

Arizona Health Care Cost Containment
System (AHCCCS)



**2013 CHILDREN'S REHABILITATIVE
SERVICES PROGRAM
MEMBER SATISFACTION REPORT**

January 2014



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1. Executive Summary

In 2013, the State of Arizona required the administration of member satisfaction surveys to Medicaid members enrolled in the Arizona Health Care Cost Containment System (AHCCCS) Children's Rehabilitative Services (CRS) Program. AHCCCS contracted with Health Services Advisory Group, Inc. (HSAG) to administer and report the results of the Consumer Assessment of Healthcare Providers and Systems (CAHPS[®]) Health Plan Survey.¹⁻¹ 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. It is important to note that in 2013 members in the CRS Program were surveyed for the first time. The 2013 CAHPS results presented in the report represent a **baseline** assessment of parents'/caretakers' satisfaction with the CRS Program; therefore, caution should be exercised when interpreting these results.

The standardized survey instrument selected was the CAHPS 5.0 Child Medicaid Health Plan Survey with the Healthcare Effectiveness Data and Information Set (HEDIS[®]) supplemental item set and the Children with Chronic Conditions (CCC) measurement set.¹⁻² The parents and caretakers of child members from the CRS Program completed the surveys from June to August 2013.

Transition from CAHPS 4.0 to 5.0 Survey

In 2012, the Agency for Healthcare Research and Quality (AHRQ) released the CAHPS 5.0 Medicaid Health Plan Surveys. Based on the CAHPS 5.0 versions, the National Committee for Quality Assurance (NCQA) introduced new HEDIS versions of the Child Health Plan Surveys in August 2012, which are referred to as the CAHPS 5.0H Child Medicaid Health Plan Surveys.¹⁻³ The following is a summary of the changes resulting from the transition to the CAHPS 5.0 Child Medicaid Health Plan Survey with CCC measurement set.¹⁻⁴

Global Ratings

There were no changes made to the four CAHPS global ratings: Rating of Health Plan, Rating of All Health Care, Rating of Personal Doctor, and Rating of Specialist Seen Most Often. The question language, response options, and placement of the global ratings remain the same; therefore, comparisons to national data were performed for all four global ratings.

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

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

¹⁻³ National Committee for Quality Assurance. *HEDIS[®] 2013, Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA Publication, 2012.

¹⁻⁴ National Committee for Quality Assurance. *HEDIS 2013 Survey Vendor Update Training*. October 25, 2012.

Composite Measures

Getting Needed Care

For the Getting Needed Care composite measure, changes were made to the question language and placement of questions included in the composite. One question item that addressed “getting care, tests, or treatment” was moved from the section of the survey titled “Your Child’s Health Plan” to the section titled “Your Child’s Health Care in the Last 6 Months.” While comparisons to national data were performed for this composite measure, the changes to the questions language and reordering of questions may impact survey results; therefore, caution should be exercised when interpreting the results of the Getting Needed Care composite measure.

Getting Care Quickly

For questions included in the Getting Care Quickly composite, changes were made to the question language. However, minimal impact is expected due to these changes; therefore, comparisons to national data were performed for this composite measure.

How Well Doctors Communicate

Minor changes were made to the question language for one question included in the How Well Doctors Communicate composite. Negligible impact is expected due to this change in question language; therefore, comparisons to national data were performed for this composite measure.

Customer Service

There were no changes to the question language, response options, or placement of the questions included in the Customer Service composite measure; therefore, comparisons to national data were performed for this composite measure.

Shared Decision Making

Changes were made to the question language, response options, and number of questions for the Shared Decision Making composite measure. All items in the composite measure were reworded to ask about “starting or stopping a prescription medicine” whereas previously the items asked about “choices for your child’s treatment or health care.” Response options for these questions were revised from “Definitely yes,” “Somewhat yes,” “Somewhat no,” and “Definitely no” to “Not at all,” “A little,” “Some,” and “A lot” to accommodate the new question language. Also, one question was added to the composite. Due to these changes, comparisons to national data could not be performed for the Shared Decision Making composite measure for 2013.

Individual Items

Coordination of Care

No changes were made to the question language, response options, or placement of the Coordination of Care individual item measure; therefore, comparisons to national data were performed for this measure.

Health Promotion and Education

For the Health Promotion and Education individual item, changes were made to the question language and response options. Response options for this item were revised from “Never,” “Sometimes,” “Usually,” and “Always” to “Yes” and “No.” As a result of the change in response options, the Health Promotion and Education individual item measure is not comparable to national data for 2013.

Children with Chronic Conditions (CCC) Composites and Items

There were no changes made to the five measures that comprise the CCC measurement set. The question language, response options, and placement of the three CCC composites: Access to Specialized Services, Family Centered Care: Personal Doctor Who Knows Child, and Coordination of Care for Children with Chronic Conditions remain the same. The question language, response options, and placement of the two CCC items: Access to Prescription Medicines and Family Centered Care: Getting Needed Information also remained unchanged. Therefore, comparisons to national data were performed for the three CCC composites and two CCC items.

General Child Performance Highlights

The General Child Results Section of this report details the CAHPS results for the CRS Program’s general child population. The following is a summary of the general child CAHPS performance highlights for the CRS Program. The performance highlights are categorized into three areas of analysis performed for the general child population:

- ◆ NCQA Comparisons
- ◆ Rates and Proportions
- ◆ Priority Assignments

NCQA Comparisons

Overall member satisfaction ratings for four CAHPS global ratings (Rating of Health Plan, Rating of All Health Care, Rating of Personal Doctor, and Rating of Specialist Seen Most Often) and four CAHPS composite measures (Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, and Customer Service) were compared to NCQA’s 2013 HEDIS Benchmarks and Thresholds for Accreditation.^{1-5,1-6} This comparison resulted in ratings of one (★) to five (★★★★★) stars on these CAHPS measures, where one is the lowest possible rating and five is the highest possible rating.¹⁻⁷ The detailed results of this comparative analysis are described in the General Child Results Section beginning on page 3-1. Table 1-1 presents the highlights from this comparison.

Table 1-1
NCQA Comparisons Highlights

Star Rating	Measure
★	Rating of Health Plan
★★	Customer Service
★★	How Well Doctors Communicate
★★	Getting Care Quickly
★★★	Getting Needed Care
★★★★	Rating of All Health Care
★★★★★	Rating of Personal Doctor
★★★★★	Rating of Specialist Seen Most Often
Star Assignments Based on Percentiles ★★★★★ 90th or Above ★★★★★ 75th – 89th ★★★ 50th - 74th ★★ 25th - 49th ★ Below 25th	

¹⁻⁵ National Committee for Quality Assurance. *HEDIS Benchmarks and Thresholds for Accreditation 2013*, Washington, DC: NCQA, July 24, 2013.

¹⁻⁶ NCQA’s benchmarks and thresholds for the child Medicaid population were used to derive the overall member satisfaction ratings; therefore, caution should be exercised when interpreting these results.

¹⁻⁷ NCQA does not publish benchmarks and thresholds for the Shared Decision Making composite measure, and Coordination of Care and Health Promotion and Education individual item measures; therefore, overall member satisfaction ratings could not be derived for these CAHPS measures.

Rates and Proportions

The rates and proportions for the CRS Program were compared to NCQA Child Medicaid Quality Compass[®] data.^{1-8,1-9} These comparisons were performed on the four global ratings, four composite measures, and one individual item measure. The detailed results of these analyses are described in the General Child Results Section beginning on page 3-4. The following are highlights of this comparison:

- ◆ The CRS Program scored at or above the national average on eight measures: Rating of All Health Care, Rating of Personal Doctor, Rating of Specialist Seen Most Often, Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Customer Service, and Coordination of Care.

Priority Assignments

Based on the results of the NCQA comparisons, priority assignments were derived for each measure.¹⁻¹⁰ Measures were assigned into one of four main categories for quality improvement (QI): top, high, moderate, and low priority. These priority areas are described in the Recommendations Section of this report beginning on page 5-2. The following are the top and high priority areas for the CRS Program:

- ◆ Rating of Health Plan
- ◆ Customer Service
- ◆ How Well Doctors Communicate
- ◆ Getting Care Quickly

¹⁻⁸ Quality Compass[®] is a registered trademark of the National Committee for Quality Assurance (NCQA).

¹⁻⁹ NCQA national averages for the child Medicaid population were used for comparative purposes. Given the potential differences in the demographics of these populations (i.e., child Medicaid and CRS), caution should be exercised when interpreting these results.

¹⁻¹⁰ Priority assignments were derived based on the CRS Program's general child population CAHPS results.

Children with Chronic Conditions (CCC) Performance Highlights

The CCC Results Section of this report details the CAHPS results for the CRS Program's CCC population. The following is a summary of the CAHPS performance highlights. The detailed results of this analysis are described in the CCC Results Section beginning on page 4-2.

Rates and Proportions

The rates and proportions for the CRS Program's CCC population were compared to NCQA Child Medicaid Quality Compass data. These comparisons were performed on the four global ratings, four composite measures, one individual item measure, and CCC composites and items. The following are highlights of this comparison:

- ◆ The CRS Program scored at or above the national average on five measures: Rating of Personal Doctor, Rating of Specialist Seen Most Often, Getting Needed Care, Customer Service, and Family-Centered Care: Getting Needed Information.

Survey Administration and Response Rates

Survey Administration

Child members eligible for surveying included those who were enrolled in the CRS Program at the time the sample was drawn and who were continuously enrolled in the CRS Program for at least five of the last six months (July through December) of 2012. In addition, child members had to be 21 years of age or younger as of December 31, 2012 to be included in the survey.²⁻¹

The standard NCQA HEDIS Specifications for Survey Measures require a sample size of 3,490 members for the CAHPS 5.0 Child Medicaid Health Plan Survey with CCC measurement set.²⁻² A random sample of 1,650 child members was selected for the CAHPS 5.0 general child sample, which represents the general population of children. Child members in the CAHPS 5.0 child sample were given a chronic condition prescreen status code of 1 or 2. A prescreen code of 1 indicated that the child member had claims or encounters that did not suggest the member had a greater probability of having a chronic condition. A prescreen code of 2 (also known as a positive prescreen status code) indicated the child member had claims or encounters that suggested the member had a greater probability of having a chronic condition.²⁻³ After selecting child members for the CAHPS 5.0 general child sample, a random sample of up to 1,840 child members with a prescreen code of 2, which represents the population of children who are more likely to have a chronic condition (i.e., CCC supplemental sample), was selected. The CRS Program met the sample size requirement of 3,490 child members (i.e., 1,650 general child and 1,840 CCC members) for the CAHPS 5.0 Child Medicaid Health Plan Survey with CCC measurement set.

The survey administration protocol was designed to achieve a high response rate from members, thus minimizing the potential effects of non-response bias. The survey process allowed members two methods by which they could complete the surveys. The first, or mail phase, consisted of a survey being mailed to the sampled members. For the CRS Program, those members who were identified as Spanish-speaking through administrative data were mailed a Spanish version of the survey. Members that were not identified as Spanish-speaking received an English version of the survey. The cover letter included with the English version of the survey had a Spanish cover letter on the back side informing members that they could call the toll-free number to request a Spanish version of the CAHPS questionnaire. The cover letter provided with the Spanish version of the CAHPS questionnaire included a text box with a toll-free number that members could call to request a survey in another language (i.e., English). A reminder postcard was sent to all non-respondents, followed by a second survey mailing and reminder postcard. The second phase, or

²⁻¹ For purposes of this report, the age criteria for child members eligible for inclusion in the CAHPS Child Medicaid Health Plan Survey was modified to include members up to 21 years of age or younger as of December 31, 2012. Please note, this deviates from standard NCQA HEDIS specifications, which define eligible child members as 18 years of age or younger as of December 31 of the measurement year.

