

2014 ADULT MEDICAID MEMBER SATISFACTION REPORT

February 2015

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



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1. Executive Summary

The State of New Hampshire requested administration of member satisfaction surveys to Medicaid members enrolled in New Hampshire Medicaid Fee-for-Service (FFS), New Hampshire Healthy Families Health Plan (NH Healthy Families), and Well Sense Health Plan (Well Sense). The New Hampshire Department of Health and Human Services (DHHS) contracted with Health Services Advisory Group, Inc. (HSAG) to administer and report the results of the Consumer Assessment of Healthcare Providers and Systems (CAHPS[®]) Health Plan Surveys.¹⁻¹ The goal of the CAHPS Health Plan Surveys is to provide performance feedback that is actionable and will aid in improving overall member satisfaction. It is important to note that in 2014 the adult Medicaid population (i.e., adult members enrolled in FFS and the two participating managed care organizations [MCOs]) was surveyed for the first time. The 2014 FFS, NH Healthy Families, and Well Sense CAHPS results presented in the report represent a **baseline** assessment of adult Medicaid members satisfaction with FFS, NH Healthy Families, and Well Sense. Therefore, caution should be exercised when interpreting the results.

The standardized survey instrument selected was the CAHPS 5.0 Adult Medicaid Health Plan Survey with the Healthcare Effectiveness Data and Information Set (HEDIS[®]) supplemental item set.¹⁻² Adult members from FFS and the two MCOs completed the surveys from July to October 2014.

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

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

Performance Highlights

The Results Section of this report details the CAHPS results for the FFS population, NH Healthy Families, Well Sense, and two statewide aggregate rates:

- ◆ New Hampshire Medicaid Program – Combined results for FFS and the two MCOs.
- ◆ New Hampshire Medicaid Managed Care Program – Combined results for the two MCOs.

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

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

NCQA Comparisons

Three-point mean scores were calculated for each CAHPS global ratings (Rating of Health Plan, Rating of All Health Care, Rating of Personal Doctor, and Rating of Specialist Seen Most Often) and four composite measures (Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, and Customer Service) and compared to NCQA’s 2014 HEDIS Benchmarks and Thresholds for Accreditation three point-mean percentile distributions.^{1-3,1-4} The detailed results of this analysis are described in the Results Section beginning on page 2-7. Table 1-1 presents the measures that scored below the 50th percentile and at or above the 90th percentile for the New Hampshire Medicaid Program aggregates, FFS, and two MCOs.

Table 1-1 NCQA Comparisons Highlights				
NH Medicaid Program	NH Medicaid Managed Care Program	Fee-For-Service	NH Healthy Families Health Plan	Well Sense Health Plan
Below the 50th Percentile				
Customer Service	Customer Service	Customer Service	Customer Service	Customer Service
Rating of Health Plan	Rating of All Health Care		Rating of All Health Care	Rating of All Health Care
Rating of All Health Care	Rating of Health Plan		Rating of Health Plan	Rating of Health Plan
			Getting Care Quickly	Rating of Specialist Seen Most Often
			Getting Needed Care	
90th Percentile or Above				
None.	None.	Getting Care Quickly	None.	None.
		Getting Needed Care		
		How Well Doctors Communicate		
<i>Please note: If the program/MCO did not score at the 90th percentile or above on any of the CAHPS measures, this is denoted as “None” in the table above.</i>				

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

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

Statewide Comparisons

In order to identify performance differences in member satisfaction between the adult FFS population and two participating MCOs, case-mix adjusted results for each were compared to the New Hampshire Medicaid Program average using standard statistical tests.¹⁻⁵ The results were case-mix adjusted for general health status, education level, and age of the respondent. These comparisons were performed on the four global ratings, five composite measures, and two individual item measures. The detailed results of the comparative analysis are described in the Results Section beginning on page 2-22.¹⁻⁶

The results of this comparative analysis revealed that FFS scored statistically better than the New Hampshire Medicaid Program average on six measures. Conversely, NH Healthy Families and Well Sense did not score statistically better or worse than the New Hampshire Medicaid Program average on any of the measures.

Priority Assignments

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

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

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

¹⁻⁶ Caution should be exercised when evaluating the statewide comparisons, given that the differences in the FFS population and MCOs may impact results.

Key Drivers of Satisfaction

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

Table 1-2 Key Drivers of Satisfaction	
Customer Service	
Respondents reported that the written materials or the Internet did not provide them with the information they needed about how their health plan works.	
Respondents reported that their health plan’s customer service did not always give them the information or help they needed.	
Rating of Health Plan	
Respondents reported that their personal doctor did not always seem informed and up-to-date about the care they received from other doctors or health providers.	
Respondents reported that the written materials or the Internet did not provide them with the information they needed about how their health plan works.	
Respondents reported that their health plan’s customer service did not always give them the information or help they needed.	
Respondents reported that forms from their health plan were often not easy to fill out.	
Rating of All Health Care	
Respondents reported that their personal doctor did not always seem informed and up-to-date about the care they received from other doctors or health providers.	
Respondents reported that the written materials or the Internet did not provide them with the information they needed about how their health plan works.	

