-10] The MCOs' three-point mean scores were then compared to the Washington Medicaid Program average using standard tests for statistical significance to determine if statistically significant differences existed. Two types of hypothesis tests were applied to these results. First, a global *F* test was calculated, which determined whether the difference between MCO means was significant. If the *F* test demonstrated MCO-level differences (i.e., p value < 0.05), then a *t*-test was performed for each MCO. The *t*-test determined whether each MCO's mean was significantly different from the Washington Medicaid Program average. This analytic

[2-9] National Committee for Quality Assurance. *HEDIS® 2014, Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA; 2013.

[2-10] Agency for Healthcare Research and Quality. *CAHPS Health Plan Survey and Reporting Kit 2008*. Rockville, MD: US Department of Health and Human Services, July 2008.

approach follows the Agency for Healthcare Research and Quality's (AHRQ's) recommended methodology for identifying significant plan-level performance differences.

Key Drivers of Satisfaction Analysis

HSAG performed an analysis of key drivers of satisfaction for the following measures: Rating of Health Plan, Rating of All Health Care, and Rating of Personal Doctor. The purpose of the key drivers of satisfaction analysis is to help decision makers identify specific aspects of care that will most benefit from quality improvement (QI) activities. The analysis provides information on: 1) how ***well*** the Washington Medicaid Program is performing on the survey item and 2) how ***important*** that item is to overall satisfaction.

The 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 with care (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 could range from 0 to 1.

For each item evaluated, the relationship between the item's problem score and performance on each of the three measures was calculated using a Pearson product moment correlation, which is defined as the covariance of the two scores divided by the product of their standard deviations. Items were then prioritized based on their overall problem score and their correlation to each measure. Key drivers of satisfaction were defined as those items that:

- Had a problem score that was greater than or equal to the median problem score for all items examined.
- Had a correlation that was greater than or equal to the median correlation for all items examined.

Limitations and Cautions

The findings presented in this CAHPS report are subject to some limitations in the survey design, analysis, and interpretation. HCA should consider these limitations when interpreting or generalizing the findings.

Case-Mix Adjustment

The demographics of a response group may impact member satisfaction. Therefore, differences in the demographics of the response group may impact CAHPS results. NCQA does not recommend case-mix adjusting CAHPS results to account for these differences.[2-11] However, for purposes of the Statewide Comparisons analysis, results were case-mix adjusted. While data for the MCOs have been adjusted for these differences in respondent general health status, education, and age, it was not possible to adjust for differences in respondent characteristics that were not measured. These characteristics can include income, employment, or any other characteristics that may not be under the MCOs' 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 MCO. Therefore, HCA should consider the potential for non-response bias when interpreting CAHPS results.

Causal Inferences

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

Mode Effects

The CAHPS survey was administered via standard or enhanced mail and telephone mixed-mode (all MCOs except Amerigroup Washington, Inc.) and standard Internet mixed-mode (Amerigroup Washington, Inc.) methodologies. The mode in which a survey is administered may have an impact on respondents' assessments of their health care experiences. Therefore, mode effects should be considered when interpreting the CAHPS results.

[2-11] Agency for Healthcare Research and Quality. *CAHPS Health Plan Survey and Reporting Kit 2008*. Rockville, MD: US Department of Health and Human Services; 2008.

Survey Vendor Effects

The CAHPS survey was administered by multiple survey vendors. NCQA developed its Survey Vendor Certification Program to ensure standardization of data collection and the comparability of results across health plans. However, due to the different processes employed by the survey vendors, there is still the small potential for vendor effects. Therefore, survey vendor effects should be considered when interpreting the CAHPS results.

Supplemental Questions

While the MCOs' CAHPS survey instruments were reviewed to ensure consistency in placement of the 10 supplemental questions HCA selected for inclusion in the CAHPS Surveys, some MCOs elected to include additional supplemental questions in their surveys. Additionally, one MCO deviated from the recommendations provided for placement of the HCA-selected supplemental questions within the survey instrument and the survey question language for one of the supplemental questions varied from the other MCOs. HCA should consider the potential differences in placement and language of supplemental questions when interpreting the Supplemental Questions results of the MCOs.

Who Responded to the Survey

A total of 8,910 surveys were mailed to adult members. A total of 2,513 surveys were completed. The CAHPS Survey response rate is the total number of completed surveys divided by all eligible members of the sample. A survey was considered complete if at least one question was answered on the survey. 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 criteria), were mentally or physically incapacitated, or had a language barrier.

Table 3-1 shows the total number of members sampled, the number of surveys completed, the number of ineligible members, and the response rates.

Table 3-1: Total Number of Respondents and Response Rates

Plan Name	Sample Size	Completes	Ineligibles	Response Rates
Washington Medicaid Program	**8,910**	**2,513**	**470**	**29.77%**
Amerigroup Washington, Inc.	1,755	351	142	21.76%
Community Health Plan of Washington	1,755	631	98	38.08%
Coordinated Care Corporation	1,620	426	83	27.72%
Molina Healthcare of Washington, Inc.	1,890	576	49	31.29%
United Health Care Community Plan	1,890	529	98	29.52%

Demographics of Adult Members

Table 3-2 through Table 3-4 depict the ages, gender, and race/ethnicity of members who completed a CAHPS survey, respectively.

Table 3-2: Adult Member Demographics—Age

Plan Name	18 to 24	25 to 34	35 to 44	45 to 54	55 to 64	65 and older
Washington Medicaid Program	**14.6%**	**18.5%**	**16.4%**	**21.2%**	**28.6%**	**0.8%**
Amerigroup Washington, Inc.	13.1%	14.0%	14.9%	22.0%	35.7%	0.3%
Community Health Plan of Washington	11.4%	15.8%	16.1%	21.6%	34.2%	0.9%
Coordinated Care Corporation	15.2%	18.2%	16.3%	18.5%	30.4%	1.4%
Molina Healthcare of Washington, Inc.	18.8%	27.7%	19.0%	17.6%	16.2%	0.8%
United Health Care Community Plan	14.5%	15.7%	15.1%	25.9%	28.5%	0.4%

Please note, percentages may not total 100% due to rounding.

Table 3-3: Adult Member Demographics—Gender

Plan Name	Male	Female
Washington Medicaid Program	**36.7%**	**63.3%**
Amerigroup Washington, Inc.	43.9%	56.1%
Community Health Plan of Washington	35.1%	64.9%
Coordinated Care Corporation	37.2%	62.8%
Molina Healthcare of Washington, Inc.	29.5%	70.5%
United Health Care Community Plan	38.7%	61.3%

Please note, percentages may not total 100% due to rounding.

Table 3-4: Adult Member Demographics—Race/Ethnicity

Plan Name	Multi-Racial	White	Black	Asian	Other
Washington Medicaid Program	**11.6%**	**67.4%**	**8.1%**	**5.7%**	**7.3%**
Amerigroup Washington, Inc.	7.3%	67.3%	13.5%	4.4%	7.6%
Community Health Plan of Washington	12.2%	68.5%	4.2%	9.7%	5.3%
Coordinated Care Corporation	12.4%	71.5%	5.9%	3.4%	6.8%
Molina Healthcare of Washington, Inc.	14.5%	65.4%	8.3%	3.6%	8.1%
United Health Care Community Plan	10.3%	65.5%	9.7%	5.8%	8.7%

Please note, percentages may not total 100% due to rounding.

Table 3-5 and Table 3-6 depict the general health status and level of education of members who completed a CAHPS survey, respectively.

Table 3-5: Adult Member Demographics—General Health Status

Plan Name	Excellent	Very Good	Good	Fair	Poor
Washington Medicaid Program	**9.7%**	**19.1%**	**33.9%**	**25.8%**	**11.5%**
Amerigroup Washington, Inc.	9.3%	14.2%	33.0%	31.6%	11.9%
Community Health Plan of Washington	11.9%	23.8%	36.6%	20.7%	7.0%
Coordinated Care Corporation	7.5%	16.3%	32.0%	28.2%	16.0%
Molina Healthcare of Washington, Inc.	9.9%	20.9%	36.1%	22.1%	11.0%
United Health Care Community Plan	9.0%	17.4%	30.8%	29.5%	13.4%
Please note, percentages may not total 100% due to rounding.					

Table 3-6: Adult Member Demographics—Education

Plan Name	8th Grade or Less	Some High School	High School Graduate	Some College	College Graduate
Washington Medicaid Program	**5.8%**	**17.2%**	**35.5%**	**33.2%**	**8.3%**
Amerigroup Washington, Inc.	6.0%	19.8%	38.8%	29.6%	5.7%
Community Health Plan of Washington	5.4%	13.6%	30.1%	36.9%	14.0%
Coordinated Care Corporation	6.9%	21.7%	37.8%	28.6%	5.0%
Molina Healthcare of Washington, Inc.	3.9%	16.7%	36.3%	35.9%	7.1%
United Health Care Community Plan	7.1%	16.4%	36.3%	32.6%	7.7%
Please note, percentages may not total 100% due to rounding.					

National Comparisons

In order to assess the overall performance of the Washington Medicaid Program, HSAG scored the four 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) on a three-point scale using an NCQA-approved scoring methodology. HSAG compared the plans' and program's three-point mean scores to NCQA HEDIS Benchmarks and Thresholds for Accreditation.[3-1]

Based on this comparison, ratings of one (★) to five (★★★★★) stars were determined for each CAHPS measure, where one is the lowest possible rating (i.e., Poor) and five is the highest possible rating (i.e., Excellent), as shown in Table 3-7.

Table 3-7: Star Ratings

Stars	Percentiles
★★★★★ Excellent	At or above the 90th percentile
★★★★ Very Good	At or between the 75th and 89th percentiles
★★★ Good	At or between the 50th and 74th percentiles
★★ Fair	At or between the 25th and 49th percentiles
★ Poor	Below the 25th percentile

The results presented in the following two tables represent the three-point mean scores for each measure, while the stars represent overall member satisfaction ratings when the three-point means were compared to NCQA HEDIS Benchmarks and Thresholds for Accreditation.[3-2]

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

3-2 NCQA does not publish national benchmarks and thresholds for the Shared Decision Making composite measure, and Coordination of Care and Health Promotion and Education individual item measures; therefore, these CAHPS measures were excluded from the National Comparisons analysis.

Table 3-8 shows the overall member satisfaction ratings on each of the four global ratings.