²⁻² National Committee for Quality Assurance. *HEDIS® 2013, Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA Publication, 2012.

²⁻³ Ibid.

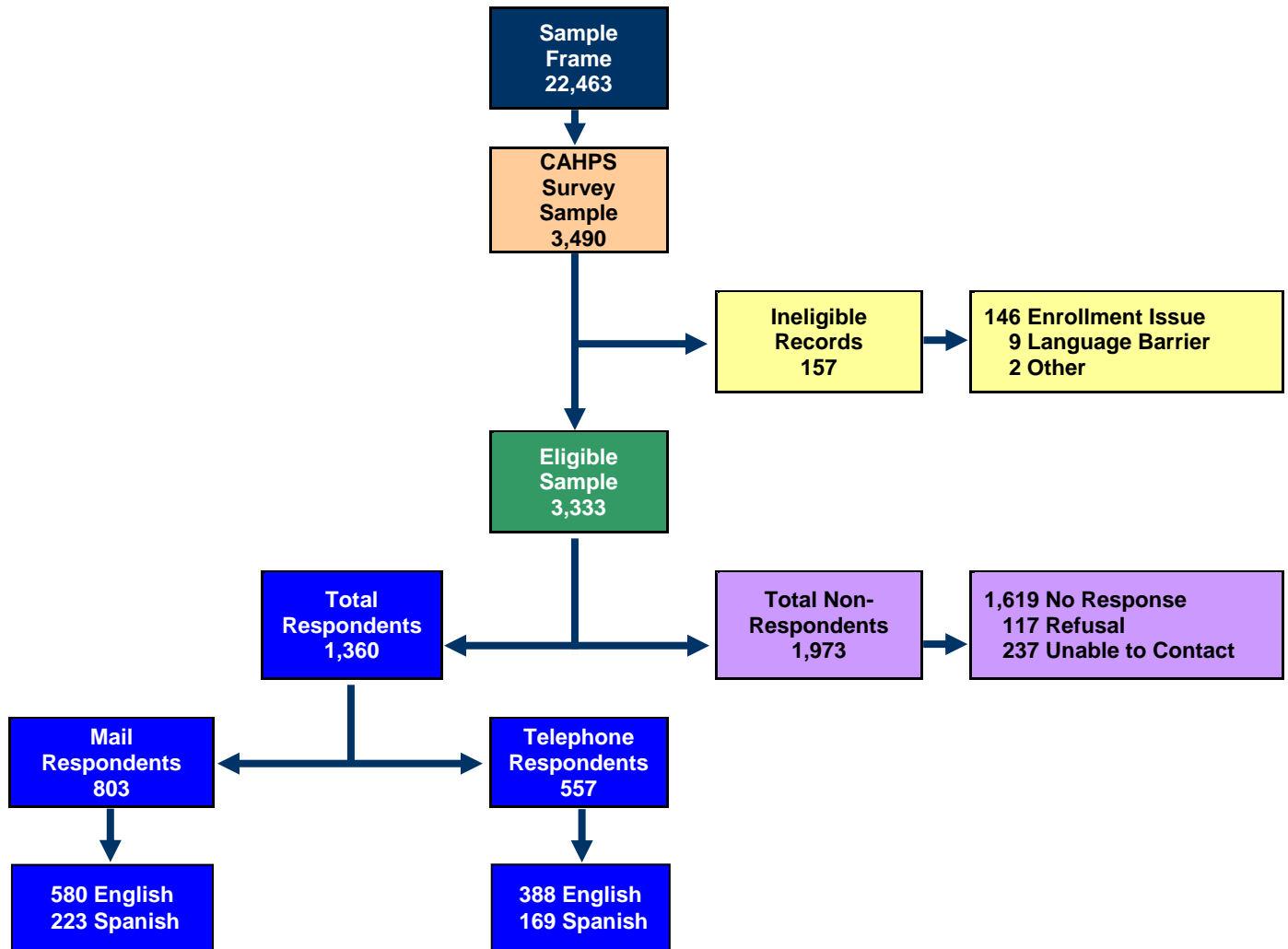
telephone phase, consisted of Computer Assisted Telephone Interviewing (CATI) for sampled members who had not mailed in a completed survey. Up to six CATI calls were made to each non-respondent. Additional information on the survey protocol is included in the Reader's Guide Section beginning on page 6-3.

Response Rates

The CAHPS 5.0 Child Medicaid Health Plan Survey administration was designed to achieve the highest possible response rate. The CAHPS Survey response rate is the total number of completed surveys divided by all eligible members of the sample. A survey was assigned a disposition code of "completed" if at least one question was answered. Eligible members included the entire random sample minus ineligible members. Ineligible members met at least one of the following criteria: they were deceased, were invalid (did not meet the eligible population criteria), or had a language barrier.

A total of 1,360 completed surveys were returned on behalf of child members. Figure 2-1, on the following page, shows the distribution of survey dispositions and response rate for the CRS Program. The survey dispositions and response rate are based on the responses of parents/caretakers of children in the general child and CCC supplemental populations.

Figure 2-1 Distribution of Surveys for CRS Program



Response Rate = 40.80%

The CRS Program’s response rate of 40.8 percent was greater than the national child Medicaid response rate reported by NCQA for 2013, which was 26.9 percent.²⁻⁴

²⁻⁴ National Committee for Quality Assurance. *HEDIS 2014 Survey Vendor Update Training*. October 24, 2013.

Child and Respondent Demographics

In general, the demographics of a response group may influence overall member satisfaction scores. For example, older and healthier respondents tend to report higher levels of member satisfaction; therefore, caution should be exercised when comparing populations that have significantly different demographic properties.²⁻⁵ Currently, NCQA does not recommend case-mix adjusting CAHPS results to account for these differences.

Table 2-1 shows the demographic characteristics of children for whom a parent or caretaker completed a CAHPS 5.0 Child Medicaid Health Plan Survey.²⁻⁶

Table 2-1
CRS Program Child Demographics
Age, Gender, Race/Ethnicity, and General Health Status

Age	
Less than 1	0.7%
1 to 3	13.1%
4 to 7	19.5%
8 to 12	29.9%
13 to 21	36.8%
Gender	
Male	51.5%
Female	48.5%
Race/Ethnicity	
Multi-Racial	10.9%
White	56.3%
Black	3.1%
Asian	1.7%
Hawaiian/Pacific Islander	0.4%
Other	27.6%
General Health Status	
Excellent	21.7%
Very Good	28.6%
Good	33.9%
Fair	13.7%
Poor	2.0%
<i>Please note: Percentages may not total 100% due to rounding.</i>	

²⁻⁵ Agency for Healthcare Research and Quality. *CAHPS Health Plan Survey and Reporting Kit 2008*. Rockville, MD: U.S. Department of Health and Human Services, July 2008.

²⁻⁶ The child demographic data presented in Table 2-1 are based on the characteristics of the general child population.

Table 2-2 depicts the self-reported age, level of education, and relationship to the child for the respondents who completed the CAHPS 5.0 Child Medicaid Health Plan Survey.²⁻⁷

**Table 2-2
CRS Program Respondent Demographics
Age, Education, and Relationship to Child**

Age	
Under 18	4.1%
18 to 24	5.3%
25 to 34	27.2%
35 to 44	34.7%
45 to 54	18.9%
55 to 64	6.8%
65 or Older	3.1%
Education	
8th Grade or Less	13.3%
Some High School	16.2%
High School Graduate	32.0%
Some College	26.2%
College Graduate	12.4%
Relationship	
Mother or Father	91.7%
Grandparent	5.3%
Other relationship	1.9%
Legal guardian	1.0%
<i>Please note: Percentages may not total 100% due to rounding.</i>	

For additional demographic information, please refer to the cross-tabulations (Tab and Banner Book) provided on the accompanying CD.

²⁻⁷ The respondent demographic data presented in Table 2-2 are based on the characteristics of the general child population.

3. General Child Results

The following presents the CAHPS results for the CRS Program’s general child population. For the general child population, a total of 650 completed surveys were returned on behalf child members. These completed surveys were used to calculate the 2013 General Child CAHPS results presented in this section.

NCQA Comparisons

In order to assess the overall performance of the CRS Program, each of the CAHPS global ratings (Rating of Health Plan, Rating of All Health Care, Rating of Personal Doctor, and Rating of Specialist Seen Most Often) and four of the CAHPS composite measures (Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, and Customer Service) were scored on a three-point scale using the scoring methodology detailed in NCQA’s HEDIS Specifications for Survey Measures.³⁻¹ The resulting three-point mean scores were compared to NCQA’s HEDIS Benchmarks and Thresholds for Accreditation.³⁻² Based on this comparison, ratings of one (★) to five (★★★★★) stars were determined for each CAHPS measure, where one is the lowest possible rating and five is the highest possible rating.^{3-3,3-4}

- ★★★★★ indicates a score at or above the 90th percentile
- ★★★★ indicates a score at or between the 75th and 89th percentiles
- ★★★ indicates a score at or between the 50th and 74th percentiles
- ★★ indicates a score at or between the 25th and 49th percentiles
- ★ indicates a score below the 25th percentile

³⁻¹ National Committee for Quality Assurance. *HEDIS® 2013, Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA Publication, 2012.

³⁻² National Committee for Quality Assurance. *HEDIS Benchmarks and Thresholds for Accreditation 2013*. Washington, DC: NCQA, July 24, 2013.

³⁻³ NCQA does not provide benchmarks and thresholds for the Shared Decision Making composite measure, and Coordination of Care and Health Promotion and Education individual measures; therefore, overall member satisfaction ratings could not be determined for these CAHPS measures.

³⁻⁴ NCQA’s benchmarks and thresholds for the child Medicaid population were used to derive the overall satisfaction ratings; therefore, caution should be exercised when interpreting these results.

Table 3-1 shows the CRS Program’s three-point mean scores and overall member satisfaction ratings on each of the four global ratings.

Table 3-1
NCQA Comparisons: Overall Member Satisfaction Ratings on the Global Ratings for CRS Program

Global Rating	Three-Point Mean	Star Rating
Rating of Health Plan	2.49	★
Rating of All Health Care	2.57	★★★★
Rating of Personal Doctor	2.70	★★★★★
Rating of Specialist Seen Most Often	2.70	★★★★★

Table 3-2 shows the CRS Program’s three-point mean scores and overall member satisfaction ratings on the four composite measures.³⁻⁵

Table 3-2
NCQA Comparisons: Overall Member Satisfaction Ratings on the Composite Measures for CRS Program

Composite Measure	Three-Point Mean	Star Rating
Getting Needed Care	2.37	★★★
Getting Care Quickly	2.58	★★
How Well Doctors Communicate	2.65	★★
Customer Service	2.43	★★

³⁻⁵ Due to the changes to the Getting Needed Care composite measure, caution should be exercised when interpreting the results of the NCQA comparisons and overall member satisfaction ratings for this measure. For detailed information on the changes to the composite measure, please refer to the Executive Summary Section of this report.

Summary of NCQA Comparisons Results

The NCQA comparisons revealed the following summary results:

- ◆ The CRS Program scored at or above the 90th percentile on two measures: Rating of Personal Doctor and Rating of Specialist Seen Most Often.
- ◆ The CRS Program scored at or between the 75th and 89th percentiles on one measure, Rating of All Health Care.
- ◆ The CRS Program scored at or between the 50th and 74th percentiles on one measure, Getting Needed Care.
- ◆ The CRS Program scored at or between the 25th and 49th percentiles on three measures: Getting Care Quickly, How Well Doctors Communicate, and Customer Service.
- ◆ The CRS Program scored below the 25th percentile on one measure, Rating of Health Plan.