The following section presents the CAHPS results for FFS, NH Healthy Families, Well Sense, and two statewide program aggregates:

- ◆ New Hampshire Medicaid Program – Combined results for FFS and the two MCOs.
- ◆ New Hampshire Medicaid Managed Care Program – Combined results for the two MCOs.

Survey Administration and Response Rates

Survey Administration

The standard NCQA HEDIS Specifications for Survey Measures require a sample size of 1,350 members for the CAHPS 5.0 Adult Medicaid Health Plan Survey.²⁻¹ Members eligible for sampling included those who were enrolled in FFS, NH Healthy Families, and Well Sense at the time the sample was drawn and who were continuously enrolled for at least five of the last six months of the measurement period (November 2013 through April 2014). Adult members eligible for sampling included those who were 18 years of age or older as of April 30, 2014.

The survey administration protocol was designed to achieve a high response rate from members, thus minimizing the potential effects of non-response bias. The survey process allowed members two methods by which they could complete the surveys. The first phase, or mail phase, consisted of a survey being mailed to the sampled members. All sampled members received an English version of the survey. A reminder postcard was sent to all non-respondents, followed by a second survey mailing and a reminder postcard. The second phase, or telephone phase, consisted of Computer Assisted Telephone Interviewing (CATI) for sampled members who had not mailed in a completed survey. A maximum of three CATI calls was made to each non-respondent. Additional information on the survey protocol is included in the Reader's Guide Section beginning on page 4-3.