Table 3-8: National Comparisons—Global Ratings

Plan Name	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often
Washington Medicaid Program	★ 2.23	★ 2.25	★★ 2.46	★★★ 2.51
Amerigroup Washington, Inc.	★ 2.15	★ 2.22	★ 2.38	★★★ 2.51
Community Health Plan of Washington	★ 2.20	★ 2.18	★★ 2.44	★ 2.40
Coordinated Care Corporation	★ 2.23	★ 2.22	★★ 2.44	★★ 2.50
Molina Healthcare of Washington, Inc.	★★ 2.33	★★ 2.29	★★★ 2.51	★★★★ 2.56
United Health Care Community Plan	★ 2.20	★★★ 2.34	★★ 2.49	★★★★ 2.57

The Washington Medicaid Program scored at or between the 50th and 74th percentiles for Rating of Specialist Seen Most Often global rating, scored at or between the 25th and 49th percentile for Rating of Personal Doctor global rating, and scored below the 25th percentile for two global ratings: Rating of Health Plan and Rating of All Health Care.

Amerigroup Washington, Inc., Community Health Plan of Washington, and Coordinated Care Corporation all scored below the 25th percentile on the Rating of Health Plan and Rating of All Health Care global ratings. Three MCOs scored at or between the 25th and 49th percentiles for the Rating of Personal Doctor global rating: Community Health Plan of Washington, Coordinated Care Corporation, and United Health Care Community Plan. Molina Healthcare of Washington, Inc. and United Health Care Community Plan scored at or between the 75th and 89th percentiles for the Rating of Specialist Seen Most Often global rating.

Table 3-9 shows the overall member satisfaction ratings on the four composite measures.

Table 3-9: National Comparisons—Composite Measures

Plan Name	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service
Washington Medicaid Program	★ 2.30	★★ 2.37	★★★★ 2.58	★ 2.46
Amerigroup Washington, Inc.	★★ 2.35	★★★ 2.42	★★ 2.51	★ 2.42
Community Health Plan of Washington	★ 2.24	★ 2.25	★★★★ 2.58	★ 2.40
Coordinated Care Corporation	★ 2.29	★ 2.34	★★★★ 2.59	★★★ 2.56
Molina Healthcare of Washington, Inc.	★ 2.27	★★ 2.39	★★★★ 2.60	★★ 2.52
United Health Care Community Plan	★★★ 2.40	★★★★ 2.45	★★★★ 2.62	★ 2.41

The Washington Medicaid Program scored at or between the 75th and 89th percentiles for the How Well Doctors Communicate composite measure, and scored at or between the 25th and 49th percentiles for the Getting Care Quickly composite measure. Two composite measures scored below the 25th percentile: Getting Needed Care and Customer Service.

Community Health Plan of Washington and Coordinated Care Corporation both scored below the 25th percentile on the Getting Needed Care and Getting Care Quickly composite measures. Community Health Plan of Washington, Coordinated Care Corporation, Molina Healthcare of Washington, Inc., and United Health Care Community Plan all scored at or between the 75th and 89th percentiles for the How Well Doctors Communicate composite measure.

Rates and Proportions

For purposes of the Rates and Proportions analysis, HSAG calculated top-box rates (i.e., rates of satisfaction) for each global rating, composite measure, and individual item measure. For the global ratings, composite measures, and individual item measures, a "top-box" response was defined as follows:

- "9" or "10" for the global ratings,
- "Usually" or "Always" for the Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, and Customer Service composite measures,
- "A lot" or "Yes" for the Shared Decision Making composite measure,
- "Usually" or "Always" for the Coordination of Care individual item measure,
- "Yes" for the Health Promotion and Education individual item measure.

The Washington Medicaid Program results were weighted based on the eligible adult population for each MCO. The 2013 NCQA adult Medicaid national averages are presented for comparison.[3-3,3-4]

3-3 The source for data contained in this publication is Quality Compass® 2013 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).

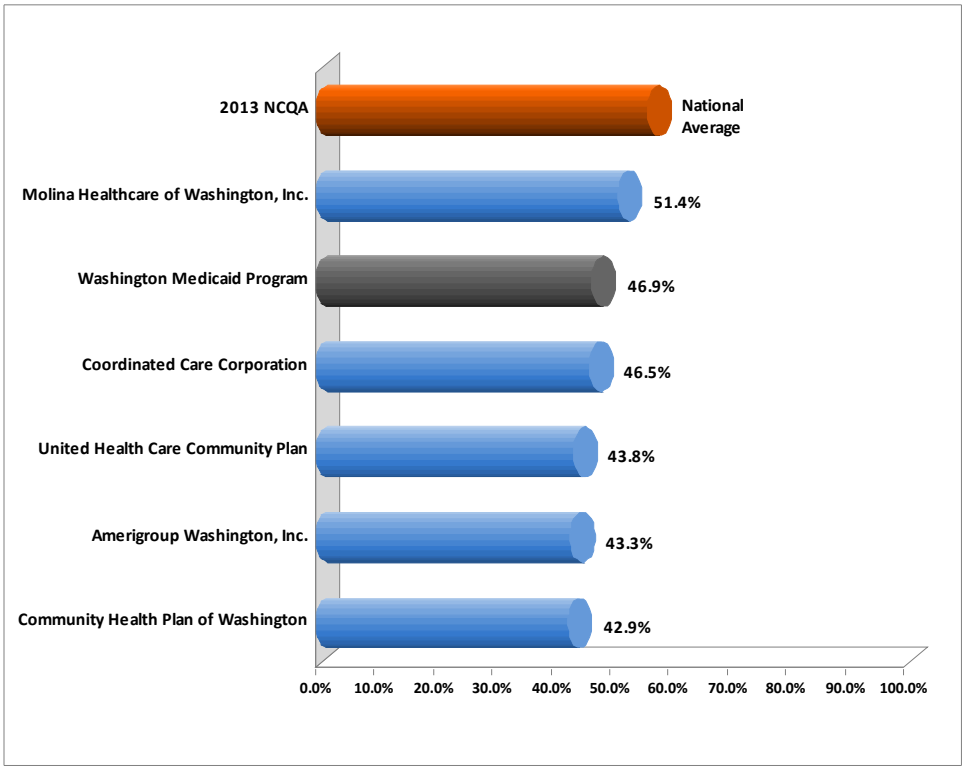
3-4 As a result of the transition from the CAHPS 4.0 to CAHPS 5.0 survey and changes to the Shared Decision Making composite measure and Health Promotion and Education individual item, 2013 NCQA national averages are not available for these CAHPS measures. Thus, comparisons could not be performed.

Global Ratings

Rating of Health Plan

Adult members were asked to rate their 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 defines as those responses with a rating of 9 or 10. Figure 3-1 shows the Rating of Health Plan top-box rates.

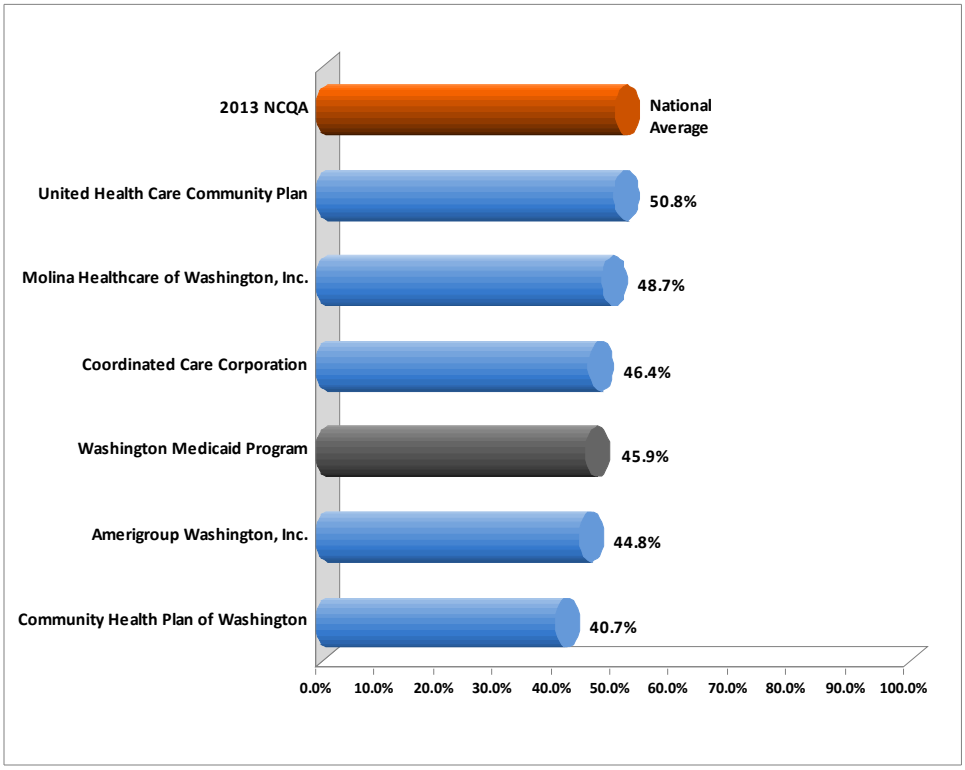
Figure 3-1: Rating of Health Plan Top-Box Rates



Rating of All Health Care

Adult members were asked to rate their 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 defines as those responses with a rating of 9 or 10. Figure 3-2 shows the Rating of All Health Care top-box rates.