Rates and Proportions

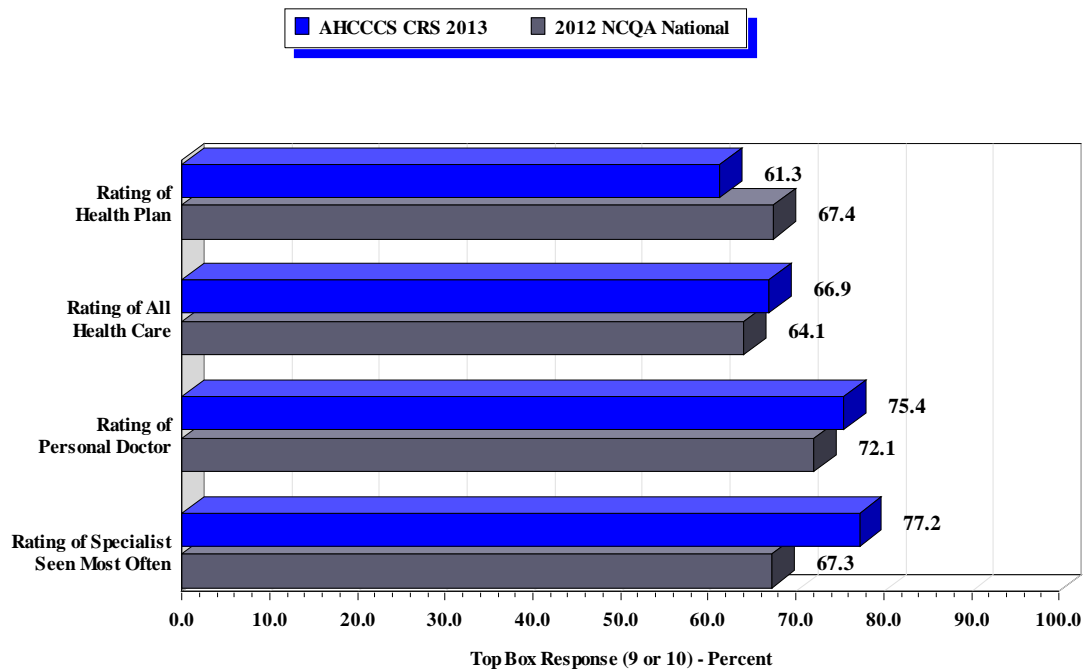
For purposes of calculating the results, question summary rates were calculated for each global rating and individual item measure, and global proportions were calculated for each composite measure. Both the question summary rates and global proportions were calculated in accordance with NCQA HEDIS Specifications for Survey Measures.³⁻⁶ The scoring of the global ratings, composite measures, and individual item measures involved assigning top-level responses a score of one, with all other responses receiving a score of zero. After applying this scoring methodology, the percentage of top-level responses was calculated in order to determine the question summary rates and global proportions. For additional detail, please refer to the *NCQA HEDIS 2013 Specifications for Survey Measures, Volume 3*.

³⁻⁶ National Committee for Quality Assurance. *HEDIS® 2013, Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA Publication, 2012.

Global Ratings

Figure 3-1 depicts the top-box question summary rates for each of the global ratings for the CRS Program and the 2012 NCQA National Child Medicaid average using responses of 9 or 10 for top-box scoring.^{3-7,3-8}

Figure 3-1 Global Ratings: Question Summary Rates

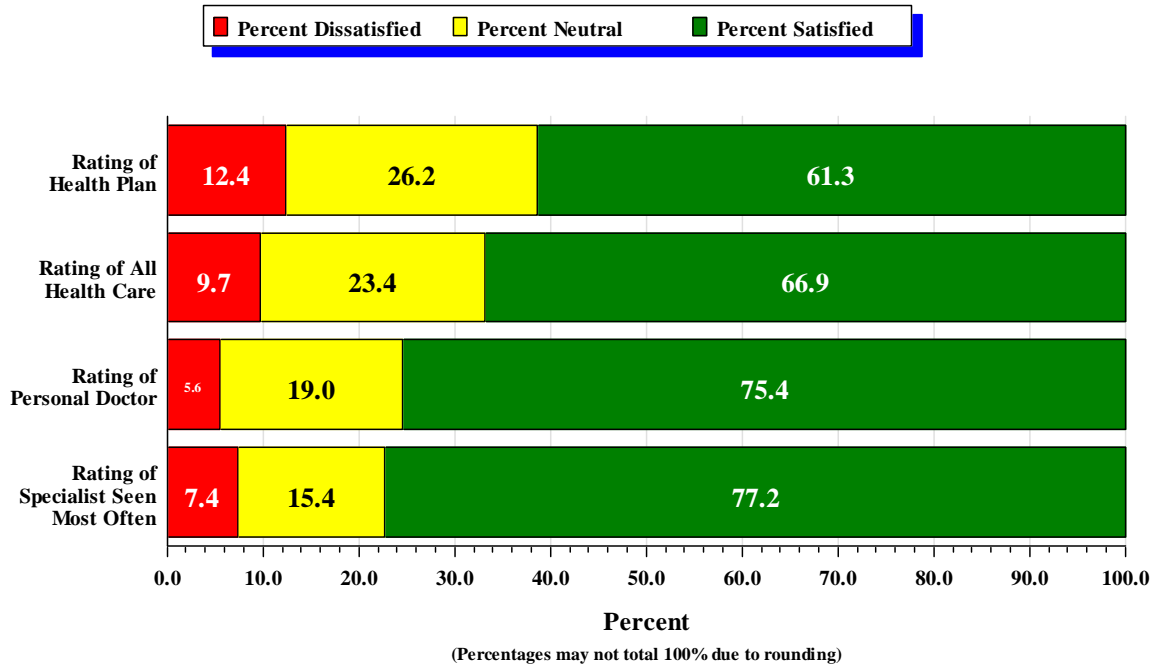


³⁻⁷ For the NCQA national child Medicaid averages, the source for data contained in this publication is Quality Compass[®] 2012 data and is used with the permission of the National Committee for Quality Assurance (NCQA). Quality Compass 2012 includes certain CAHPS data. Any data display, analysis, interpretation, 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).

³⁻⁸ NCQA national averages for the child Medicaid population were used for comparative purposes. Given the potential differences in the demographics of these populations (i.e., child Medicaid and CRS), caution should be exercised when interpreting these results.

For each global rating question, responses were classified into one of three response categories: “0 to 6,” “7 to 8,” and “9 to 10.” Figure 3-2 depicts the proportion of respondents who fell into each response category for each global rating for the CRS Program.

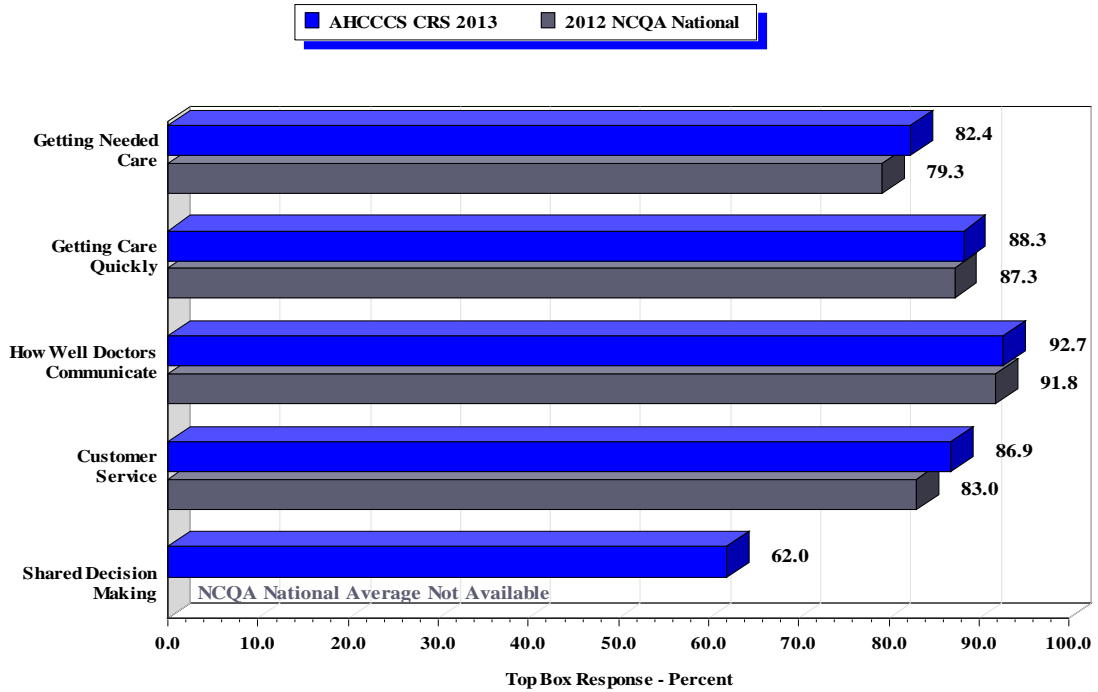
Figure 3-2 Global Ratings: Proportion of Responses



Composite Measures

Figure 3-3 depicts the top-box global proportions for the CRS Program and the 2012 NCQA National Child Medicaid average using responses of “Usually” or “Always” for top-box scoring of Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, and Customer Service, and responses of “A lot” or “Yes” for top-box scoring of Shared Decision Making.^{3-9,3-10}

Figure 3-3 Composite Measures: Global Proportions

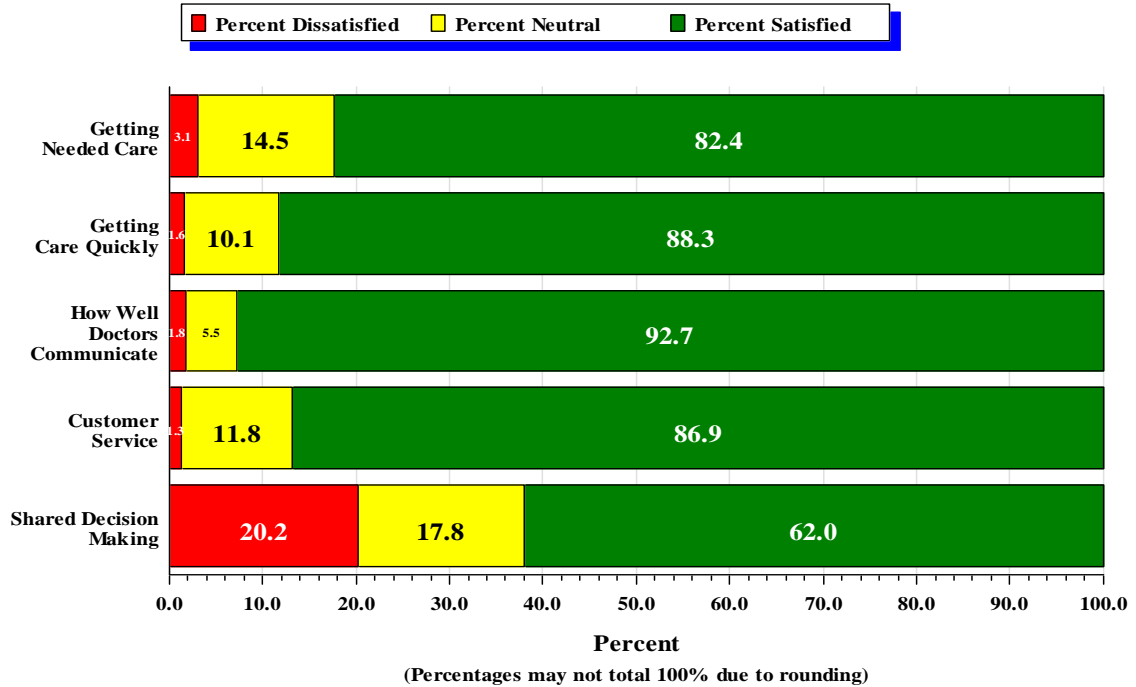


³⁻⁹ Due to the changes to the Getting Needed Care composite measure, caution should be exercised when interpreting the comparisons to NCQA national averages. For detailed information on the changes to the composite measure, please refer to the Executive Summary Section of this report.