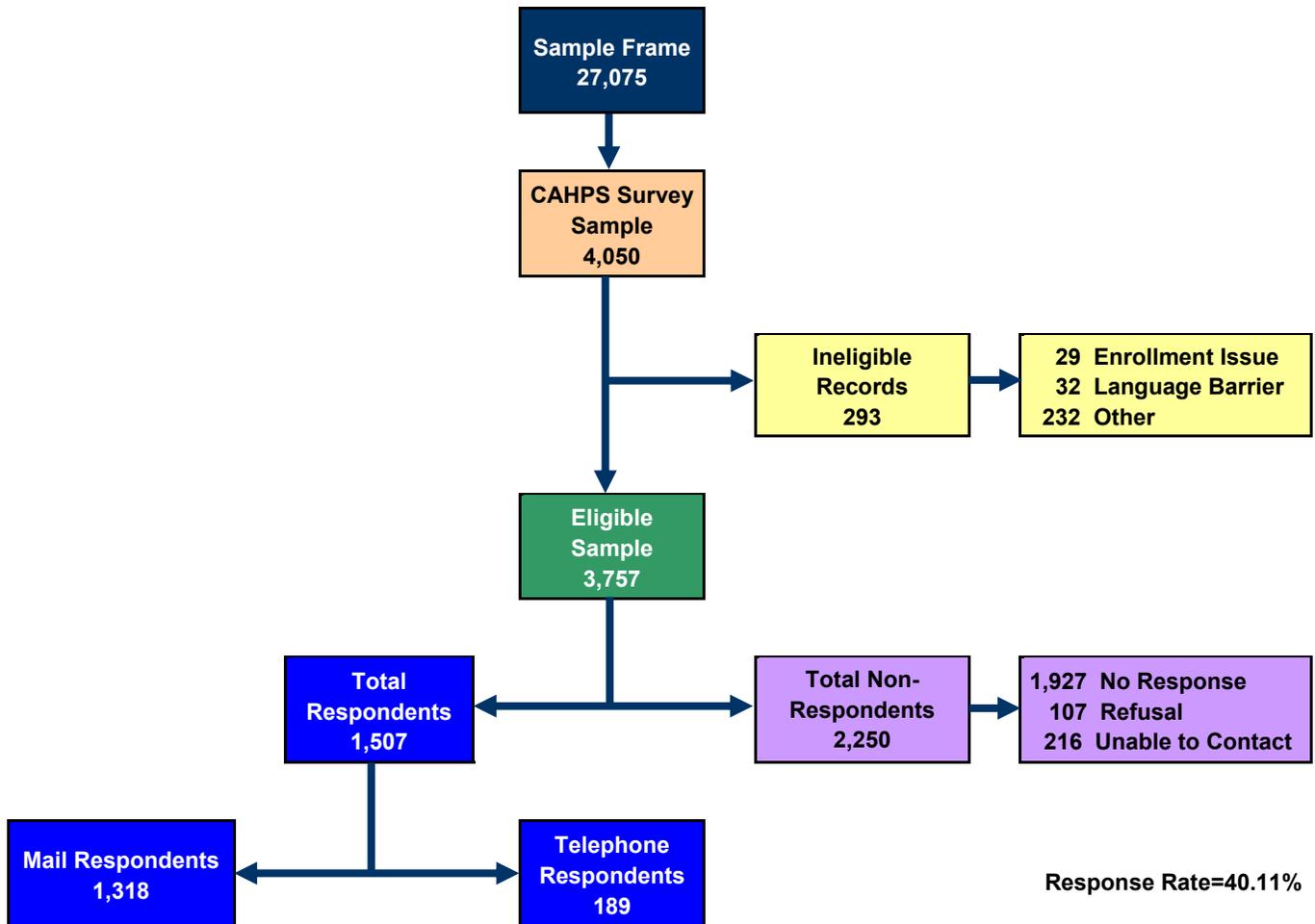
Response Rates

The New Hampshire CAHPS 5.0 Adult Medicaid Health Plan Survey administration was designed to achieve the highest possible response rate. The CAHPS Survey response rate is the total number of completed surveys divided by all eligible members of the sample. A member's survey was assigned a 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), were mentally or physically unable to complete the survey, or had a language barrier.

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

A total of 1,507 adult members returned a completed survey, including 608 FFS, 486 NH Healthy Families, and 413 Well Sense members. These completed surveys were used to calculate the New Hampshire Medicaid Program results presented throughout this report. Figure 2-1 shows the distribution of survey dispositions and response for the New Hampshire Adult Medicaid Program in total.

Figure 2-1—Distribution of Surveys for New Hampshire Adult Medicaid Program (FFS and MCOs Combined)