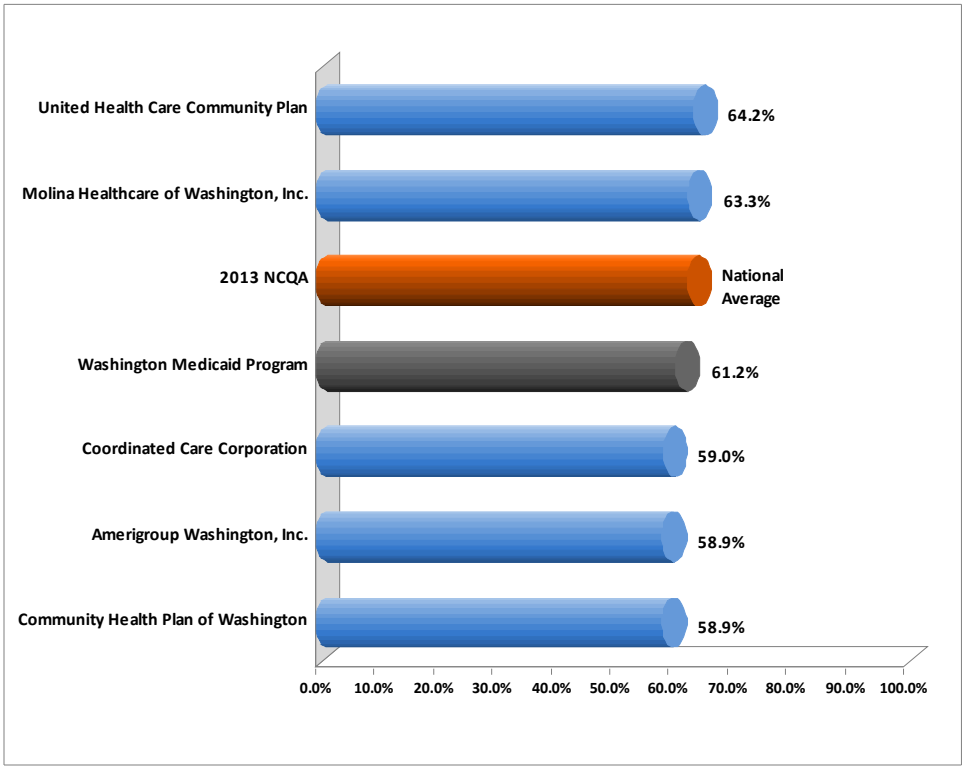
Figure 3-2: Rating of All Health Care Top-Box Rates



Rating of Personal Doctor

Adult members were asked to rate their 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 defines as those responses with a rating of 9 or 10. Figure 3-3 shows the Rating of Personal Doctor top-box rates.

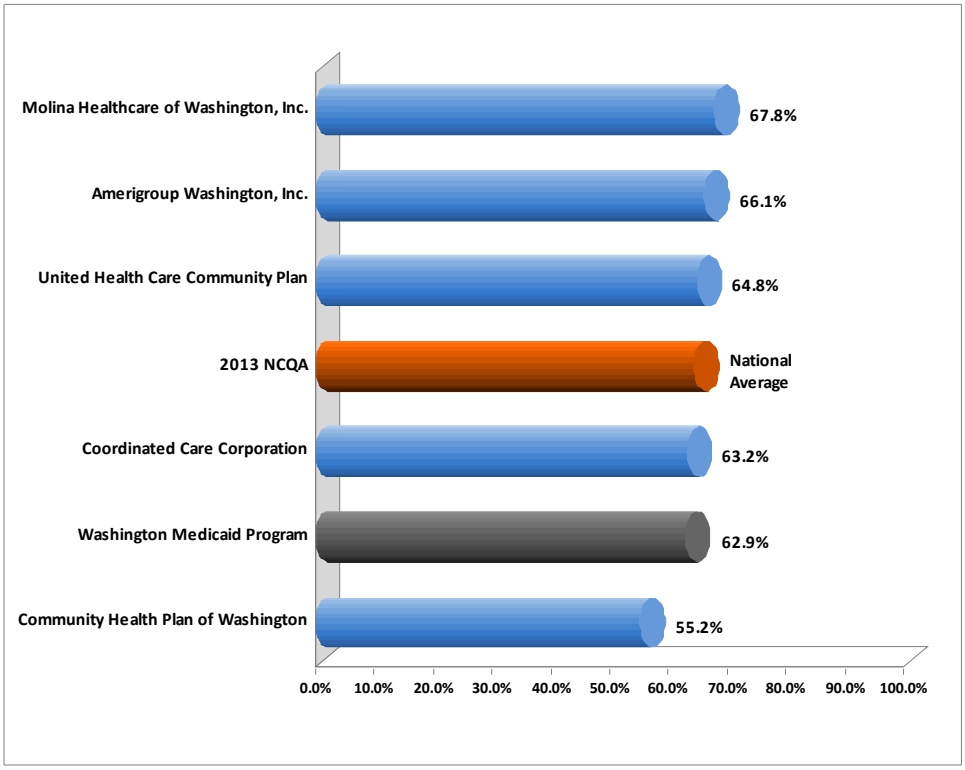
Figure 3-3: Rating of Personal Doctor Top-Box Rates



Rating of Specialist Seen Most Often

Adult members were asked to rate their specialist 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 defines as those responses with a rating of 9 or 10. Figure 3-4 shows the Rating of Specialist Seen Most Often top-box rates.

Figure 3-4: Rating of Specialist Seen Most Often Top-Box Rates



Composite Measures

Getting Needed Care

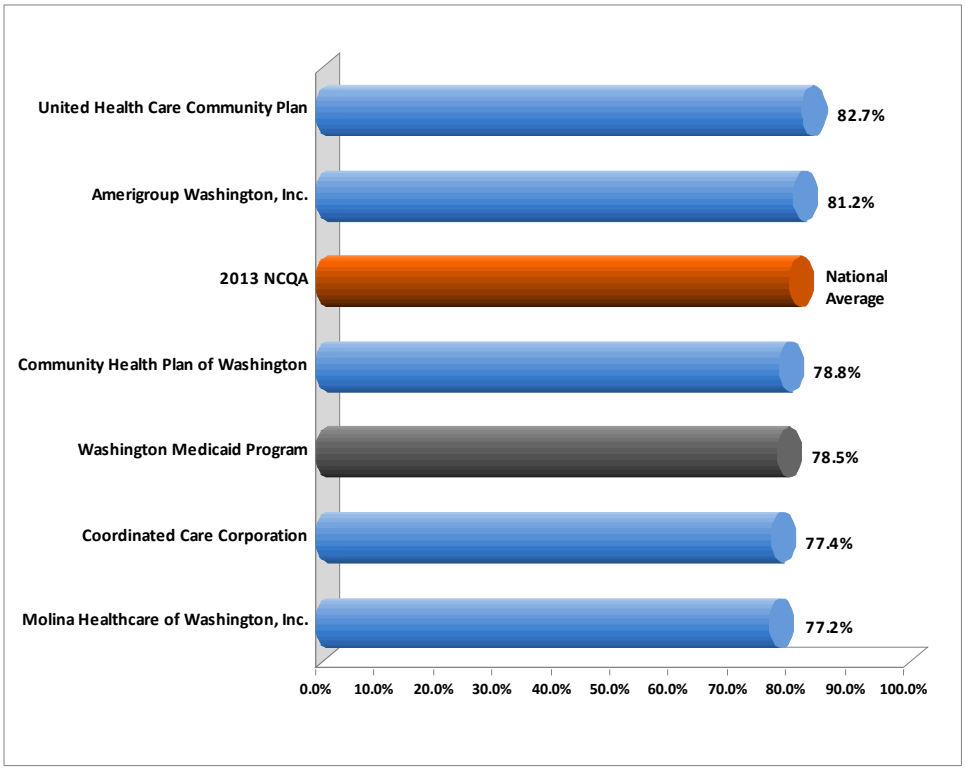
Two questions (Questions 14 and 25 in the CAHPS Adult Medicaid Health Plan Survey) were asked to assess how often it was easy to get needed care:

- **Question 14**. In the last 6 months, how often was it easy to get the care, tests, or treatment you needed?
  - Never
  - Sometimes
  - Usually
  - Always
- **Question 25.** In the last 6 months, how often did you get an appointment to see a specialist as soon as you needed?
  - Never
  - Sometimes
  - Usually
  - Always

For purposes of the Rates and Proportions analysis, HSAG calculated top-box rates for the Getting Needed Care composite measure, which represents the percentage of members who answered "Usually" or "Always" to these questions.

Figure 3-5 shows the Getting Needed Care top-box rates.

Figure 3-5: Getting Needed Care Top-Box Rates



Getting Care Quickly

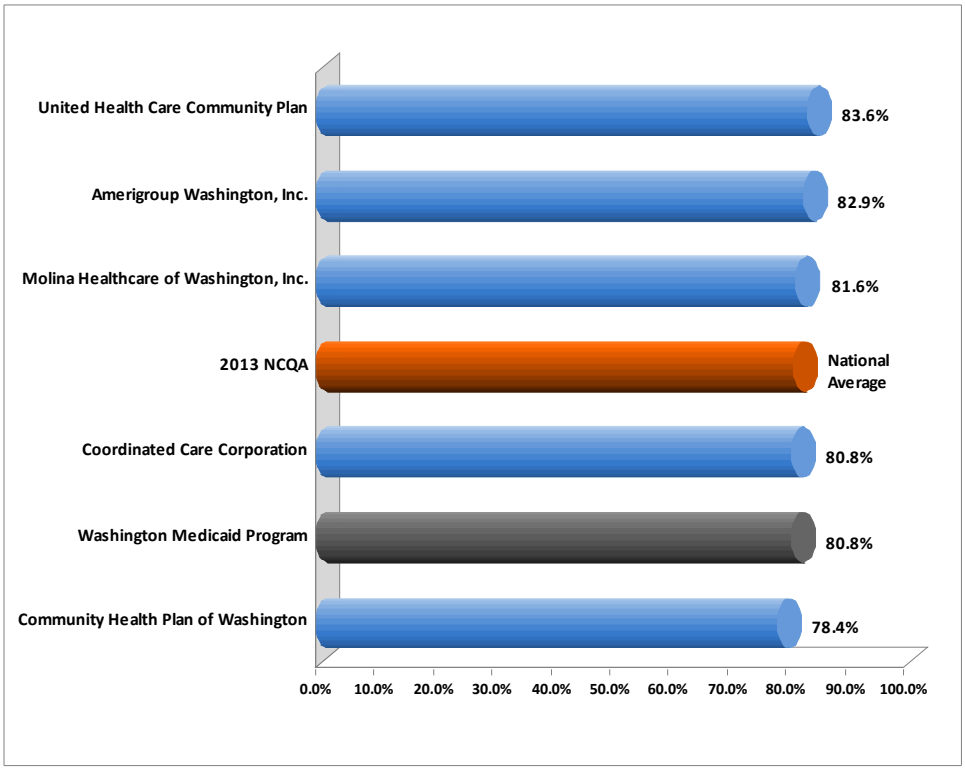
Two questions (Questions 4 and 6 in the CAHPS Adult Medicaid Health Plan Survey) were asked to assess how often adult members received care quickly:

- **Question 4**. In the last 6 months, when you needed care right away, how often did you get care as soon as you needed?
  - Never
  - Sometimes
  - Usually
  - Always
- **Question 6**. In the last 6 months, how often did you get an appointment for a check-up or routine care at a doctor's office or clinic as soon as you needed?
  - Never
  - Sometimes
  - Usually
  - Always

For purposes of the Rates and Proportions analysis, HSAG calculated top-box rates for the Getting Care Quickly composite measure, which represents the percentage of members who answered "Usually" or "Always" to these questions.