³⁻¹⁰ Due to the changes to the Shared Decision Making composite measure, comparisons to NCQA national averages could not be performed for 2013. For detailed information on the changes to the composite measure, please refer to the Executive Summary Section of this report.

For Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, and Customer Service, responses were classified into one of three response categories as follows: “Never,” “Sometimes,” and “Usually/Always.” For Shared Decision Making, responses were classified into one of three response categories as follows: “Not at all/A little/No,” “Some,” and “A lot/Yes.” Figure 3-4 depicts the proportion of respondents who fell into each response category for each composite measure for the CRS Program.

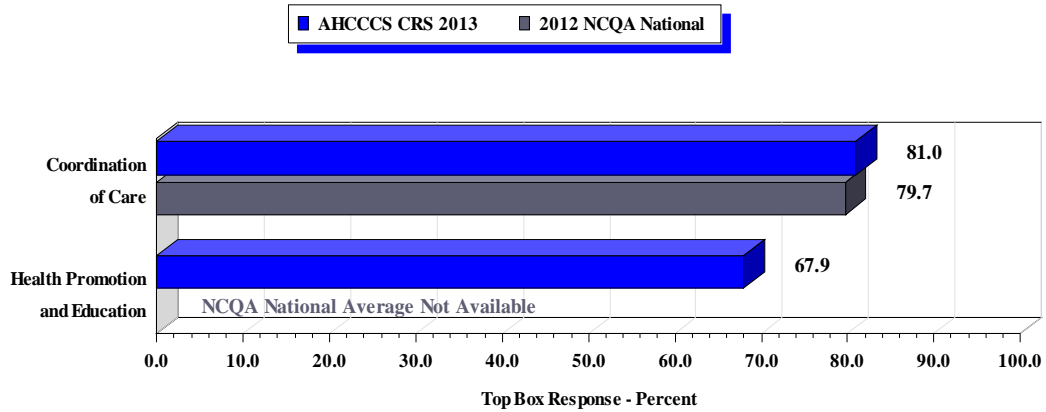
Figure 3-4 Composite Measures: Proportion of Responses



Individual Item Measures

Figure 3-5 depicts the top-box question summary rates for the CRS Program and the 2012 NCQA National Child Medicaid average using responses of “Usually” or “Always” for top-box scoring of Coordination of Care, and responses of “Yes” for top-box scoring of Health Promotion and Education.³⁻¹¹

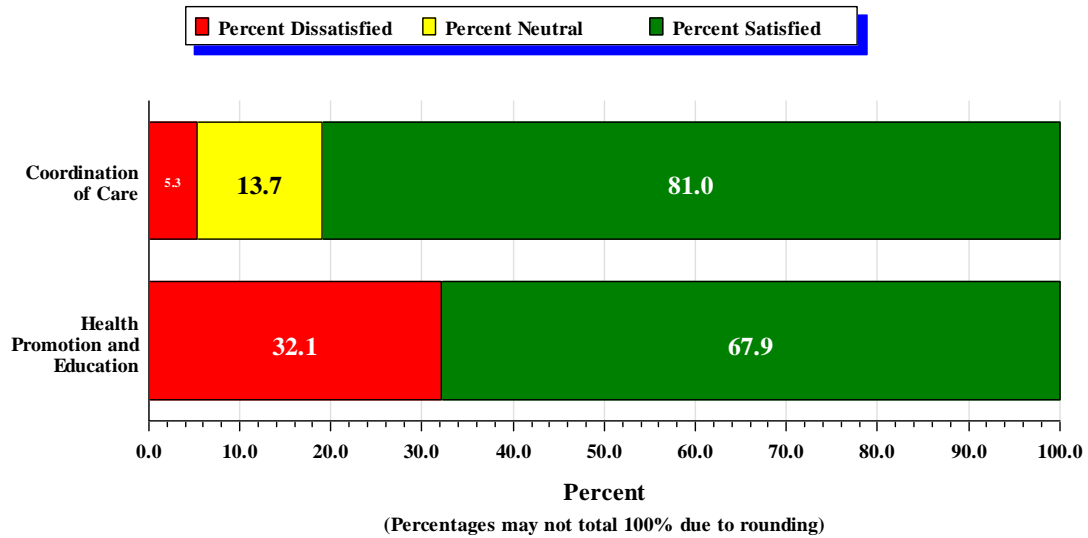
Figure 3-5 Individual Item Measures: Question Summary Rates



³⁻¹¹ Due to changes to the Health Promotion and Education individual item measure, comparisons to NCQA national averages could not be performed for 2013. For detailed information on changes to this individual measure, please refer to the Executive Summary section of this report.

For Coordination of Care, responses were classified into one of three response categories: “Never,” “Sometimes,” and “Usually/Always.” For Health Promotion and Education, responses were classified into one of two response categories: “No” or “Yes.” Figure 3-6 depicts the proportion of respondents who fell into each response category for each individual item measure for the CRS Program.

Figure 3-6 Individual Item Measures: Proportion of Responses



Summary of Rates and Proportions

Evaluation of the CRS Program's rates and proportions for the general child population revealed the following summary results.

- ◆ The CRS Program scored at or above the national average on eight measures: Rating of All Health Care, Rating of Personal Doctor, Rating of Specialist Seen Most Often, Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Customer Service, and Coordination of Care.
- ◆ The CRS Program scored below the national average on one measure, Rating of Health Plan.

Chronic Conditions Classification

A series of questions included in the CAHPS 5.0 Child Medicaid Health Plan Survey with CCC measurement set was used to identify children with chronic conditions (i.e., CCC screener questions). This series contains five sets of survey questions that focus on specific health care needs and conditions. Child members with affirmative responses to all of the questions in at least one of the following five categories were considered to have a chronic condition:

- ◆ Child needed or used prescription medicine.
- ◆ Child needed or used more medical care, mental health services, or educational services than other children of the same age need or use.
- ◆ Child had limitations in the ability to do what other children of the same age do.
- ◆ Child needed or used special therapy.
- ◆ Child needed or used mental health treatment or therapy.

The survey responses for child members in both the general child sample and the CCC supplemental sample were analyzed to determine which child members had chronic conditions. Therefore, the general population of children (i.e., the general child sample) included children with and without chronic conditions based on the responses to the survey questions.

Based on parents'/caretakers' responses to the CCC screener questions, the CRS Program had 903 completed CAHPS Child Medicaid Health Plan Surveys for the CCC population. These completed surveys were used to calculate the 2013 CCC CAHPS results presented in this section. It is important to note that 2013 is the first year the CAHPS Child Medicaid Health Plan Survey with the CCC measurement set was administered to the CRS population. Therefore, the CAHPS results presented in this section represent a **baseline** assessment of the parents'/caretakers' satisfaction with the care and services provided by the CRS Program.

Rates and Proportions

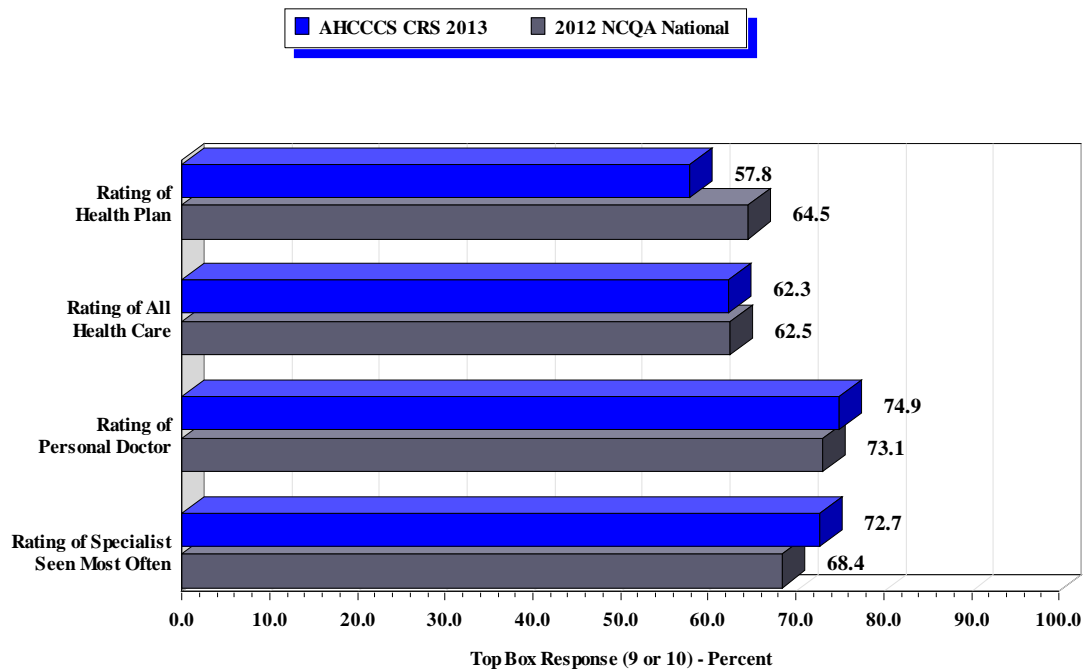
For purposes of calculating the CCC results, question summary rates were calculated for each global rating and individual item measure, and global proportions were calculated for each composite measure. Both the question summary rates and global proportions were calculated in accordance with NCQA HEDIS Specifications for Survey Measures.⁴⁻¹ The scoring of the global ratings, composite measures, individual item measures, and CCC composites and items involved assigning top-level responses a score of one, with all other responses receiving a score of zero. After applying this scoring methodology, the percentage of top-level responses was calculated in order to determine the question summary rates and global proportions. For additional details, please refer to the *NCQA HEDIS 2013 Specifications for Survey Measures, Volume 3*.

⁴⁻¹ National Committee for Quality Assurance. *HEDIS® 2013, Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA Publication, 2012.

Global Ratings

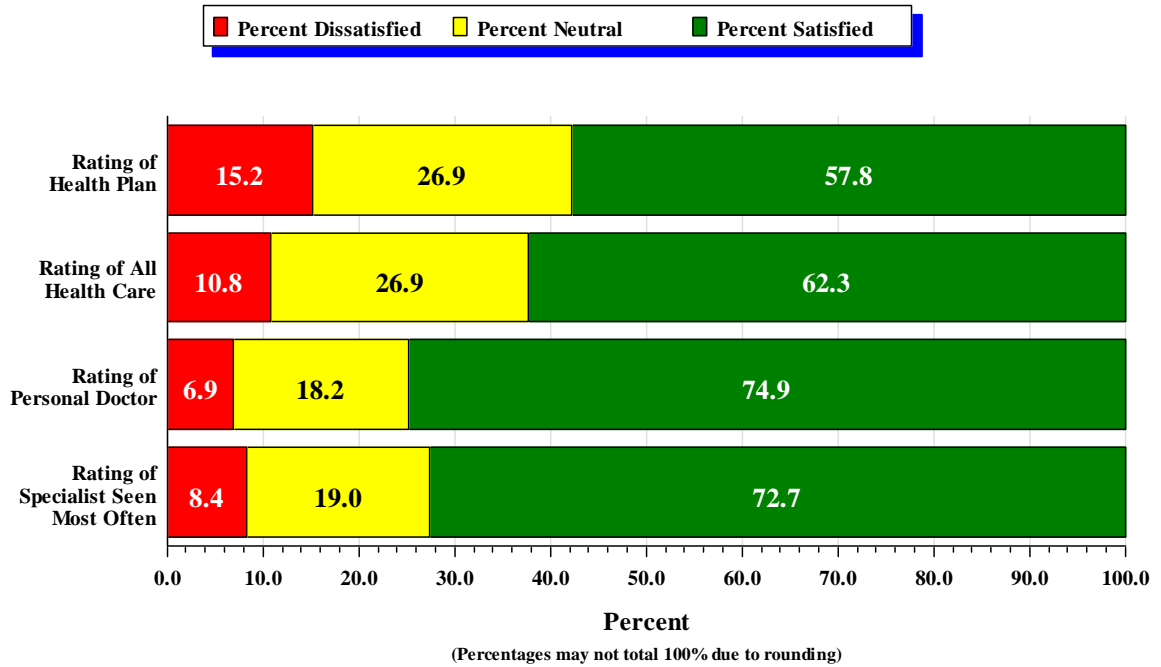
Figure 4-1 depicts the top-box question summary rates for each of the global ratings for the CRS Program and the 2012 NCQA National Child Medicaid average using responses of 9 or 10 for top-box scoring.