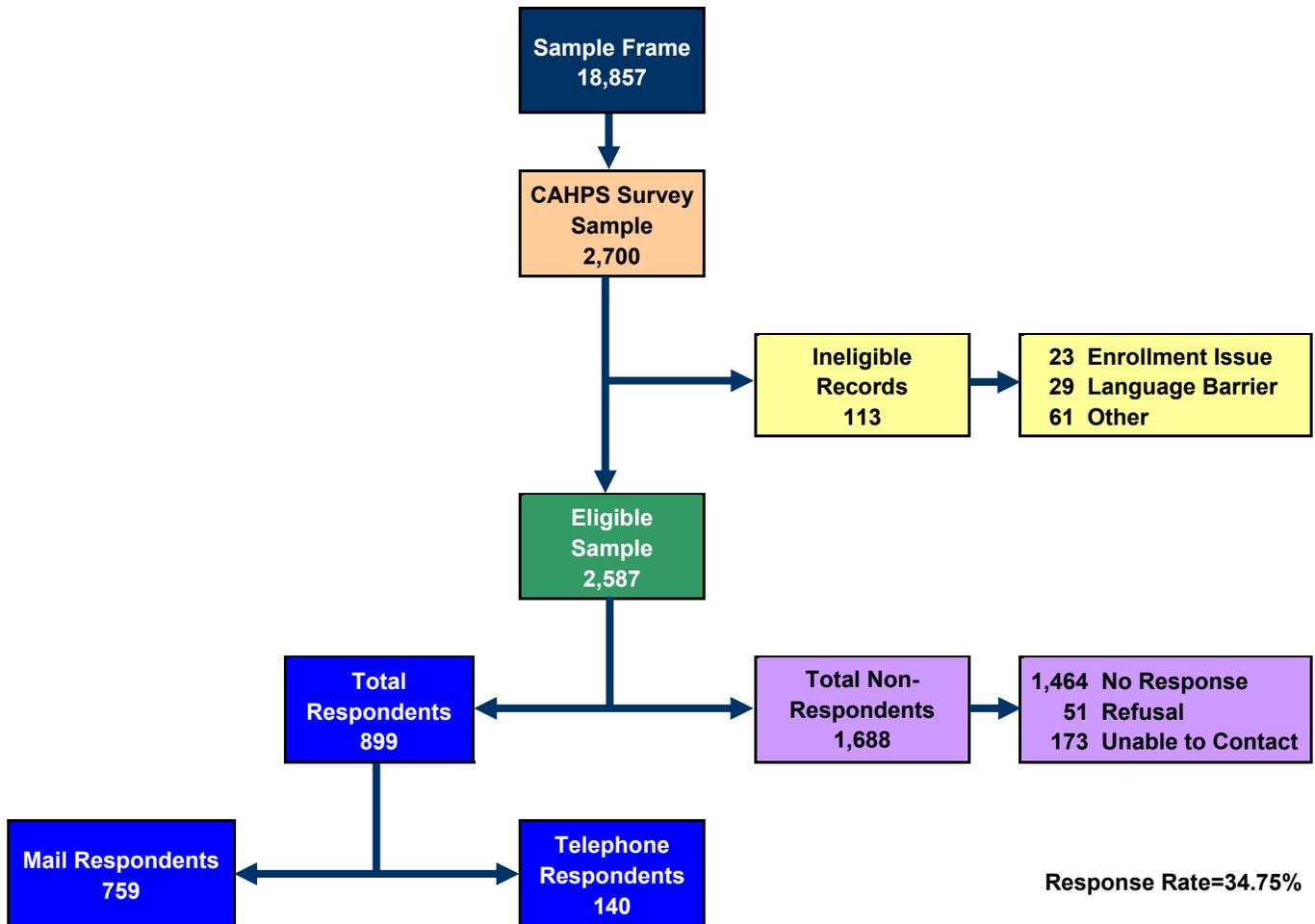


The 2014 New Hampshire Adult Medicaid Program total response rate of 40.1 percent was 11.5 percentage points above the national adult Medicaid response rate reported by NCQA for 2014, which was 28.6 percent.²⁻²

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

A total of 899 adult managed care members returned a completed survey, including 486 NH Healthy Families and 413 Well Sense members. These completed surveys were used to calculate the New Hampshire Medicaid Managed Care Program results presented throughout this report. Figure 2-2 shows the distribution of survey dispositions and response rates for the New Hampshire Medicaid Managed Care Program.

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



The 2014 New Hampshire Adult Medicaid Managed Care Program total response rate of 34.8 percent was 6.2 percentage points above the national adult Medicaid response rate reported by NCQA for 2014, which was 28.6 percent.²⁻³

²⁻³ National Committee for Quality Assurance. *HEDIS 2015 Survey Vendor Update Training*. October 23, 2014.

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

Table 2-1 Sample Distribution and Response Rate					
Plan Name	Total Sample	Ineligible Records	Eligible Sample	Total Respondents	Response Rate
NH Medicaid Program	4,050	293	3,757	1,507	40.11%
Fee-For-Service	1,350	180	1,170	608	51.97%
NH Medicaid Managed Care Program	2,700	113	2,587	899	34.75%
NH Healthy Families Health Plan	1,350	52	1,298	486	37.44%
Well Sense Health Plan	1,350	61	1,289	413	32.04%

Respondent Demographics

In general, the demographics of a response group influence overall member satisfaction scores. For example, older and healthier respondents tend to report higher levels of member satisfaction; therefore, caution should be exercised when comparing populations that have significantly different demographic properties.²⁻⁴

Table 2-2 through Table 2-6 show CAHPS 5.0 Adult Medicaid Health Plan Survey respondents' self-reported age, gender, race/ethnicity, education, and general health status.

Table 2-2 Respondent Demographics—Age						
Plan Name	18 to 24	25 to 34	35 to 44	45 to 54	55 to 64	65 and Older
NH Medicaid Program	10.0%	15.0%	12.5%	17.1%	19.2%	26.2%
Fee-For-Service	2.6%	7.9%	9.3%	15.7%	16.6%	47.8%
NH Medicaid Managed Care Program	15.0%	19.7%	14.6%	18.1%	20.9%	11.7%
NH Healthy Families Health Plan	16.3%	15.9%	14.2%	17.2%	23.4%	13.1%
Well Sense Health Plan	13.6%	24.1%	15.1%	19.1%	18.1%	10.1%

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

Table 2-3 Respondent Demographics—Gender		
Plan Name	Male	Female
NH Medicaid Program	36.6%	63.4%
Fee-For-Service	36.1%	63.9%
NH Medicaid Managed Care Program	36.9%	63.1%
NH Healthy Families Health Plan	38.6%	61.4%
Well Sense Health Plan	34.8%	65.2%

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

²⁻⁴ Agency for Healthcare Research and Quality. *CAHPS Health Plan Survey and Reporting Kit 2008*. Rockville, MD: US Department of Health and Human Services, July 2008.