Figure 3-6 shows the Getting Care Quickly top-box rates.

Figure 3-6: Getting Care Quickly Top-Box Rates



How Well Doctors Communicate

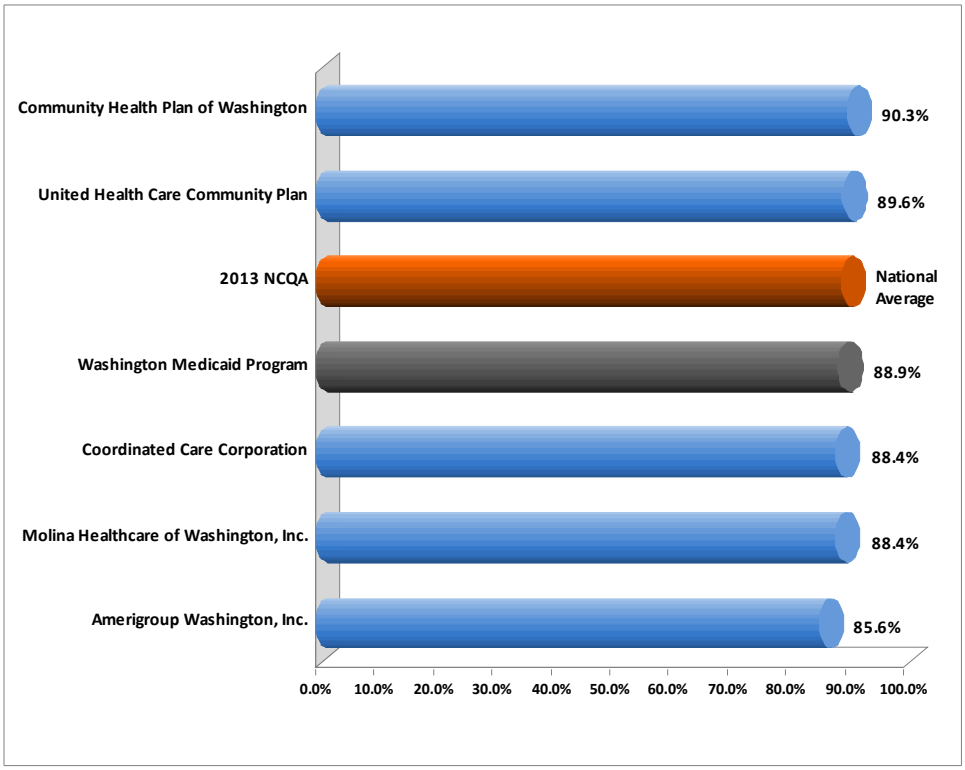
A series of four questions (Questions 17, 18, 19, and 20 in the CAHPS Adult Medicaid Health Plan Survey) was asked to assess how often doctors communicated well:

- **Question 17**. In the last 6 months, how often did your personal doctor explain things in a way that was easy to understand?
  - Never
  - Sometimes
  - Usually
  - Always
- **Question 18**. In the last 6 months, how often did your personal doctor listen carefully to you?
  - Never
  - Sometimes
  - Usually
  - Always
- **Question 19**. In the last 6 months, how often did your personal doctor show respect for what you had to say?
  - Never
  - Sometimes
  - Usually
  - Always
- **Question 20**. In the last 6 months, how often did your personal doctor spend enough time with you?
  - Never
  - Sometimes
  - Usually
  - Always

For purposes of the Rates and Proportions analysis, HSAG calculated top-box rates for the How Well Doctors Communicate composite measure, which represents the percentage of members who answered "Usually" or "Always" to these questions.

Figure 3-7 shows the How Well Doctors Communicate top-box rates.

Figure 3-7: How Well Doctors Communicate Top-Box Rates



Customer Service

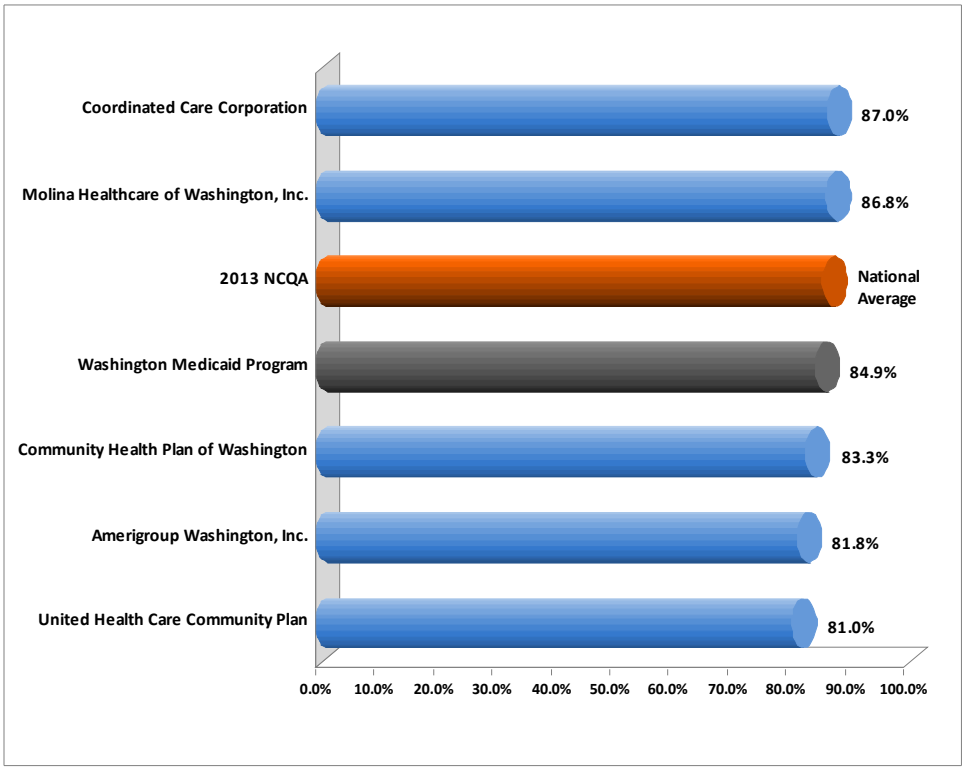
Two questions (Questions 31 and 32 in the CAHPS Adult Medicaid Health Plan Survey) were asked to assess how often adult members were satisfied with customer service:

- **Question 31**. In the last 6 months, how often did your health plan's customer service give you the information or help you needed?
  - Never
  - Sometimes
  - Usually
  - Always
- **Question 32**. In the last 6 months, how often did your health plan's customer service staff treat you with courtesy and respect?
  - Never
  - Sometimes
  - Usually
  - Always

For purposes of the Rates and Proportions analysis, HSAG calculated top-box rates for the Customer Service composite measure, which represents the percentage of members who answered "Usually" or "Always" to these questions.

Figure 3-8 shows the Customer Service top-box rates.

Figure 3-8: Customer Service Top-Box Rates



Shared Decision Making

Three questions (Questions 10, 11, and 12 in the CAHPS Adult Medicaid Health Plan Survey) were asked regarding the involvement of adult members in decision making when stopping or starting prescription medicine:[3-5]

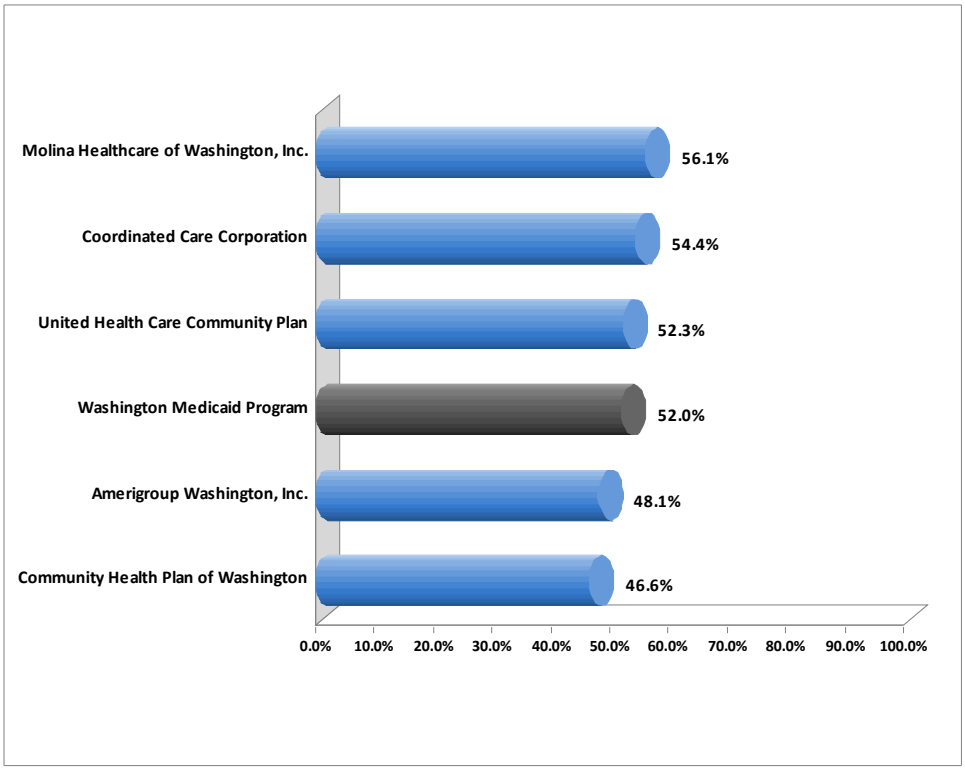
- **Question 10**. When you talked about starting or stopping a prescription medicine, how much did a doctor or other health provider talk about the reasons you might want to take a medicine?
  - Not at all
  - A little
  - Some
  - A lot
- **Question 11**. When you talked about starting or stopping a prescription medicine, how much did a doctor or other health provider talk about the reasons you might not want to take a medicine?
  - Not at all
  - A little
  - Some
  - A lot
- **Question 12**. When you talked about starting or stopping a prescription medicine, did a doctor or other health provider ask you what you thought was best for you?
  - Yes
  - No

For purposes of the Rates and Proportions analysis, HSAG calculated top-box rates for the Shared Decision Making composite measure, which represents the percentage of members who answered "A lot" or "Yes" to these questions.

[3-5] With the transition to the CAHPS 5.0 Adult Medicaid Health Plan Survey and changes to the Shared Decision Making composite measure, 2013 NCQA national averages are not available for this CAHPS measure.

Figure 3-9 shows the Shared Decision Making top-box rates.