Figure 4-1 Global Ratings: Question Summary Rates



For each global rating question, responses were classified into one of three response categories: “0 to 6,” “7 to 8,” and “9 to 10.” Figure 4-2 depicts the proportion of respondents who fell into each response category for each global rating for the CRS Program.

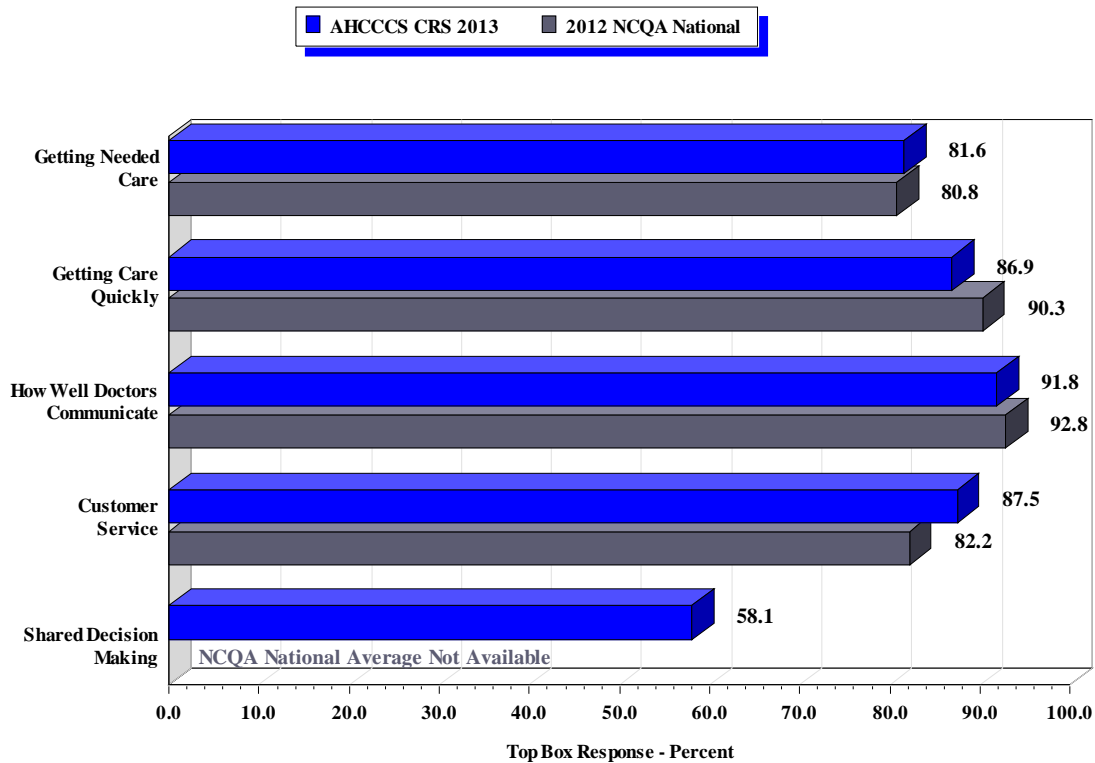
Figure 4-2 Global Ratings: Proportion of Responses



Composite Measures

Figure 4-3 depicts the top-box global proportions for the CRS Program and the 2012 NCQA National Child Medicaid average using responses of “Usually” or “Always” for top-box scoring of Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, and Customer Service, and responses of “A lot” or “Yes” for top-box scoring of Shared Decision Making.^{4-2,4-3}

Figure 4-3 Composite Measures: Global Proportions

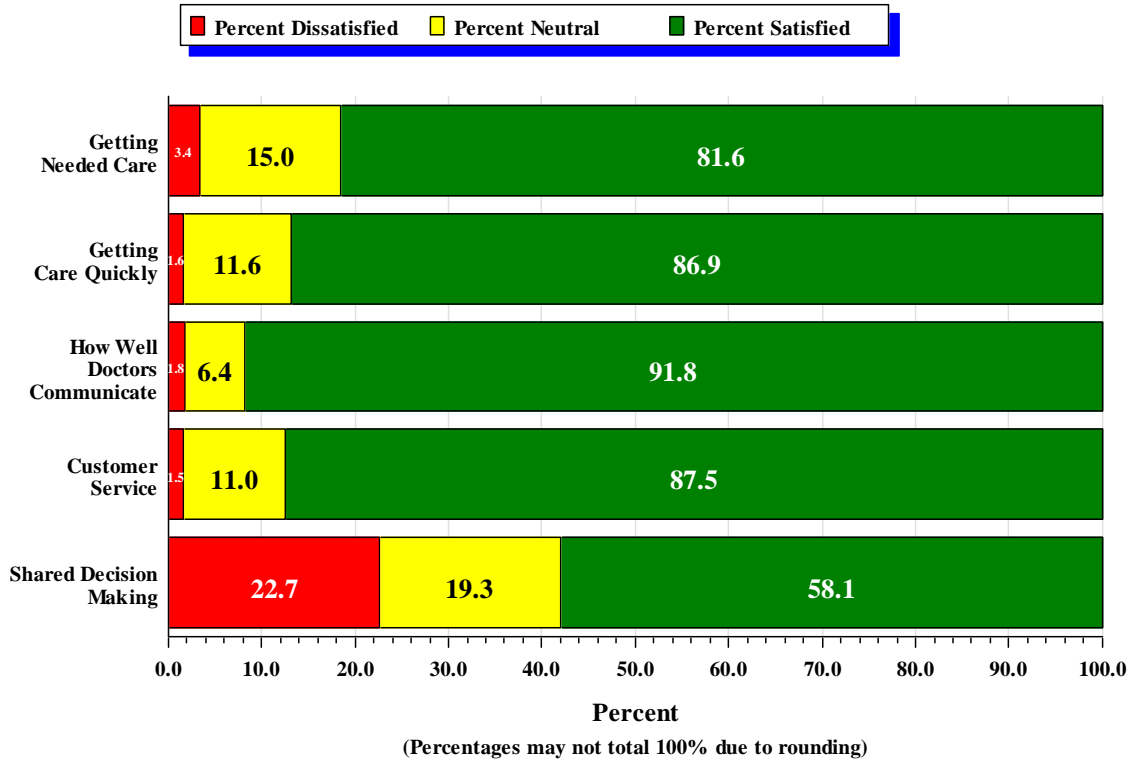


⁴⁻² Due to changes to the Getting Needed Care composite measure, caution should be exercised when interpreting the comparisons to NCQA national averages. For detailed information on the changes to the composite measure, please refer to the Executive Summary Section of this report.

⁴⁻³ Due to changes to the Shared Decision Making composite measure, comparisons to NCQA national averages could not be performed for 2013. For detailed information on the changes to the composite measure, please refer to the Executive Summary Section of this report.

For Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, and Customer Service, responses were classified into one of three response categories as follows: “Never,” “Sometimes,” and “Usually/Always.” For Shared Decision Making, responses were classified into one of three response categories as follows: “Not at all/A little/No,” “Some,” and “A lot/Yes.” Figure 4-4 depicts the proportion of respondents who fell into each response category for each composite measure for the CRS Program.

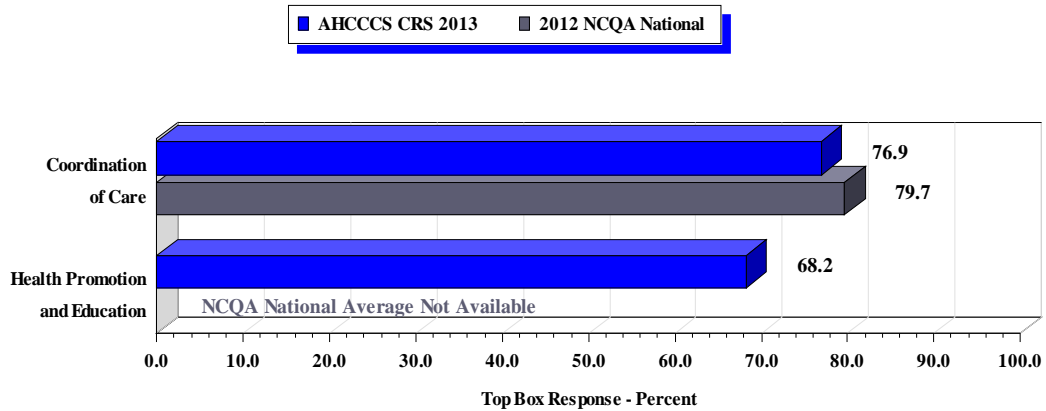
Figure 4-4 Composite Measures: Proportion of Responses



Individual Item Measures

Figure 4-5 depicts the top-box question summary rates for the CRS Program and the 2012 NCQA National Child Medicaid average using responses of “Usually” or “Always” for top-box scoring of Coordination of Care, and responses of “Yes” for top-box scoring of Health Promotion and Education.⁴⁻⁴

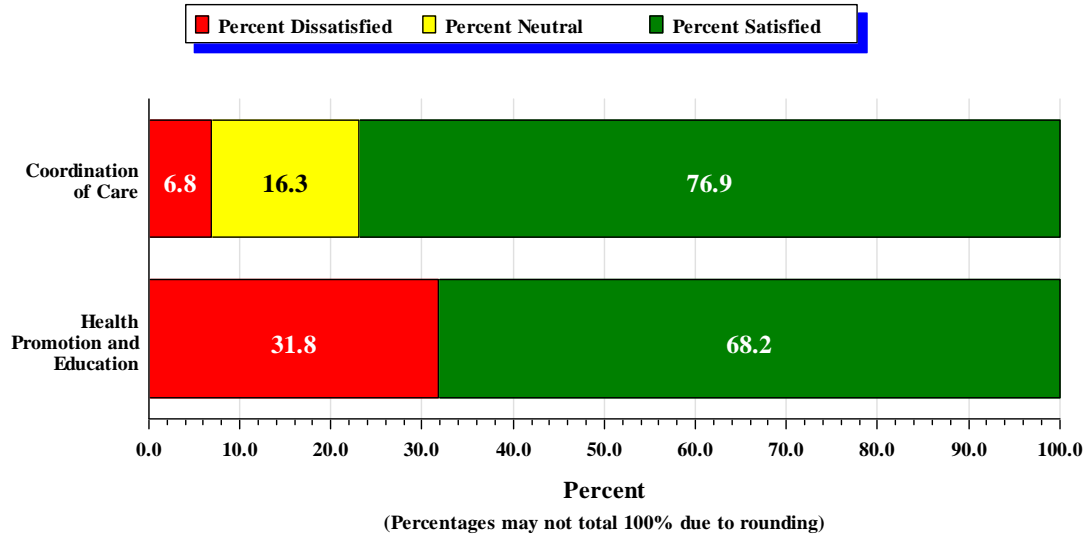
Figure 4-5 Individual Item Measures: Question Summary Rates



⁴⁻⁴ Due to changes to the Health Promotion and Education individual item measure, comparisons to NCQA national averages could not be performed for 2013. For detailed information on changes to this individual measure, please refer to the Executive Summary section of this report.