**Table 2-4
Respondent Demographics— Race/Ethnicity**

Plan Name	Multi-Racial	White	Black	Asian	Native American	Other
NH Medicaid Program	6.6%	86.7%	1.7%	2.0%	0.9%	2.0%
Fee-For-Service	5.4%	90.5%	1.2%	1.0%	0.7%	1.2%
NH Medicaid Managed Care Program	7.5%	84.2%	2.1%	2.7%	1.1%	2.5%
NH Healthy Families Health Plan	7.8%	82.1%	3.0%	3.0%	1.3%	2.8%
Well Sense Health Plan	7.2%	86.7%	1.0%	2.3%	0.8%	2.0%

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

**Table 2-5
Respondent Demographics—Education**

Plan Name	8th Grade or Less	Some High School	High School Graduate	Some College	College Graduate
NH Medicaid Program	11.2%	18.1%	42.0%	21.9%	6.8%
Fee-For-Service	12.8%	18.5%	38.8%	22.2%	7.7%
NH Medicaid Managed Care Program	10.1%	17.8%	44.2%	21.7%	6.2%
NH Healthy Families Health Plan	10.3%	17.9%	45.5%	21.0%	5.3%
Well Sense Health Plan	9.9%	17.6%	42.6%	22.4%	7.4%

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

**Table 2-6
Respondent Demographics—General Health Status**

Plan Name	Excellent	Very Good	Good	Fair	Poor
NH Medicaid Program	6.7%	18.7%	31.2%	32.4%	11.0%
Fee-For-Service	3.8%	15.1%	30.4%	38.8%	11.9%
NH Medicaid Managed Care Program	8.7%	21.2%	31.7%	28.2%	10.3%
NH Healthy Families Health Plan	8.4%	21.8%	30.8%	28.4%	10.6%
Well Sense Health Plan	9.0%	20.5%	32.7%	27.9%	10.0%

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

NCQA Comparisons

In order to assess the overall performance of the New Hampshire Medicaid Program, New Hampshire Medicaid Managed Care Program, FFS, and participating MCOs, the four CAHPS global ratings and four CAHPS composite measures were scored on a three-point scale using the scoring methodology detailed in NCQA’s HEDIS Specifications for Survey Measures.²⁻⁵ The resulting three-point mean scores were compared to NCQA’s HEDIS Benchmarks and Thresholds for Accreditation three-point means for the 50th and 90th percentiles.²⁻⁶

Table 2-7 shows the three-point mean scores and NCQA national benchmarks and thresholds for the 50th and 90th percentiles on each of the four global ratings.

Table 2-7 NCQA Comparisons—Global Ratings				
Plan Name	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often
NH Medicaid Program	2.265	2.302	2.522	2.550
Fee-For-Service	2.410	2.391	2.544	2.585
NH Medicaid Managed Care Program	2.168	2.246	2.508	2.522
NH Healthy Families Health Plan	2.149	2.231	2.500	2.563
Well Sense Health Plan	2.189	2.264	2.516	2.476
NCQA Benchmarks and Thresholds				
50th percentile	2.40	2.32	2.50	2.51
90th percentile	2.54	2.42	2.57	2.59

²⁻⁵ National Committee for Quality Assurance. *HEDIS® 2014, Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA Publication, 2013.

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

Table 2-8 shows the three-point mean scores and NCQA national benchmarks and thresholds for the 50th and 90th percentiles for the four composite measures.²⁻⁷

Table 2-8 NCQA Comparisons—Composite Measures				
Plan Name	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service
NH Medicaid Program	2.417	2.488	2.626	2.368
Fee-For-Service	2.482	2.561	2.649	2.374 ⁺
NH Medicaid Managed Care Program	2.374	2.442	2.611	2.367
NH Healthy Families Health Plan	2.368	2.400	2.602	2.378
Well Sense Health Plan	2.381	2.488	2.621	2.356
NCQA Benchmarks and Thresholds				
50th percentile	2.37	2.41	2.54	2.54
90th percentile	2.46	2.49	2.64	2.61

Please note: Scores with fewer than 100 respondents are denoted with a cross (+). If there are fewer than 100 respondents for a measure, caution should be exercised when interpreting the results.

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

²⁻⁷ National Committee for Quality Assurance. *HEDIS Benchmarks and Thresholds for Accreditation 2014*. Washington, DC: NCQA, January 30, 2014.

Summary of NCQA Comparisons Results

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

Table 2-9 NCQA Comparisons Highlights				
NH Medicaid Program	NH Medicaid Managed Care Program	Fee-For-Service	NH Healthy Families Health Plan	Well Sense Health Plan
Below the 50th Percentile				
Customer Service	Customer Service	Customer Service	Customer Service	Customer Service
Rating of Health Plan	Rating of All Health Care		Rating of All Health Care	Rating of All Health Care
Rating of All Health Care	Rating of Health Plan		Rating of Health Plan	Rating of Health Plan
			Getting Care Quickly	Rating of Specialist Seen Most Often
			Getting Needed Care	
90th Percentile or Above				
None.	None.	Getting Care Quickly	None.	None.
		Getting Needed Care		
		How Well Doctors Communicate		
<i>Please note: If the program/MCO did not score at the 90th percentile or above on any of the CAHPS measures, this is denoted as "None" in the table above.</i>				

Rates and Proportions

For purposes of calculating the results, question summary rates were calculated for each global rating and individual item measure, and global proportions were calculated for each composite measure. Both the question summary rates and global proportions were calculated in accordance with NCQA HEDIS Specifications for Survey Measures.²⁻⁸ The scoring of the global ratings, composite measures, and individual item measures involved assigning top-level responses a score of one, with all other responses receiving a score of zero. After applying this scoring methodology, the percentage of top-level responses was calculated in order to determine the question summary rates and global proportions. For additional details, please refer to the *NCQA HEDIS 2014 Specifications for Survey Measures, Volume 3*.