Figure 3-9: Shared Decision Making Top-Box Rates



As previously noted, due to changes to the Shared Decision Making composite measure, 2013 NCQA national averages are not available for this measure. Therefore, comparisons could not be performed and the national average is not presented in the figure above.

Individual Item Measures

Coordination of Care

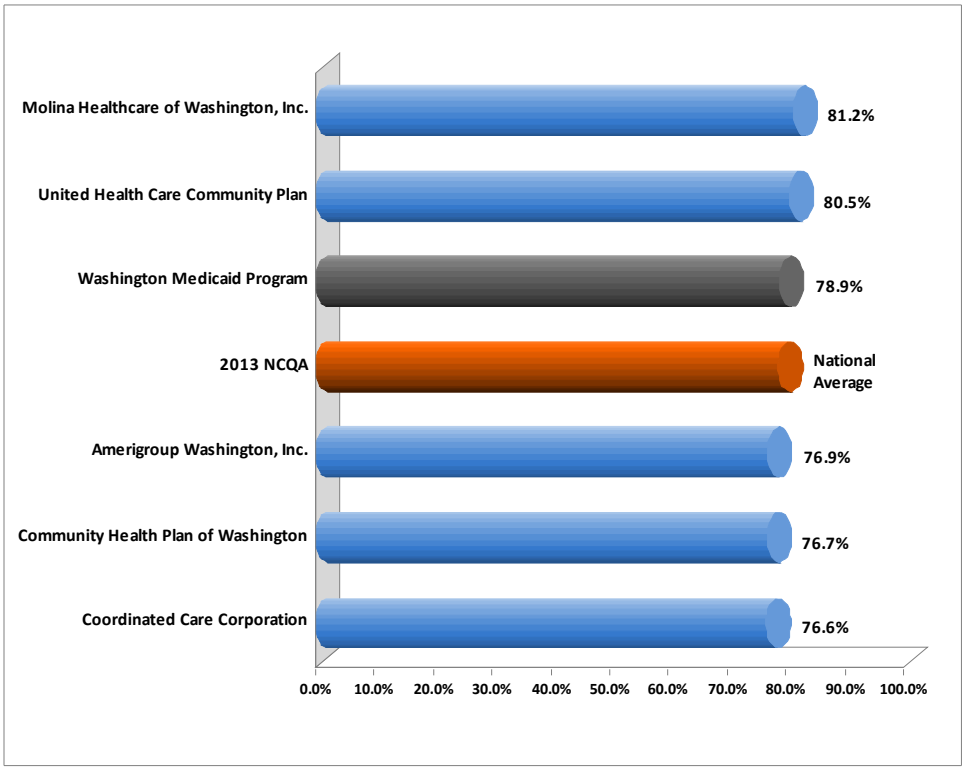
One question (Question 22 in the CAHPS Adult Medicaid Health Plan Survey) was asked to assess how often adult members' personal doctors seemed informed and up-to-date about care they received from another doctor:

- **Question 22**. In the last 6 months, how often did your personal doctor seem informed and up-to-date about the care you got from these doctors or other health providers?
  - Never
  - Sometimes
  - Usually
  - Always

For purposes of the Rates and Proportions analysis, HSAG calculated top-box rates for the Coordination of Care individual item measure, which represents the percentage of members who answered "Usually" or "Always" to this question.

Figure 3-10 shows the Coordination of Care top-box rates.

Figure 3-10: Coordination of Care Top-Box Rates



Health Promotion and Education

One question (Question 8 in the CAHPS Adult Medicaid Health Plan Survey) was asked of adult members to assess if their doctors talked with them about specific things they could do to prevent illness:[3-6]

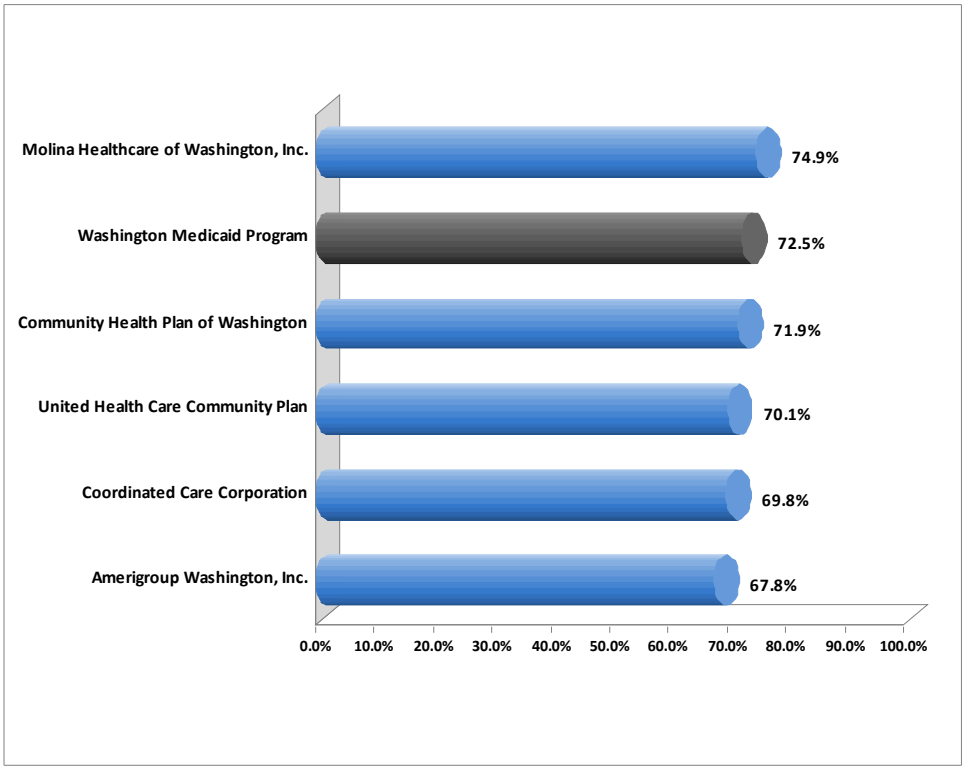
- **Question 8.** In the last 6 months, did you and a doctor or other health provider talk about specific things you could do to prevent illness?
  - Yes
  - No

For purposes of the Rates and Proportions analysis, HSAG calculated top-box rates for the Health Promotion and Education individual item measure, which represents the percentage of members who answered "Yes" to this question.

[3-6] With the transition to the CAHPS 5.0 Adult Medicaid Health Plan Survey and changes to the Health Promotion and Education individual item measure, 2013 NCQA national averages are not available for this CAHPS measure.

Figure 3-11 shows the Health Promotion and Education top-box rates.

Figure 3-11: Health Promotion and Education Top-Box Rates



As previously noted, due to changes to the Health Promotion and Education individual item measure, 2013 NCQA national averages are not available for this measure. Therefore, comparisons could not be performed and the national average is not presented in the figure above.

Statewide Comparisons

In order to identify performance differences in member satisfaction between the five MCOs, the three-point mean scores of each MCO were compared to one another using standard tests for statistical significance.[3-7] For purposes of the Statewide Comparisons analysis, the three-point mean scores were case-mix adjusted. Case-mix refers to the characteristics of respondents used in adjusting the results for comparability among health plans. Results were case-mix adjusted for general health status, education level, and age of the respondent.[3-8] Given that differences in case-mix can result in differences in ratings between 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).

The scoring of the global ratings, composite measures, and individual item measures three-point means involved assigning responses a score of one, two, or three. After applying this scoring methodology, the mean of responses was calculated in order to determine the three-point means. For additional detail on the calculation of three-point means, please refer to the *NCQA HEDIS 2014 Specifications for Survey Measures, Volume 3*.

The case-mix adjusted three-point mean scores of each MCO were then compared to one another to identify if differences in member satisfaction were statistically significant. Statistically significant differences are noted in the tables by arrows. An MCO that performed statistically better than the Washington Medicaid Program average is denoted with an upward (↑) arrow. Conversely, an MCO that performed statistically worse than the Washington Medicaid Program average is denoted with a downward (↓) arrow. If an MCO's score is not statistically different than the Washington Medicaid Program average, the MCO's score is denoted with a horizontal (↔) arrow.

Table 3-10 through Table 3-12, on the following page, show the results of the Statewide Comparisons analysis for the global ratings, composite measures, and individual items measures, respectively. **NOTE: These three-point mean scores may differ from those presented in the NCQA Comparison tables because they have been adjusted for differences in case mix (i.e., the three-point means presented have been case-mix adjusted).**

3-7 Caution should be exercised when interpreting the results of the Statewide Comparisons, given that population and plan differences may impact CAHPS results.

3-8 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 3-10: Statewide Comparisons—Global Ratings								
Plan Name	Rating of Health Plan		Rating of All Health Care		Rating of Personal Doctor		Rating of Specialist Seen Most Often	
Washington Medicaid Program	**2.25**		**2.25**		**2.47**		**2.50**	
Amerigroup Washington, Inc.	2.15	↔	2.23	↔	2.38	↔	2.52	↔
Community Health Plan of Washington	2.17	↔	2.12	↓	2.41	↔	2.38	↓
Coordinated Care Corporation	2.24	↔	2.25	↔	2.46	↔	2.50	↔
Molina Healthcare of Washington, Inc.	2.34	↑	2.30	↔	2.52	↔	2.57	↔
United Health Care Community Plan	2.21	↔	2.34	↑	2.50	↔	2.58	↔

↑ *Indicates the plan's score is statistically better than the Washington Medicaid Program average.*
↔ *Indicates the plan's score is not statistically different than the Washington Medicaid Program average.*
↓ *Indicates the plan's score is statistically worse than the Washington Medicaid Program average.*

Table 3-11: Statewide Comparisons—Composite Measures										
Plan Name	Getting Needed Care		Getting Care Quickly		How Well Doctors Communicate		Customer Service		Shared Decision Making	
Washington Medicaid Program	**2.28**		**2.35**		**2.59**		**2.47**		**2.26**	
Amerigroup Washington, Inc.	2.34	↔	2.41	↔	2.52	↔	2.43	↔	2.17	↔
Community Health Plan of Washington	2.21	↓	2.23	↓	2.55	↔	2.37	↓	2.18	↔
Coordinated Care Corporation	2.30	↔	2.35	↔	2.61	↔	2.56	↔	2.32	↔
Molina Healthcare of Washington, Inc.	2.28	↔	2.40	↔	2.60	↔	2.52	↔	2.30	↔
United Health Care Community Plan	2.41	↑	2.45	↑	2.62	↔	2.42	↔	2.27	↔

↑ *Indicates the plan's score is statistically better than the Washington Medicaid Program average.*
↔ *Indicates the plan's score is not statistically different than the Washington Medicaid Program average.*
↓ *Indicates the plan's score is statistically worse than the Washington Medicaid Program average.*

Table 3-12: Statewide Comparisons—Individual Measures				
Plan Name	Coordination of Care		Health Promotion and Education	
Washington Medicaid Program	**2.45**		**2.31**	
Amerigroup Washington, Inc.	2.25	↔	2.33	↔
Community Health Plan of Washington	2.20	↔	2.44	↔
Coordinated Care Corporation	2.30	↔	2.39	↔
Molina Healthcare of Washington, Inc.	2.43	↔	2.54	↑
United Health Care Community Plan	2.33	↔	2.36	↔

↑ *Indicates the plan's score is statistically better than the Washington Medicaid Program average.*
↔ *Indicates the plan's score is not statistically different than the Washington Medicaid Program average.*
↓ *Indicates the plan's score is statistically worse than the Washington Medicaid Program average.*

Summary of Statewide Comparisons Results

The Statewide Comparisons revealed the following results.