For Coordination of Care, responses were classified into one of three response categories: “Never,” “Sometimes,” and “Usually/Always.” For Health Promotion and Education, responses were classified into one of two response categories: “No” or “Yes.” Figure 4-6 depicts the proportion of respondents who fell into each response category for each individual item measure for the CRS Program.

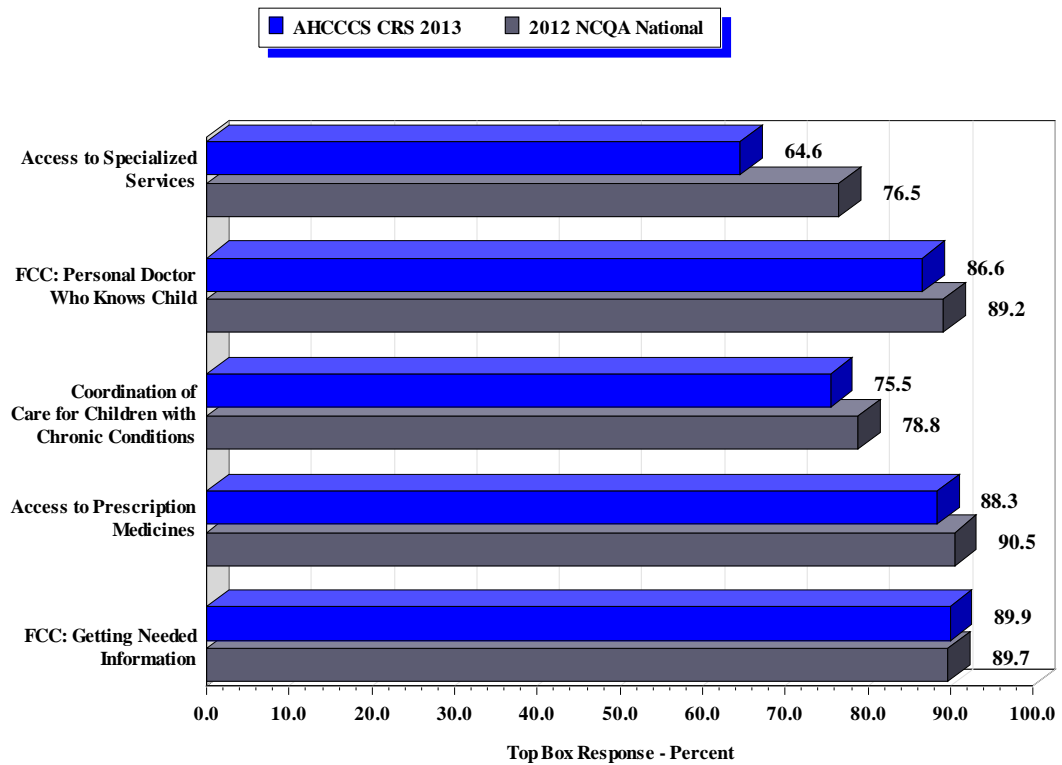
Figure 4-6 Individual Item Measures: Proportion of Responses



CCC Composites and Items

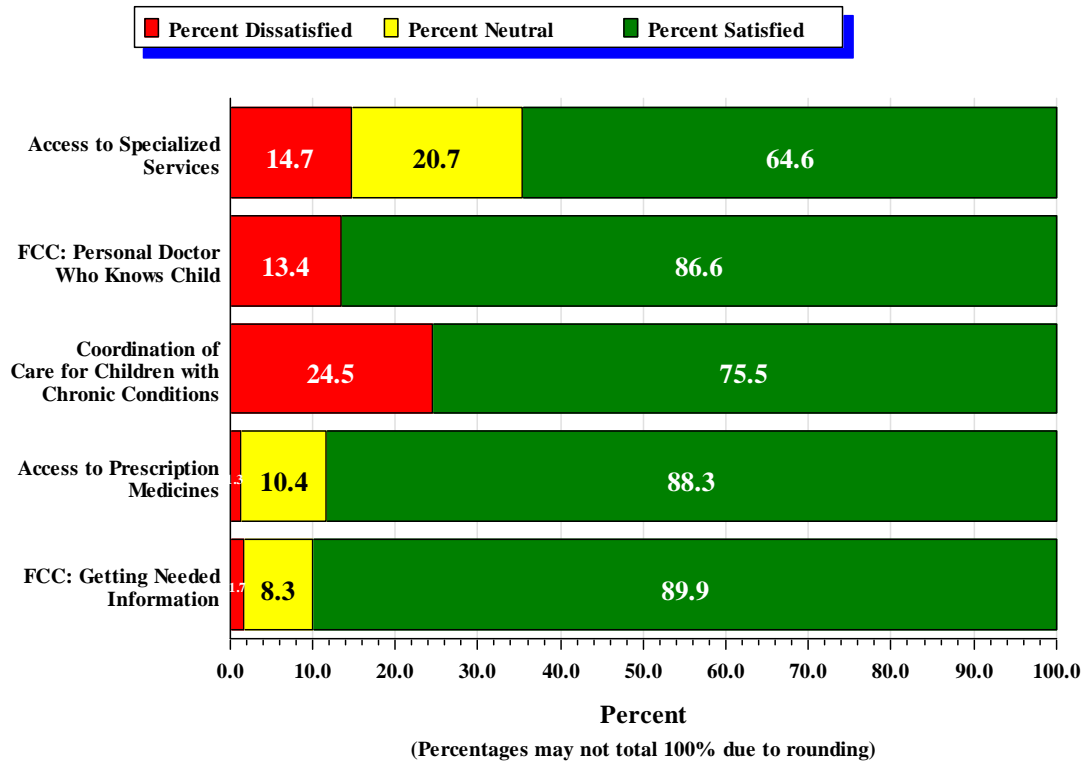
Figure 4-7 depicts the top-box question summary rates for the CRS Program and the 2012 NCQA National Child Medicaid average using responses of “Usually” or “Always” for top-box scoring of Access to Specialized Services, Access to Prescription Medicines, and Family-Centered Care (FCC): Getting Needed Information, and responses of “Yes” for top-box scoring of FCC: Personal Doctor Who Knows Child and Coordination of Care for Children with Chronic Conditions.

Figure 4-7 CCC Composites and Items: Global Proportions/Question Summary Rates



For Access to Specialized Services, Access to Prescription Medicines, and FCC: Getting Needed Information, responses were classified into one of three response categories as follows: “Never,” “Sometimes,” and “Usually/Always.” For FCC: Personal Doctor Who Knows Child and Coordination of Care for Children with Chronic Conditions, responses were classified into one of two response categories: “No” and “Yes.” Figure 4-8 depicts the proportion of respondents who fell into each response category for each individual item measure for the CRS Program.

Figure 4-8 CCC Composites and Items: Proportion of Responses



Summary of CCC Rates and Proportions

Evaluation of the CRS Program's rates and proportions for the CCC population revealed the following summary results.

- ◆ The CRS Program scored at or above the national average on five measures: Rating of Personal Doctor, Rating of Specialist Seen Most Often, Getting Needed Care, Customer Service, and FCC: Getting Needed Information.

- ◆ The CRS Program scored below the national average on nine measures: Rating of Health Plan, Rating of All Health Care, Getting Care Quickly, How Well Doctors Communicate, Coordination of Care, Access to Specialized Services, FCC: Personal Doctor Who Knows Child, Coordination of Care for Children with Chronic Conditions, and Access to Prescription Medicines.

Recommendations for Quality Improvement

This section presents Child Medicaid CAHPS recommendations for the CRS Program for each CAHPS measure. The recommendations presented in this section should be viewed as potential suggestions for QI. Additional sources of QI information, such as other HEDIS results, should be incorporated into a comprehensive QI plan. A number of resources are available to assist state Medicaid agencies and programs with the implementation of CAHPS-based QI initiatives. A comprehensive list of these resources is included on page 5-17.

Priority Assignments

This section defines QI priority assignments for each global rating and composite measure. The priority assignments are grouped into four main categories for QI: top, high, moderate, and low priority. The priority assignments are based on the results of the NCQA comparisons for the general child population.^{5-1,5-2}

Table 5-1 shows how the priority assignments are determined for the CRS Program on each CAHPS measure.

Table 5-1
Derivation of Priority Assignments on Each CAHPS Measure

NCQA Comparisons (Star Ratings)	Priority Assignment
★	Top
★★	High
★★★	Moderate
★★★★	Low
★★★★★	Low

Table 5-2 shows the priority assignments for the CRS Program.

Table 5-2
CRS Program's Priority Assignments

Measure	NCQA Comparisons (Star Ratings)	Priority Assignments
Rating of Health Plan	★	Top
Customer Service	★★	High
How Well Doctors Communicate	★★	High
Getting Care Quickly	★★	High
Getting Needed Care	★★★	Moderate
Rating of All Health Care	★★★★	Low
Rating of Personal Doctor	★★★★★	Low
Rating of Specialist Seen Most Often	★★★★★	Low

⁵⁻¹ Due to the transition from the CAHPS 4.0 to 5.0 Child Medicaid Health Plan Survey, comparisons to national data could not be performed for the Shared Decision Making composite measure and Health Promotion and Education individual item measure; therefore, priority assignments cannot be derived for these measures.

⁵⁻² NCQA does not provide benchmarks for the Coordination of Care individual item measure; therefore, priority assignments cannot be derived for this measure.

Global Ratings

Rating of Health Plan

In order to improve the overall Rating of Health Plan, QI activities should target alternatives to one-on-one visits, health plan operations, online patient portals, and promoting QI initiatives.

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

In order to improve the Rating of All Health Care measure, QI activities should target member perception of access to care, patient and family engagement advisory councils, and facilitating coordinated 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 policies and scripts in place, the late patient can be notified the provider has moved onto the next patient and will work the late patient into the rotation as time permits. This type of structure allows the late patient to still receive care without causing delay in the appointments of other patients. Additionally, having a well-written script prepared in the event of an uncommon but expected situation, allows staff to work quickly in providing timely access to care while following protocol.

Patient and Family Engagement Advisory Councils

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

Facilitate Coordinated Care

Health plans should assist in facilitating the process of coordinated care between providers and care coordinators to ensure child members are receiving the care and services most appropriate for their health care needs. Coordinated care is most effective when care coordinators and providers organize their efforts to deliver the same message to parents and caretakers of child members. Members are more likely to play an active role in the management of their child's health care and benefit from care coordination efforts if they are receiving the same information from both care coordinator and providers. Improving the system-level coordination between providers and care coordinators will

enhance the service and care received by members. Additionally, providing patient registries or clinical information systems that allow providers and care coordinators to enter information on patients (e.g., notes from a telephone call or a physician visit) can help reduce duplication of services and facilitate care coordination.

Involving Families in Care Coordination

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

Rating of Personal Doctor

In order to improve the Rating of Personal Doctor measure, QI activities should target maintaining truth in scheduling, patient-direct feedback, physician-patient communication, and improving shared decision making.

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

In order to improve the overall performance on the Rating of Specialist Seen Most Often global rating, QI activities should target planned visit management, skills training, and telemedicine.

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.

Composite Measures

Getting Needed Care

In order to improve members' satisfaction under the Getting Needed Care measure, QI activities should target appropriate health care providers, providing interactive workshops, "max-packing," language concordance programs, and streamlining the referral process.

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 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 call "max packing." "Max-packing" is a model designed to maximize each patient's office visit, which in many cases eliminates the need for extra appointments. Max-packing strategies could include using a checklist of preventive care services to anticipate the patient's future medical needs and guide the process of taking care of those needs during a scheduled visit, whenever possible. Processes also could 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 since such physicians typically 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.