The New Hampshire Medicaid Program and New Hampshire Medicaid Managed Care Program results were weighted. The results were weighted based on the total eligible population for each surveyed adult population (i.e., FFS and/or MCOs). The 2013 NCQA national data for the 90th and 50th percentiles are also presented for comparison. CAHPS scores with fewer than 100 respondents are denoted with a cross (+). Caution should be exercised when interpreting results for those measures with fewer than 100 respondents.

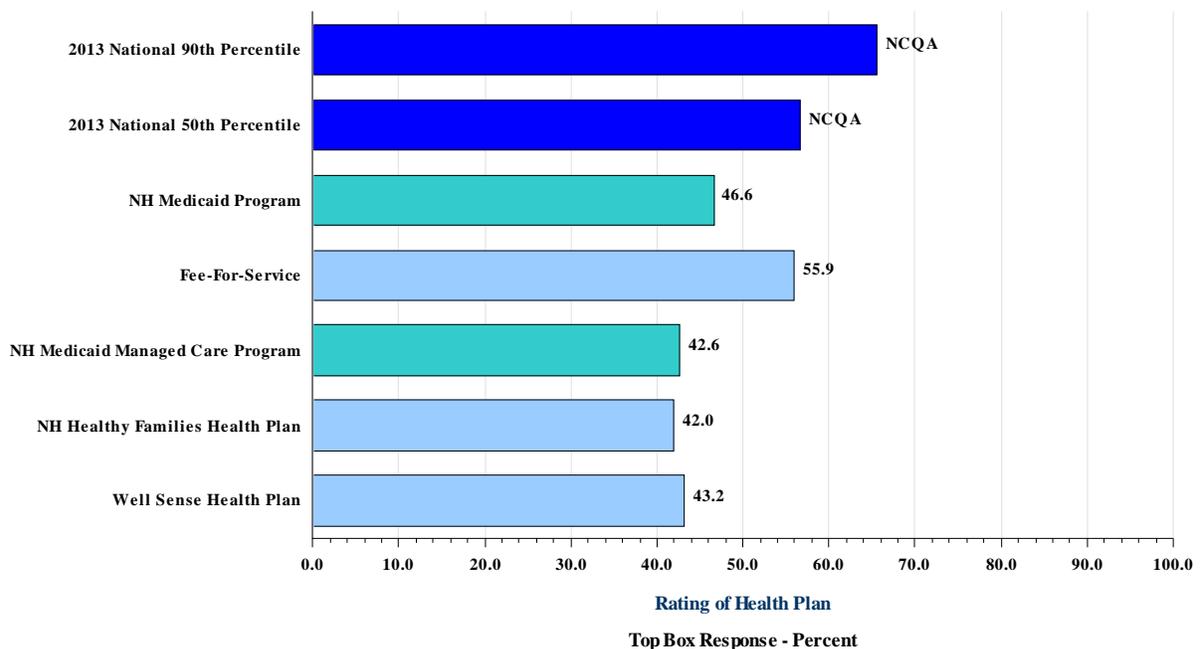
²⁻⁸ National Committee for Quality Assurance. *HEDIS® 2014, Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA Publication, 2013.

Global Ratings

Rating of Health Plan

Adult members were asked to rate their health plan on a scale of 0 to 10, with 0 being the “worst health plan possible” and 10 being the “best health plan possible.” Top-level responses were defined as those responses with a rating of 9 or 10. Figure 2-3 shows the 2013 NCQA national data for the 90th and 50th percentiles, and the 2014 Rating of Health Plan question summary rates for FFS, NH Healthy Families, Well Sense, and the New Hampshire Medicaid and Managed Care Program aggregates.^{2-9,2-10,2-11}