- Amerigroup Washington, Inc. and Coordinated Care Corporation did not score statistically *better* or *worse* than the Washington Medicaid Program average on any of the CAHPS measures.
- Community Health Plan of Washington scored statistically *worse* than the Washington Program Medicaid average on five CAHPS measures: Rating of All Health Care, Rating of Specialist Seen Most Often, Getting Needed Care, Getting Care Quickly, and Customer Service.
- Molina Healthcare of Washington, Inc. scored statistically *better* than the Washington Medicaid Program average on two CAHPS measures: Rating of Health Plan and Health Promotion and Education.
- United Health Care Community Plan scored statistically *better* than the Washington Medicaid Program average on three CAHPS measures: Rating of All Health Care, Getting Needed Care, and Getting Care Quickly.

Supplemental Items Results

HCA selected 10 supplemental items for inclusion in the MCOs' CAHPS 5.0 Adult Medicaid Health Plan Survey. The supplemental items focused on a number of topics, including treatment or counseling, special medical equipment, pain management, access to specialist care, and coordinating care among health providers. The MCOs contracted with separate survey vendors to administer the CAHPS Survey. Table 3-13 details the survey language and response options for each of the supplemental items. Table 3-14 though Table 3-23 shows the results for each supplemental item.[3-9] For these supplemental items, the number and percentage of responses for each item are presented.

Table 3-13: Supplemental Items

Question		Response Options
SQ1.	In the last 6 months, did you need any treatment or counseling for a personal or family problem?	Yes No
SQ2.	In the last 6 months, how often was it easy to get the treatment or counseling you needed through your health plan?	Never Sometimes Usually Always
SQ3.	In the last 6 months, did you have a health problem for which you needed special medical equipment, such as a cane, a wheelchair, or oxygen equipment?	Yes No
SQ4.	In the last 6 months, how often was it easy to get the medical equipment you needed through your health plan?	Never Sometimes Usually Always
SQ5.	In the last 6 months, did you and your personal doctor talk about pain?	Yes No
SQ6.	In the last 6 months, how often did pain limit your ability to do the things you needed to do?	Never Sometimes Usually Always
SQ7.	In the last 6 months, do you think that your personal doctor understood the impact that pain has on your life?	Yes No

[3-9] Given the differences in placement and sequence of the HCA-selected supplemental items within Community Health Plan of Washington's survey instrument, caution should be exercised when interpreting the plan's results of the supplemental items.

Table 3-13: Supplemental Items		
	Question	**Response Options**
SQ8.	Were any of the following a reason it was not easy to get an appointment with a specialist? [Mark one or more/Mark all that apply/Check all that apply].[3-10]	Your doctor did not think you needed to see a specialist Your health plan approval or authorization was delayed You weren't sure where to find a list of specialists in your health plan or network The specialist you had to choose from were too far away You did not have enough specialists to choose from The specialist you wanted did not belong to your health plan or network You could not get an appointment at a time that was convenient Some other reason
SQ9.	In the last 6 months, did anyone from your health plan, personal doctor's office of clinic help coordinate care among these doctors or other health providers?	Yes No I did not receive care from a doctor or other health provider besides my personal doctor in the last 6 months
SQ10.	How satisfied are you with the help you received to coordinate your care in the last 6 months?	Very dissatisfied Dissatisfied Neither dissatisfied nor satisfied Satisfied Very Satisfied

[3-10] For this supplemental item, Community Health Plan of Washington did not include survey language to indicate that more than one response option could be selected (e.g., "Mark one or more." or "Mark all that apply."). Based on the supplemental item data provided for Community Health Plan of Washington, respondents were allowed to select only one response option for this supplemental item.

Treatment or Counseling

Adult members were asked if they needed treatment or counseling for a personal or family problem (Supplemental Item 1). Table 3-14 displays the responses for this question.

Table 3-14
Needed Treatment or Counseling

	Yes		No	
	N	%	N	%
Amerigroup Washington, Inc.	84	24.3%	261	75.7%
Community Health Plan of Washington	97	18.7%	421	81.3%
Coordinated Care Corporation	66	18.8%	286	81.3%
Molina Healthcare of Washington, Inc.	115	23.8%	368	76.2%
United Health Care Community Plan	112	23.2%	371	76.8%

Adult members were asked to assess how often was it easy to get the treatment or counseling they needed through their health plan (Supplemental Item 2). Table 3-15 displays the responses for this question.

Table 3-15
Access to Treatment or Counseling

	Never		Sometimes		Usually		Always	
	N	%	N	%	N	%	N	%
Amerigroup Washington, Inc.	11	13.4%	9	11.0%	16	19.5%	46	56.1%
Community Health Plan of Washington	20	21.5%	13	14.0%	20	21.5%	40	43.0%
Coordinated Care Corporation	5	7.9%	8	12.7%	12	19.0%	38	60.3%
Molina Healthcare of Washington, Inc.	9	8.4%	10	9.3%	33	30.8%	55	51.4%
United Health Care Community Plan	15	14.4%	10	9.6%	29	27.9%	50	48.1%

Special Medical Equipment

Adult members were asked if they had a health problem for which they needed special medical equipment, such as a cane, a wheelchair, or oxygen equipment (Supplemental Item 3). Table 3-16 displays the responses for this question.

Table 3-16
Had a Problem for Which Special Medical Equipment Is Needed

	Yes		No	
	N	%	N	%
Amerigroup Washington, Inc.	52	15.0%	295	85.0%
Community Health Plan of Washington	46	9.0%	466	91.0%
Coordinated Care Corporation	47	13.4%	303	86.6%
Molina Healthcare of Washington, Inc.	71	14.8%	410	85.2%
United Health Care Community Plan	84	17.4%	400	82.6%

Adult members were asked to assess how often was it easy to get medical equipment they needed through their health plan (Supplemental Item 4). Table 3-17 displays the responses for this question.

Table 3-17
Easy to Get Needed Medical Equipment

	Never		Sometimes		Usually		Always	
	N	%	N	%	N	%	N	%
Amerigroup Washington, Inc.	11	24.4%	6	13.3%	8	17.8%	20	44.4%
Community Health Plan of Washington	9	20.9%	8	18.6%	10	23.3%	16	37.2%
Coordinated Care Corporation	5	11.4%	7	15.9%	8	18.2%	24	54.5%
Molina Healthcare of Washington, Inc.	12	17.4%	8	11.6%	14	20.3%	35	50.7%
United Health Care Community Plan	20	26.3%	8	10.5%	19	25.0%	29	38.2%

Pain Management

Adult members were asked if they talked with their personal doctor about pain (Supplemental Item 5). Table 3-18 displays the responses for this question.

Table 3-18
Talk with Personal Doctor About Pain

	Yes		No	
	N	%	N	%
Amerigroup Washington, Inc.	161	46.7%	184	53.3%
Community Health Plan of Washington	245	48.6%	259	51.4%
Coordinated Care Corporation	177	50.0%	177	50.0%
Molina Healthcare of Washington, Inc.	238	49.6%	242	50.4%
United Health Care Community Plan	239	50.2%	237	49.8%

Adult members were asked to assess how often pain limited their ability to do the things they needed to do (Supplemental Item 6). Table 3-19 displays the responses for this question.

Table 3-19
How Often Pain Limited Ability to Do Things

	Never		Sometimes		Usually		Always	
	N	%	N	%	N	%	N	%
Amerigroup Washington, Inc.	105	31.1%	107	31.7%	45	13.3%	81	24.0%
Community Health Plan of Washington	202	40.6%	140	28.1%	73	14.7%	83	16.7%
Coordinated Care Corporation	121	35.0%	104	30.1%	53	15.3%	68	19.7%
Molina Healthcare of Washington, Inc.	177	37.0%	135	28.2%	72	15.0%	95	19.8%
United Health Care Community Plan	149	31.9%	129	27.6%	72	15.4%	117	25.1%

Adult members were asked if they thought their personal doctor understood the impact pain has on their life (Supplemental Item 7). Table 3-20 displays the responses for this question.

Table 3-20
Doctor Understood the Impact of Pain on Life

	Yes		No	
	N	%	N	%
Amerigroup Washington, Inc.	140	63.9%	79	36.1%
Community Health Plan of Washington	179	62.6%	107	37.4%
Coordinated Care Corporation	143	67.8%	68	32.2%
Molina Healthcare of Washington, Inc.	186	65.5%	98	34.5%
United Health Care Community Plan	208	67.8%	99	32.2%

Access to Specialist Care

Adult members were asked about the reason(s) it was not easy to get an appointment with a specialist (Supplemental Item 8).[3-11] Table 3-21 displays the number and percentage of members who selected each response option.