Care Coordination Team

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

Getting Care Quickly

In order to improve members' satisfaction under the Getting Care Quickly measure, QI activities should target decreasing no-show appointments, electronic communication, nurse advice help lines, open access scheduling, and patient flow.

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

In order to improve clients' satisfaction under the How Well Doctors Communicate measure, QI activities should focus on communication tools, improving health literacy, and language barriers.

Communication Tools for Patients

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

Improve Health Literacy

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

Additionally, health literacy coaching can be implemented to ease the inclusion of health literacy into physician practice. Health plans can offer a 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 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

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

Call Centers

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

Creating an Effective Customer Service Training Program

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

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

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

Customer Service Performance Measures

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

Accountability and Improvement of Care

Although the administration of the CAHPS survey takes place at the program level, the accountability for the performance lies at both the program and provider network level. Table 5-3 provides a summary of the responsible parties for various aspects of care.⁵⁻³

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

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

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

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

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

⁵⁻³ Edgman-Levitan S, Shaller D, McInnes K, et al. *The CAHPS® Improvement Guide: Practical Strategies for Improving the Patient Care Experience*. Department of Health Care Policy Harvard Medical School, October 2003.

Quality Improvement References

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

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

Survey Administration

Survey Overview

The survey instrument selected was the CAHPS 5.0 Child Medicaid Health Plan Survey with the HEDIS supplemental item set and CCC measurement set. The CAHPS 5.0H Health Plan Surveys are a set of standardized surveys that assess patient perspectives on care. Originally, CAHPS was a five-year collaborative project sponsored by AHRQ. The CAHPS questionnaires and consumer reports were developed under cooperative agreements among AHRQ, Harvard Medical School, RAND, and the Research Triangle Institute (RTI). In 1997, NCQA, in conjunction with AHRQ, created the CAHPS 2.0H Survey measure as part of NCQA's HEDIS.⁶⁻¹ In 2002, AHRQ convened the CAHPS Instrument Panel to re-evaluate and update the CAHPS Health Plan Surveys and to improve the state-of-the-art methods for assessing clients' experiences with care.⁶⁻² The result of this re-evaluation and update process was the development of the CAHPS 3.0H Health Plan Surveys. The goal of the CAHPS 3.0H Health Plan Surveys was to effectively and efficiently obtain information from the person receiving care. In 2006, AHRQ released the CAHPS 4.0 Health Plan Surveys. Based on the CAHPS 4.0 versions, NCQA introduced new HEDIS versions of the Adult Health Plan Survey in 2007 and the Child Health Plan Survey in 2009, which are referred to as the CAHPS 4.0H Health Plan Surveys.^{6-3,6-4} In 2012, AHRQ released the CAHPS 5.0 Health Plan Surveys. Based on the CAHPS 5.0 versions, NCQA introduced new HEDIS versions of the Adult and Child Health Plan Surveys in August 2012, which are referred to as the CAHPS 5.0H Health Plan Surveys.⁶⁻⁵

The sampling and data collection procedures for the CAHPS 5.0 Health Plan Surveys are designed to capture accurate and complete information about consumer-reported experiences with health care. The sampling and data collection procedures promote both the standardized administration of survey instruments and the comparability of the resulting data.

⁶⁻¹ National Committee for Quality Assurance. *HEDIS® 2002, Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA Publication, 2001.

⁶⁻² National Committee for Quality Assurance. *HEDIS® 2003, Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA Publication, 2002.

⁶⁻³ National Committee for Quality Assurance. *HEDIS® 2007, Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA Publication, 2006.

⁶⁻⁴ National Committee for Quality Assurance. *HEDIS® 2009, Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA Publication, 2008.

⁶⁻⁵ National Committee for Quality Assurance. *HEDIS® 2013, Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA Publication, 2012.

The CAHPS 5.0 Child Medicaid Health Plan Survey with the HEDIS supplemental item set and CCC measurement set includes 83 core questions that yield 16 measures of satisfaction. These measures include four global rating questions, five composite measures, two individual item measures, and five CCC composite measures/items. The global measures (also referred to as global ratings) reflect overall satisfaction with the health plan, health care, personal doctors, and specialists. The composite measures are sets of questions grouped together to address different aspects of care (e.g., “Getting Needed Care” or “Getting Care Quickly”). The individual item measures are individual questions that look at a specific area of care (i.e., “Coordination of Care” and “Health Promotion and Education”).

Table 6-1 lists the global ratings, composite measures, individual item measures, and CCC composites/items included in the CAHPS 5.0 Child Medicaid Health Plan Survey with CCC measurement set.

**Table 6-1
CAHPS Measures**

Global Ratings	Composite Measures	Individual Item Measures	CCC Composites/Items
Rating of Health Plan	Getting Needed Care	Coordination of Care	Access to Specialized Services
Rating of All Health Care	Getting Care Quickly	Health Promotion and Education	FCC: Personal Doctor Who Knows Child
Rating of Personal Doctor	How Well Doctors Communicate		Coordination of Care for Children with Chronic Conditions
Rating of Specialist Seen Most Often	Customer Service		Access to Prescription Medicines
	Shared Decision Making		FCC: Getting Needed Information

Sampling Procedures

The members eligible for sampling included those who were CRS Program members at the time the sample was drawn and who were continuously enrolled for at least five of the last six months (July through December) of 2012. The members eligible for sampling included those who were 21 years of age or younger (as of December 31, 2012).

The standard NCQA specifications for survey measures require a sample size of 1,650 for the general population and 1,840 for the CCC supplemental population (for a total 3,490 child members) for the CAHPS 5.0 Child Medicaid Health Plan Survey with CCC measurement set. For the CRS Program, a random sample of 1,650 child members was selected for the CAHPS 5.0 general child sample, which represents the general population of children. After selecting child members for the CAHPS 5.0 general child sample, a random sample of up to 1,840 child members with a prescreen code of 2, which represents the population of children who are more likely to have a chronic condition (i.e., CCC supplemental sample) was selected. For the CRS Program, a total of 3,490 child members (i.e., 1,650 general child and 1,840 CCC members) was selected.

Survey Protocol

The CAHPS 5.0 Health Plan Survey process allows for two methods by which members can complete a survey. The first, or mail phase, consisted of a survey being mailed to all sampled members. For the CRS Program, those members who were identified as Spanish-speaking through administrative data were mailed a Spanish version of the survey. Members that were not identified as Spanish-speaking received an English version of the survey. The cover letter included with the English version of the survey had a Spanish cover letter on the back side informing members that they could call the toll-free number to request a Spanish version of the CAHPS questionnaire. The cover letter provided with the Spanish version of the CAHPS questionnaire included a text box with a toll-free number that members could call to request a survey in another language (i.e., English). A reminder postcard was sent to all non-respondents, followed by a second survey mailing and reminder postcard. The second phase, or telephone phase, consisted of CATI of sampled members who had not mailed in a completed survey. A series of up to six CATI calls was made to each non-respondent. It has been shown that the addition of the telephone phase aids in the reduction of non-response bias by increasing the number of respondents who are more demographically representative of a program's population.⁶⁻⁶

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

- ◆ Were 21 years of age or younger as of December 31, 2012.
- ◆ Were currently enrolled in the CRS Program.
- ◆ Had been continuously enrolled for at least five of the last six months of 2012.
- ◆ Had Medicaid as a payer.

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

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

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

Table 6-2 shows the CAHPS timeline used in the administration of the CRS Program's CAHPS 5.0 Child Medicaid Health Plan Surveys. The timeline is based on NCQA HEDIS Specifications for Survey Measures.⁶⁻⁷

**Table 6-2
CAHPS 5.0 Survey Timeline**

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

⁶⁻⁷ National Committee for Quality Assurance. *HEDIS® 2013, Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA Publication, 2012.

Methodology

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

Response Rates

The administration of the CAHPS 5.0 Child Medicaid Health Plan Survey is comprehensive and is designed to achieve the highest possible response rate. NCQA defines the response rate as the total number of completed surveys divided by all eligible members of the sample.⁶⁻⁸ A survey is assigned a disposition code of "completed" if at least one question is answered within the survey. Eligible members include the entire random sample (including any oversample) minus ineligible members. Ineligible members of the sample met one or more of the following criteria: were deceased, were invalid (did not meet criteria described on page 6-3), or had a language barrier.

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

Child and Respondent Demographics

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

⁶⁻⁸ National Committee for Quality Assurance. *HEDIS® 2013, Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA Publication, 2012.

NCQA Comparisons

An analysis of the CRS Program's CAHPS 5.0 Child Medicaid Health Plan Survey results was conducted using NCQA HEDIS Specifications for Survey Measures.⁶⁻⁹ Per these specifications, no case-mix adjustment is performed on the results. NCQA also requires a minimum of 100 responses on each item in order to report the item as a valid CAHPS Survey result.

In order to perform the NCQA comparisons, a three-point mean score was determined for each CAHPS measure. The resulting three-point mean scores were compared to published NCQA Benchmarks and Thresholds to derive the overall member satisfaction ratings (i.e., star ratings) for each CAHPS measure, except for the Shared Decision Making composite and Coordination of Care and Health Promotion and Education individual item measures.⁶⁻¹⁰ NCQA does not publish benchmarks and thresholds for these measures; therefore, star ratings could not be assigned. For detailed information on the derivation of three-point mean scores, please refer to *NCQA HEDIS 2013 Specifications for Survey Measures, Volume 3*.

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

- ★★★★★ indicates a score at or above the 90th percentile
- ★★★★ indicates a score at or between the 75th and 89th percentiles
- ★★★ indicates a score at or between the 50th and 74th percentiles
- ★★ indicates a score at or between the 25th and 49th percentiles
- ★ indicates a score below the 25th percentile

⁶⁻⁹ National Committee for Quality Assurance. *HEDIS® 2013, Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA Publication, 2012.

⁶⁻¹⁰ As previously noted, NCQA's benchmarks and thresholds for the child Medicaid population were used to derive the overall member satisfaction ratings; therefore, caution should be exercised when interpreting these results.

Table 6-3 shows the benchmarks and thresholds used to derive the overall member satisfaction ratings on each CAHPS measure.⁶⁻¹¹

Table 6-3
Overall Child Medicaid Member Satisfaction Ratings Crosswalk

Measure	90th Percentile	75th Percentile	50th Percentile	25th Percentile
Rating of Health Plan	2.67	2.62	2.57	2.51
Rating of All Health Care	2.59	2.57	2.52	2.49
Rating of Personal Doctor	2.69	2.65	2.62	2.58
Rating of Specialist Seen Most Often	2.66	2.62	2.59	2.53
Getting Needed Care	2.50	2.45	2.36	2.29
Getting Care Quickly	2.69	2.66	2.61	2.54
How Well Doctors Communicate	2.75	2.72	2.68	2.63
Customer Service	2.58	2.51	2.46	2.40

Rates and Proportions

Rates and proportions were presented that compared member satisfaction performance between the CRS Program and the 2012 NCQA National Child Medicaid Average, if applicable. For purposes of this analysis, question summary rates were calculated for each global rating and individual item measure, and global proportions were calculated for each composite measure. Both the question summary rates and global proportions were calculated in accordance with NCQA HEDIS Specifications for Survey Measures.⁶⁻¹² The scoring of the global ratings, composite measures, individual item measures, and CCC composites and items involved assigning top-level responses a score of one, with all other responses receiving a score of zero. After applying this scoring methodology, the percentage of top-level responses was calculated in order to determine the question summary rates and global proportions. For additional detail, please refer to the *NCQA HEDIS 2013 Specifications for Survey Measures, Volume 3*.

⁶⁻¹¹ National Committee for Quality Assurance. *HEDIS Benchmarks and Thresholds for Accreditation 2013*. Washington, DC: NCQA, July 24, 2013.