Figure 2-3—Rating of Health Plan

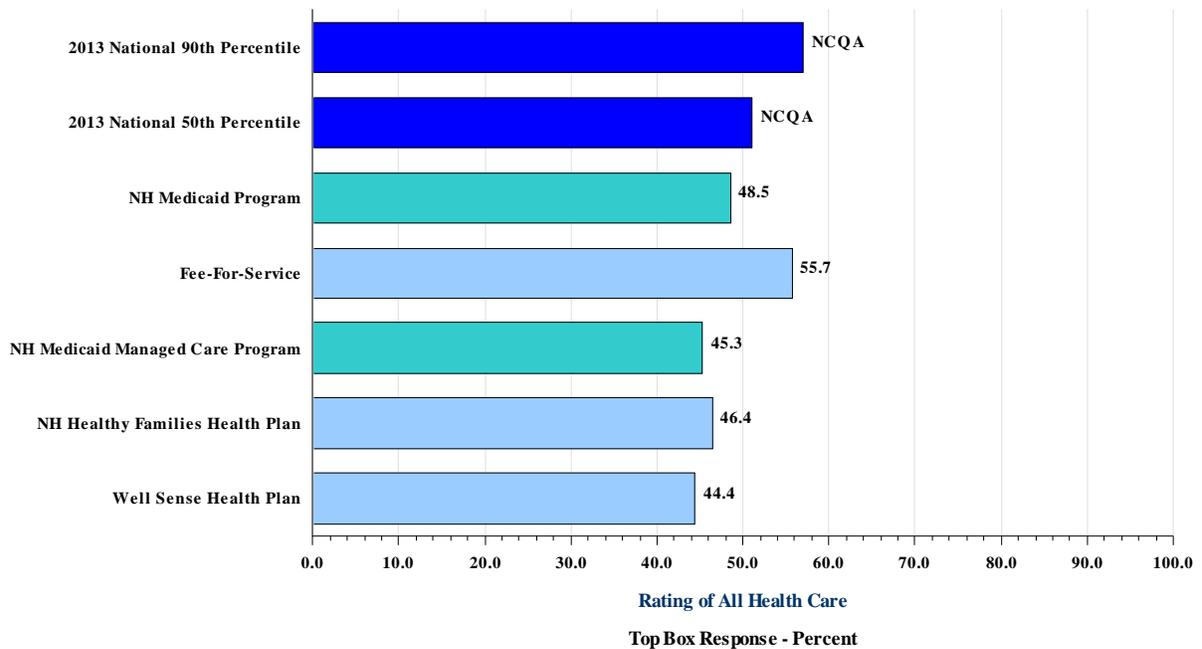


- ²⁻⁹ The 2014 NH Medicaid Program scores presented in this section are derived from the combined results of the FFS population, NH Healthy Families, and Well Sense. The 2014 NH Medicaid Managed Care Program scores presented in this section are derived from the combined results of the two participating MCOs: NH Healthy Families and Well Sense.
- ²⁻¹⁰ NCQA national data were not available for 2014 at the time this report was prepared; therefore, 2013 NCQA national data are presented in this section.
- ²⁻¹¹ The source for the NCQA national data contained in this publication is Quality Compass[®] 2013 data and is used with the permission of the National Committee for Quality Assurance (NCQA). Quality Compass 2013 includes certain CAHPS data. Any data display, analysis, interpretation, or conclusion based on these data is solely that of the authors, and NCQA specifically disclaims responsibility for any such display, analysis, interpretation, or conclusion. Quality Compass[®] is a registered trademark of NCQA. CAHPS[®] is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Rating of All Health Care

Adult members were asked to rate all their health care on a scale of 0 to 10, with 0 being the “worst health care possible” and 10 being the “best health care possible.” Top-level responses were defined as those responses with a rating of 9 or 10. Figure 2-4 shows the 2013 NCQA national data for the 90th and 50th percentiles, and the 2014 Rating of All Health Care question summary rates for FFS, NH Healthy Families, Well Sense, and the New Hampshire Medicaid and Managed Care Program aggregates.