Table 3-21
Reason It Was Difficult to Make Appointment with Specialist

Response/Plan Name	Yes	
Doctor Did Not Think Client Needed to See a Specialist	**N**	**%**
Amerigroup Washington, Inc.	30	16.3%
Community Health Plan of Washington	49	23.1%
Coordinated Care Corporation	44	23.0%
Molina Healthcare of Washington, Inc.	60	24.9%
United Health Care Community Plan	54	20.6%
Health Plan Did Not Approve Client to See Specialist	**N**	**%**
Amerigroup Washington, Inc.	28	15.2%
Community Health Plan of Washington	24	11.3%
Coordinated Care Corporation	30	15.7%
Molina Healthcare of Washington, Inc.	41	17.0%
United Health Care Community Plan	45	17.2%
Client Did Not Know Where to Find a List of Specialists in Network	**N**	**%**
Amerigroup Washington, Inc.	42	22.8%
Community Health Plan of Washington	13	6.1%
Coordinated Care Corporation	23	12.0%
Molina Healthcare of Washington, Inc.	30	12.4%
United Health Care Community Plan	58	22.1%
The Specialists to Choose From Were Too Far Away	**N**	**%**
Amerigroup Washington, Inc.	18	9.8%
Community Health Plan of Washington	17	8.0%
Coordinated Care Corporation	21	11.0%
Molina Healthcare of Washington, Inc.	33	13.7%
United Health Care Community Plan	39	14.9%

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

[3-11] As previously noted, all of the MCOs, with the exception of Community Health Plan of Washington, allowed more than one response option to be selected for this supplemental item. Based on the survey instrument provided to HSAG, language to indicate that more than one response option could be selected (e.g., "Mark one or more." or "Mark all that apply.") was not included in the survey instrument administered by Community Health Plan of Washington.

Table 3-21 Reason It Was Difficult to Make Appointment with Specialist		
Response/Plan Name	**Yes**	
There Were Not Enough Specialists to Choose From	**N**	**%**
Amerigroup Washington, Inc.	13	7.1%
Community Health Plan of Washington	9	4.2%
Coordinated Care Corporation	14	7.3%
Molina Healthcare of Washington, Inc.	24	10.0%
United Health Care Community Plan	41	15.6%
Desired Specialist Was Not in Network	**N**	**%**
Amerigroup Washington, Inc.	36	19.6%
Community Health Plan of Washington	15	7.1%
Coordinated Care Corporation	28	14.7%
Molina Healthcare of Washington, Inc.	39	16.2%
United Health Care Community Plan	59	22.5%
Could Not Get and Appointment as a Convenient Time	**N**	**%**
Amerigroup Washington, Inc.	22	12.0%
Community Health Plan of Washington	21	9.9%
Coordinated Care Corporation	34	17.8%
Molina Healthcare of Washington, Inc.	51	21.2%
United Health Care Community Plan	45	17.2%
Some Other Reason	**N**	**%**
Amerigroup Washington, Inc.	83	45.1%
Community Health Plan of Washington	64	30.2%
Coordinated Care Corporation	64	33.5%
Molina Healthcare of Washington, Inc.	82	34.0%
United Health Care Community Plan	87	33.2%
Please note, respondents may have marked more than one response option; therefore, percentages will not total 100%.		

Care Coordination Among Other Health Providers

Adult members were asked if anyone from their health plan, personal doctor's office or clinic helped coordinate their care among doctor's or health providers (Supplemental Item 9). Table 3-22 displays the responses for this question.

Table 3-22
Received Help Coordinating Care Among Different Providers

	Yes		No		Did Not Receive Care from Other Provider	
	N	%	N	%	N	%
Amerigroup Washington, Inc.	101	32.1%	175	55.6%	39	12.4%
Community Health Plan of Washington	136	26.7%	373	73.3%	0	0%
Coordinated Care Corporation	118	36.4%	144	44.4%	62	19.1%
Molina Healthcare of Washington, Inc.	164	36.0%	207	45.5%	84	18.5%
United Health Care Community Plan	170	37.1%	239	52.2%	49	10.7%

Adult members were asked how satisfied they were with the help they received to coordinate care in the last 6 months (Supplemental Item 10). Table 3-23 displays the responses for this question.

Table 3-23
Satisfied with Help Coordinating Care

	Very dissatisfied		Dissatisfied		Neutral		Satisfied		Very satisfied	
	N	%	N	%	N	%	N	%	N	%
Amerigroup Washington, Inc.	3	3.0%	3	3.0%	6	6.1%	36	36.4%	51	51.5%
Community Health Plan of Washington	8	6.1%	3	2.3%	9	6.8%	56	42.4%	56	42.4%
Coordinated Care Corporation	4	3.6%	5	4.5%	9	8.0%	47	42.0%	47	42.0%
Molina Healthcare of Washington, Inc.	7	4.3%	7	4.3%	18	11.0%	72	44.2%	59	36.2%
United Health Care Community Plan	11	6.5%	10	6.0%	16	9.5%	66	39.3%	65	38.7%

Key Drivers of Satisfaction

HSAG performed an analysis of key drivers for three measures: Rating of Health Plan, Rating of All Health Care, and Rating of Personal Doctor. The analysis provides information on: 1) how well the Washington Medicaid Program is performing on the survey item (i.e., question), and 2) how important the item is to overall satisfaction.

Key drivers of satisfaction are defined as those items that (1) have a problem score that is greater than or equal to the program's median problem score for all items examined, and (2) have a correlation that is greater than or equal to the program's median correlation for all items examined. For additional information on the assignment of problem scores, please refer to the Reader's Guide section. Table 4-1 depicts those items identified for each of the three measures as being key drivers of satisfaction for the Washington Medicaid Program.

Table 4-1: Washington Medicaid Program Key Drivers of Satisfaction
Rating of Health Plan
Respondents reported that their health plan's customer service did not always give them the information or help they needed.
Respondents reported that information in written materials or on the Internet about how the health plan works did not always provide the information they needed.
Respondents reported that forms from their health plan were often not easy to fill out.
Rating of All Health Care
Respondents reported that when they talked about starting or stopping a prescription medicine, a doctor or other health provider did not ask what they thought was best for them.
Respondents reported that their personal doctor did not always seem informed and up-to-date about the care they received from other doctors or health providers.
Respondents reported that it was often not easy to obtain appointments with specialists.
Rating of Personal Doctor
Respondents reported that it was not always easy to get the care, tests, or treatment they thought they needed through their health plan.
Respondents reported that their personal doctor did not always seem informed and up-to-date about the care they received from other doctors or health providers.

Recommendations for Quality Improvement

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, the surveys also play an important role as a QI tool for health care organizations, which can use the standardized data and results to identify relative strengths and weaknesses in their performance, determine where they need to improve, and track their progress over time. Below are general QI recommendations based on the most up-to-date information in the CAHPS literature. For additional information, refer to the QI references beginning on page 5-14.

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.

Rating of All Health Care

Access to Care

Health plans should identify potential barriers for patients receiving appropriate access to care. Access to care issues include obtaining the care that the patient and/or physician deemed necessary, obtaining timely urgent care, locating a personal doctor, or receiving adequate assistance when calling a physician office. The health plan should attempt to reduce any hindrances a patient might encounter while seeking care. Standard practices and established protocols can assist in this process by ensuring access to care issues are handled consistently across all practices. For example, health plans can develop standardized protocols and scripts for common occurrences within the provider office setting, such as late patients. With proactive polices and scripts in place, the late patient can be notified the provider has moved onto the next patient and will work the late patient into the rotation as time permits. This type of structure allows the late patient to still receive care without causing delay in the appointments of other patients. Additionally, having a well-written script prepared in the event of an uncommon but expected situation, allows staff to work quickly in providing timely access to care while following protocol.

Patient and Family Engagement and Advisory Councils

Since both patients and families have the direct experience of an illness or health care system, their perspectives can provide significant insight when performing an evaluation of health care processes. Therefore, health plans should consider creating opportunities and functional roles that include the patients and families who represent the populations they serve. Patient and family members could serve as advisory council members providing new perspectives and serving as a resource to health care processes. Patient interviews on services received and family inclusion in care planning can be an effective strategy for involving members in the design of care and obtaining their input and feedback on how to improve the delivery of care. Further, involvement in advisory councils can provide a structure and process for ongoing dialogue and creative problem-solving between the health plan and its members. The councils' roles within a health plan organization can vary and responsibilities may include input into or involvement in: program development, implementation, and evaluation; marketing of health care services; and design of new materials or tools that support the provider-patient relationship.

Rating of Personal Doctor

Maintain Truth in Scheduling

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

Direct Patient Feedback

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

Physician-Patient Communication

Health plans should encourage physician-patient communication to improve patient satisfaction and outcomes. Indicators of good physician-patient communication include providing clear explanations, listening carefully, and being understanding of patients' perspectives. Health plans can also create specialized workshops focused on enhancing physicians' communication skills, relationship building, and the importance of physician-patient communication. Training sessions can include topics such as improving listening techniques, patient-centered interviewing skills, collaborative communication which involves allowing the patient to discuss and share in the decision making process, as well as effectively communicating expectations and goals of health care treatment. In addition, workshops can include training on the use of tools that improve physician-patient communication. Examples of effective tools include visual medication schedules and the "Teach Back" method, which has patients communicate back the information the physician has provided.

Improving Shared Decision Making

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

Rating of Specialist Seen Most Often

Planned Visit Management

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

Skills Training for Specialists

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

Telemedicine

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

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.

Language Concordance Programs

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

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.

Getting Care Quickly

Decrease No-Show Appointments

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

Electronic Communication

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

Nurse Advice Help Line

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

Open Access Scheduling

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

Patient Flow Analysis

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

How Well Doctors Communicate

Communication Tools for Patients

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

Improve Health Literacy

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

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

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

Language Barriers

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

Customer Service

Call Centers

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

Creating an Effective Customer Service Training Program

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

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

The key to ensuring that employees carry out the skills they learned in training is to not only provide motivation, but implement a support structure when they are back on the job so that they are held responsible. It is advised that all employees sign a commitment statement to affirm the

course of action agreed upon. Health plans should ensure leadership is involved in the training process to help establish camaraderie between managers and employees and to help employees realize the impact of their role in making change.

Customer Service Performance Measures

Setting plan-level customer service standards can assist in addressing areas of concern and serve as domains for which health plans can evaluate and modify internal customer service performance measures, such as call center representatives' call abandonment rates (i.e., average rate of disconnects), the amount of time it takes to resolve a member's inquiry about prior authorizations, and the number of member complaints. Collected measures should be communicated with providers and staff members. Additionally, by tracking and reporting progress internally and modifying measures as needed, customer service performance is more likely to improve.

Shared Decision Making

Skills Training for Physicians

Health plans should encourage skills training for all physicians. Implementing a shared decision making model requires physician recognition that patients have the ability to make choices that affect their health care. Therefore, one key to a successful shared decision making model is ensuring that physicians are properly trained.

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

Shared Decision Making Materials

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

Patient Education

Patients who are educated about their medical condition(s) are more likely to play an active role in the management of their own health. Health plans can provide members with educational literature and information. Items such as brochures on a specific medical condition and a copy of

the assessment and plan portions of the physician's progress notes together with a glossary of terms can empower patients with the information they need to ask informed questions and express personal values and opinions about their condition and treatment options. Access to this information also can improve members' understanding of their medical condition(s) and treatment plan, as well as facilitate discussion about their health care.