⁶⁻¹² National Committee for Quality Assurance. *HEDIS® 2013, Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA Publication, 2012.

Limitations and Cautions

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

Case-Mix Adjustment

As described in the respondent demographics subsection, 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.⁶⁻¹³

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. Therefore, the potential for non-response bias should be considered when interpreting CAHPS results.

Causal Inferences

Although this report examines whether members report differences in satisfaction with various aspects of their health care experiences, these differences may not be completely attributable to the CRS Program given the structure of the program (i.e., child members enrolled in the CRS Program may have received well-child and primary care services from a separate system of care, such as AHCCCS' Acute Care health plans). The survey by itself does not necessarily reveal the exact cause of these differences. As such, caution should be exercised when interpreting these results.

Baseline Results

It is important to note that in 2013 the CRS Program was surveyed for the first time. The 2013 CAHPS results presented in the report represent a **baseline** assessment of parents'/caretakers' satisfaction with the CRS Program; therefore, caution should be exercised when interpreting results.

⁶⁻¹³ Agency for Healthcare Research and Quality. *CAHPS Health Plan Survey and Reporting Kit 2008*. Rockville, MD: U.S. Department of Health and Human Services, July 2008.

7. Survey Instrument

The survey instrument selected for the 2013 CRS Program Child Medicaid Member Satisfaction Survey was the CAHPS 5.0 Child Medicaid Health Plan Survey with HEDIS supplemental item set and CCC measurement set. This section provides a copy of the survey instrument.



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

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

If you want to know more about this study, please call 1-877-455-9242.

SURVEY INSTRUCTIONS

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



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

- Yes ➔ *Go to Question 1*
- No

↓ **START HERE** ↓

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

1. Our records show that your child is now in [HEALTH PLAN NAME/STATE MEDICAID PROGRAM NAME]. Is that right?

- Yes ➔ *Go to Question 3*
- No

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



YOUR CHILD'S HEALTH CARE IN THE LAST 6 MONTHS

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

3. In the last 6 months, did your child have an illness, injury, or condition that **needed care right away** in a clinic, emergency room, or doctor's office?
- Yes
 No → **Go to Question 5**
4. In the last 6 months, when your child **needed care right away**, how often did your child get care as soon as he or she needed?
- Never
 Sometimes
 Usually
 Always
5. In the last 6 months, did you make any appointments for a **check-up or routine care** for your child at a doctor's office or clinic?
- Yes
 No → **Go to Question 7**
6. In the last 6 months, when you made an appointment for a **check-up or routine care** for your child at a doctor's office or clinic, how often did you get an appointment as soon as your child needed?
- Never
 Sometimes
 Usually
 Always
7. In the last 6 months, **not** counting the times your child went to an emergency room, how many times did he or she go to a doctor's office or clinic to get health care?
- None → **Go to Question 16**
 1 time
 2
 3
 4
 5 to 9
 10 or more times

8. In the last 6 months, did you and your child's doctor or other health provider talk about specific things you could do to prevent illness in your child?
- Yes
 No
9. In the last 6 months, how often did you have your questions answered by your child's doctors or other health providers?
- Never
 Sometimes
 Usually
 Always
10. In the last 6 months, did you and your child's doctor or other health provider talk about starting or stopping a prescription medicine for your child?
- Yes
 No → **Go to Question 14**
11. When you talked about your child starting or stopping a prescription medicine, how much did a doctor or other health provider talk about the reasons you might want your child to take a medicine?
- Not at all
 A little
 Some
 A lot
12. When you talked about your child starting or stopping a prescription medicine, how much did a doctor or other health provider talk about the reasons you might **not** want your child to take a medicine?
- Not at all
 A little
 Some
 A lot
13. When you talked about your child starting or stopping a prescription medicine, did a doctor or other health provider ask you what you thought was best for your child?
- Yes
 No

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

0 1 2 3 4 5 6 7 8 9 10

Worst Health Care Possible Best Health Care Possible

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

- Never
- Sometimes
- Usually
- Always

16. Is your child now enrolled in any kind of school or daycare?

- Yes
- No → **Go to Question 19**

17. In the last 6 months, did you need your child's doctors or other health providers to contact a school or daycare center about your child's health or health care?

- Yes
- No → **Go to Question 19**

18. In the last 6 months, did you get the help you needed from your child's doctors or other health providers in contacting your child's school or daycare?

- Yes
- No

SPECIALIZED SERVICES

19. Special medical equipment or devices include a walker, wheelchair, nebulizer, feeding tubes, or oxygen equipment. In the last 6 months, did you get or try to get any special medical equipment or devices for your child?

- Yes
- No → **Go to Question 22**

20. In the last 6 months, how often was it easy to get special medical equipment or devices for your child?

- Never
- Sometimes
- Usually
- Always

21. Did anyone from your child's health plan, doctor's office, or clinic help you get special medical equipment or devices for your child?

- Yes
- No

22. In the last 6 months, did you get or try to get special therapy such as physical, occupational, or speech therapy for your child?

- Yes
- No → **Go to Question 25**

23. In the last 6 months, how often was it easy to get this therapy for your child?

- Never
- Sometimes
- Usually
- Always

24. Did anyone from your child's health plan, doctor's office, or clinic help you get this therapy for your child?

- Yes
- No

25. In the last 6 months, did you get or try to get treatment or counseling for your child for an emotional, developmental, or behavioral problem?

- Yes
- No → **Go to Question 28**

26. In the last 6 months, how often was it easy to get this treatment or counseling for your child?

- Never
- Sometimes
- Usually
- Always



27. Did anyone from your child's health plan, doctor's office, or clinic help you get this treatment or counseling for your child?
- Yes
 - No
28. In the last 6 months, did your child get care from more than one kind of health care provider or use more than one kind of health care service?
- Yes
 - No → *Go to Question 30*
29. In the last 6 months, did anyone from your child's health plan, doctor's office, or clinic help coordinate your child's care among these different providers or services?
- Yes
 - No
- 29a. How satisfied are you with the help you got to coordinate your child's care in the last 6 months?
- Very dissatisfied
 - Dissatisfied
 - Neither dissatisfied nor satisfied
 - Satisfied
 - Very satisfied

YOUR CHILD'S PERSONAL DOCTOR

30. A personal doctor is the one your child would see if he or she needs a checkup, has a health problem or gets sick or hurt. Does your child have a personal doctor?
- Yes
 - No → *Go to Question 45*
31. In the last 6 months, how many times did your child visit his or her personal doctor for care?
- None → *Go to Question 41*
 - 1 time
 - 2
 - 3
 - 4
 - 5 to 9
 - 10 or more times

32. In the last 6 months, how often did your child's personal doctor explain things about your child's health in a way that was easy to understand?
- Never
 - Sometimes
 - Usually
 - Always
33. In the last 6 months, how often did your child's personal doctor listen carefully to you?
- Never
 - Sometimes
 - Usually
 - Always
34. In the last 6 months, how often did your child's personal doctor show respect for what you had to say?
- Never
 - Sometimes
 - Usually
 - Always
35. Is your child able to talk with doctors about his or her health care?
- Yes
 - No → *Go to Question 37*
36. In the last 6 months, how often did your child's personal doctor explain things in a way that was easy for your child to understand?
- Never
 - Sometimes
 - Usually
 - Always
37. In the last 6 months, how often did your child's personal doctor spend enough time with your child?
- Never
 - Sometimes
 - Usually
 - Always



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

- Yes
 No

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

- Yes
 No -> Go to Question 41

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

- Never
 Sometimes
 Usually
 Always

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

0 1 2 3 4 5 6 7 8 9 10
Worst Personal Doctor Possible Best Personal Doctor Possible

41a. Some doctor's offices remind patients between visits about tests, treatment or appointments. In the last 6 months, did you get any reminders about your child's care between visits with your child's personal doctor?

- Yes
 No

41b. In the last 6 months, did your child's doctor or other health provider ask you if there are things that make it hard for you to take care of your child's health?

- Yes
 No

41c. In the last 6 months, did a doctor or other health provider talk with you about specific goals for your child's health?

- Yes
 No

42. Does your child have any medical, behavioral, or other health conditions that have lasted for more than 3 months?

- Yes
 No -> Go to Question 45

43. Does your child's personal doctor understand how these medical, behavioral, or other health conditions affect your child's day-to-day life?

- Yes
 No

44. Does your child's personal doctor understand how your child's medical, behavioral, or other health conditions affect your family's day-to-day life?

- Yes
 No

GETTING HEALTH CARE FROM SPECIALISTS

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

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

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

- Yes
 No -> Go to Question 49



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

- Never
- Sometimes
- Usually
- Always

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

- None → *Go to Question 49*
- 1 specialist
- 2
- 3
- 4
- 5 or more specialists

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

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

YOUR CHILD'S HEALTH PLAN

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

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

- Yes
- No → *Go to Question 52*

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

- Never
- Sometimes
- Usually
- Always

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

- Never
- Sometimes
- Usually
- Always

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

- Yes
- No → *Go to Question 54*

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

- Never
- Sometimes
- Usually
- Always

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

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

PRESCRIPTION MEDICINES

55. In the last 6 months, did you get or refill any prescription medicines for your child?

- Yes
- No → *Go to Question 58*

56. In the last 6 months, how often was it easy to get prescription medicines for your child through his or her health plan?

- Never
- Sometimes
- Usually
- Always



57. Did anyone from your child's health plan, doctor's office, or clinic help you get your child's prescription medicines?

- Yes
- No

ABOUT YOUR CHILD AND YOU

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

- Excellent
- Very good
- Good
- Fair
- Poor

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

- Excellent
- Very good
- Good
- Fair
- Poor

60. Does your child currently need or use medicine prescribed by a doctor (other than vitamins)?

- Yes
- No → *Go to Question 63*

61. Is this because of any medical, behavioral, or other health condition?

- Yes
- No → *Go to Question 63*

62. Is this a condition that has lasted or is expected to last for at least 12 months?

- Yes
- No

63. Does your child need or use more medical care, more mental health services, or more educational services than is usual for most children of the same age?

- Yes
- No → *Go to Question 66*

64. Is this because of any medical, behavioral, or other health condition?

- Yes
- No → *Go to Question 66*

65. Is this a condition that has lasted or is expected to last for at least 12 months?

- Yes
- No

66. Is your child limited or prevented in any way in his or her ability to do the things most children of the same age can do?

- Yes
- No → *Go to Question 69*

67. Is this because of any medical, behavioral, or other health condition?

- Yes
- No → *Go to Question 69*

68. Is this a condition that has lasted or is expected to last for at least 12 months?

- Yes
- No

69. Does your child need or get special therapy such as physical, occupational, or speech therapy?

- Yes
- No → *Go to Question 72*

70. Is this because of any medical, behavioral, or other health condition?

- Yes
- No → *Go to Question 72*

71. Is this a condition that has lasted or is expected to last for at least 12 months?

- Yes
- No

72. Does your child have any kind of emotional, developmental, or behavioral problem for which he or she needs or gets treatment or counseling?

- Yes
- No → *Go to Question 74*



73. Has this problem lasted or is it expected to last for at least 12 months?

- Yes
- No

74. What is your child's age?

- Less than 1 year old

YEARS OLD (write in)

75. Is your child male or female?

- Male
- Female

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

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

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

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

78. What is your age?

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

79. Are you male or female?

- Male
- Female

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

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

81. How are you related to the child?

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

82. Did someone help you complete this survey?

- Yes → **Go to Question 83**
- No → **Thank you. Please return the completed survey in the postage-paid envelope.**

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

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

THANK YOU

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

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

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



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

CD Contents

- ◆ CRS Program Child Medicaid CAHPS Report
- ◆ CRS Program Child Medicaid Cross-tabulations (Tab and Banner Book)

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