Quality Improvement References

The following references offer additional guidance on possible approaches to CAHPS-related QI activities.

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Survey Instrument

The survey instrument selected was the CAHPS 5.0 Adult Medicaid Survey with the HEDIS supplemental item set. This section provides a copy of the survey instrument.

CAHPS® 5.0H Adult Questionnaire (Medicaid)

SURVEY INSTRUCTIONS

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

☑ Yes ➔**If Yes, Go to Question 1**

☐ No

{This box should be placed on the Cover Page}

Your privacy is protected. All information that would let someone identify you or your family will be kept private. {SURVEY VENDOR NAME} will not share your personal information with anyone without your OK.

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

If you want to know more about this study, please call {SURVEY VENDOR TOLL-FREE TELEPHONE NUMBER}.

1. **Our records show that you are now in {INSERT HEALTH PLAN NAME/ STATE MEDICAID PROGRAM NAME}. Is that right?**
   - [1] ☐ Yes ➔**If Yes, Go to Question 3**
   - [2] ☐ No

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

   _____

YOUR HEALTH CARE IN THE LAST 6 MONTHS

These questions ask about your own health care. Do <u>not</u> include care you got when you stayed overnight in a hospital. Do <u>not</u> include the times you went for dental care visits.

3. **In the last 6 months, did you have an illness, injury, or condition that <u>needed care right away</u> in a clinic, emergency room, or doctor's office?**
   - [1] ☐ Yes
   - [2] ☐ No ➔**If No, Go to Question 5**

4. **In the last 6 months, when you <u>needed care right away</u>, how often did you get care as soon as you needed?**
   - [1] ☐ Never
   - [2] ☐ Sometimes
   - [3] ☐ Usually
   - [4] ☐ Always

5. **In the last 6 months, did you make any appointments for a <u>check-up or routine care</u> at a doctor's office or clinic?**
   - [1] ☐ Yes
   - [2] ☐ No ➔**If No, Go to Question 7**

6. **In the last 6 months, how often did you get an appointment for a <u>check-up or routine care</u> at a doctor's office or clinic as soon as you needed?**
   - [1] ☐ Never
   - [2] ☐ Sometimes
   - [3] ☐ Usually
   - [4] ☐ Always

7. **In the last 6 months, <u>not</u> counting the times you went to an emergency room, how many times did you go to a doctor's office or clinic to get health care for yourself?**
   - [0] ☐ None ➔**If None, Go to Question 15**
   - [1] ☐ 1 time
   - [2] ☐ 2
   - [3] ☐ 3
   - [4] ☐ 4
   - [5] ☐ 5 to 9
   - [6] ☐ 10 or more times

8. **In the last 6 months, did you and a doctor or other health provider talk about specific things you could do to prevent illness?**
   - [1] ☐ Yes
   - [2] ☐ No

9. **In the last 6 months, did you and a doctor or other health provider talk about starting or stopping a prescription medicine?**
   - [1] ☐ Yes
   - [2] ☐ No ➔**If No, Go to Question 13**

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

1 ☐ Not at all
2 ☐ A little
3 ☐ Some
4 ☐ A lot

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

1 ☐ Not at all
2 ☐ A little
3 ☐ Some
4 ☐ A lot

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

1 ☐ Yes
2 ☐ 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 health care in the last 6 months?

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

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

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

YOUR PERSONAL DOCTOR

15. A personal doctor is the one you would see if you need a check-up, want advice about a health problem, or get sick or hurt. Do you have a personal doctor?

1 ☐ Yes
2 ☐ No ➔ **If No, Go to Question 24**

16. **In the last 6 months, how many times did you visit your personal doctor to get care for yourself?**

- [0] ☐ None ➔**If None, Go to Question 23**
- [1] ☐ 1 time
- [2] ☐ 2
- [3] ☐ 3
- [4] ☐ 4
- [5] ☐ 5 to 9
- [6] ☐ 10 or more times

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

- [1] ☐ Never
- [2] ☐ Sometimes
- [3] ☐ Usually
- [4] ☐ Always

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

- [1] ☐ Never
- [2] ☐ Sometimes
- [3] ☐ Usually
- [4] ☐ Always

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

- [1] ☐ Never
- [2] ☐ Sometimes
- [3] ☐ Usually
- [4] ☐ Always

20. **In the last 6 months, how often did your personal doctor spend enough time with you?**

- [1] ☐ Never
- [2] ☐ Sometimes
- [3] ☐ Usually
- [4] ☐ Always

21. **In the last 6 months, did you get care from a doctor or other health provider besides your personal doctor?**

- [1] ☐ Yes
- [2] ☐ No ➔**If No, Go to Question 23**

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

- [1] ☐ Never
- [2] ☐ Sometimes
- [3] ☐ Usually
- [4] ☐ Always

23. **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 personal doctor?**

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

GETTING HEALTH CARE FROM SPECIALISTS

When you answer the next questions, do <u>not</u> include dental visits or care you got when you stayed overnight in a hospital.

24. 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 to see a specialist?

1☐ Yes

2☐ No ➔**If No, Go to Question 28**

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

1☐ Never

2☐ Sometimes

3☐ Usually

4☐ Always

26. How many specialists have you seen in the last 6 months?

0☐ None ➔**If None, Go to Question 28**

1☐ 1 specialist

2☐ 2

3☐ 3

4☐ 4

5☐ 5 or more specialists

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

00☐ 0 Worst specialist possible

01☐ 1

02☐ 2

03☐ 3

04☐ 4

05☐ 5

06☐ 6

07☐ 7

08☐ 8

09☐ 9

10☐ 10 Best specialist possible

YOUR HEALTH PLAN

The next questions ask about your experience with your health plan.

28. In the last 6 months, did you look for any information in written materials or on the Internet about how your health plan works?

1☐ Yes

2☐ No ➔**If No, Go to Question 30**

29. In the last 6 months, how often did the written materials or the Internet provide the information you needed about how your health plan works?

1☐ Never

2☐ Sometimes

3☐ Usually

4☐ Always

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

[1] ☐ Yes

[2] ☐ No ➔**If No, Go to Question 33**

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

[1] ☐ Never

[2] ☐ Sometimes

[3] ☐ Usually

[4] ☐ Always

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

[1] ☐ Never

[2] ☐ Sometimes

[3] ☐ Usually

[4] ☐ Always

33. In the last 6 months, did your health plan give you any forms to fill out?

[1] ☐ Yes

[2] ☐ No ➔**If No, Go to Question 35**

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

[1] ☐ Never

[2] ☐ Sometimes

[3] ☐ Usually

[4] ☐ Always

35. 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 health plan?

[00] ☐ 0 Worst health plan possible

[01] ☐ 1

[02] ☐ 2

[03] ☐ 3

[04] ☐ 4

[05] ☐ 5

[06] ☐ 6

[07] ☐ 7

[08] ☐ 8

[09] ☐ 9

[10] ☐ 10 Best health plan possible

ABOUT YOU

36. In general, how would you rate your overall health?

[1] ☐ Excellent

[2] ☐ Very Good

[3] ☐ Good

[4] ☐ Fair

[5] ☐ Poor

37. In general, how would you rate your overall <u>mental or emotional</u> health?

[1] ☐ Excellent

[2] ☐ Very Good

[3] ☐ Good

[4] ☐ Fair

[5] ☐ Poor

38. Have you had either a flu shot or flu spray in the nose since July 1, 2013?

[1] ☐ Yes
[2] ☐ No
[3] ☐ Don't know

39. Do you now smoke cigarettes or use tobacco every day, some days, or not at all?

[1] ☐ Every day
[2] ☐ Some days
[3] ☐ Not at all ➔ **If Not at all, Go to Question 43**
[4] ☐ Don't know ➔ **If Don't know, Go to Question 43**

40. In the last 6 months, how often were you advised to quit smoking or using tobacco by a doctor or other health provider in your plan?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

41. In the last 6 months, how often was medication recommended or discussed by a doctor or health provider to assist you with quitting smoking or using tobacco? Examples of medication are: nicotine gum, patch, nasal spray, inhaler, or prescription medication.

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

42. In the last 6 months, how often did your doctor or health provider discuss or provide methods and strategies other than medication to assist you with quitting smoking or using tobacco? Examples of methods and strategies are: telephone helpline, individual or group counseling, or cessation program.

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

43. Do you take aspirin daily or every other day?

[1] ☐ Yes
[2] ☐ No
[3] ☐ Don't know

44. Do you have a health problem or take medication that makes taking aspirin unsafe for you?

[1] ☐ Yes
[2] ☐ No
[3] ☐ Don't know

45. Has a doctor or health provider ever discussed with you the risks and benefits of aspirin to prevent heart attack or stroke?

[1] ☐ Yes
[2] ☐ No

46. Are you aware that you have any of the following conditions? Mark one or more.

[a] ☐ High cholesterol
[b] ☐ High blood pressure
[c] ☐ Parent or sibling with heart attack before the age of 60

47. Has a doctor ever told you that you have any of the following conditions? Mark one or more.

- [a] ☐ A heart attack
- [b] ☐ Angina or coronary heart disease
- [c] ☐ A stroke
- [d] ☐ Any kind of diabetes or high blood sugar

48. In the last 6 months, did you get health care 3 or more times for the same condition or problem?

- [1] ☐ Yes
- [2] ☐ No ➔**If No, Go to Question 50**

49. Is this a condition or problem that has lasted for at least 3 months? Do not include pregnancy or menopause.

- [1] ☐ Yes
- [2] ☐ No

50. Do you now need or take medicine prescribed by a doctor? Do not include birth control.

- [1] ☐ Yes
- [2] ☐ No ➔**If No, Go to Question 52**

51. Is this medicine to treat a condition that has lasted for at least 3 months? Do not include pregnancy or menopause.

- [1] ☐ Yes
- [2] ☐ No

52. What is your age?

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

53. Are you male or female?

- [1] ☐ Male
- [2] ☐ Female

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

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

55. Are you of Hispanic or Latino origin or descent?

- [1] ☐ Yes, Hispanic or Latino
- [2] ☐ No, Not Hispanic or Latino

56. What is your race? Mark one or more.

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

57. Did someone help you complete this survey?

- [1] ☐ Yes ➔**If Yes, Go to Question 58**
- [2] ☐ No ➔**Thank you. Please return the completed survey in the postage-paid envelope.**

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

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

THANK YOU

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