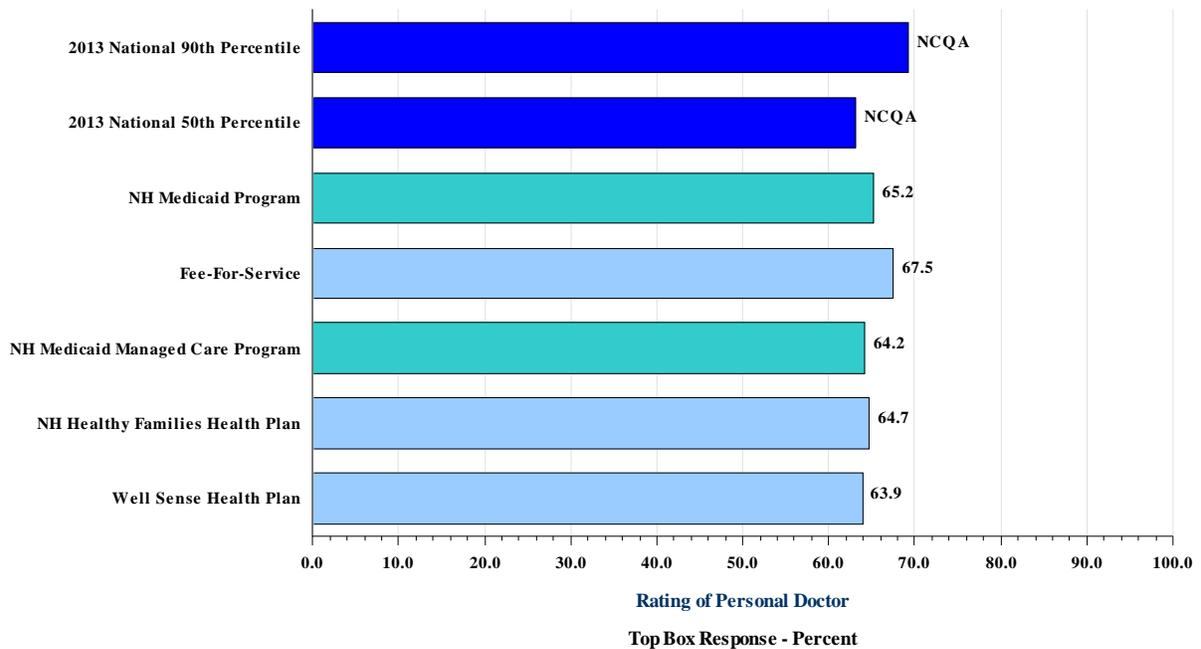
Figure 2-4—Rating of All Health Care



Rating of Personal Doctor

Adult members were asked to rate their personal doctor on a scale of 0 to 10, with 0 being the “worst personal doctor possible” and 10 being the “best personal doctor possible.” Top-level responses were defined as those responses with a rating of 9 or 10. Figure 2-5 shows the 2013 NCQA national data for the 90th and 50th percentiles, and the 2014 Rating of Personal Doctor question summary rates for FFS, NH Healthy Families, Well Sense, and the New Hampshire Medicaid and Managed Care Program aggregates.

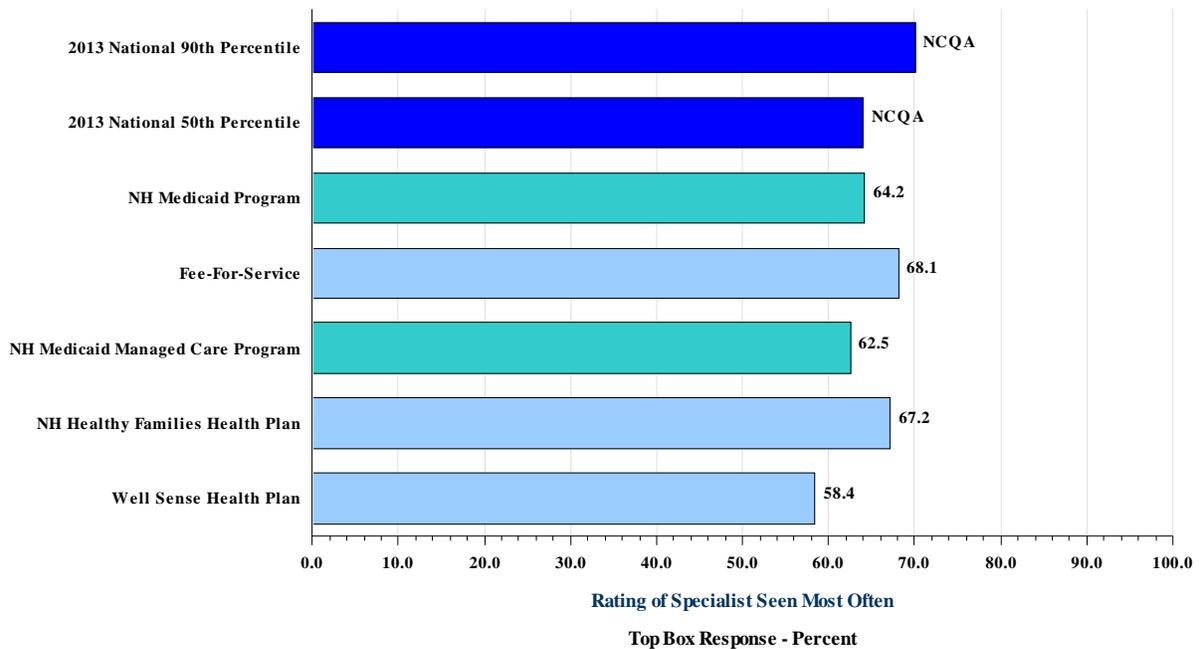
Figure 2-5—Rating of Personal Doctor



Rating of Specialist Seen Most Often

Adult members were asked to rate the specialist they saw most often on a scale of 0 to 10, with 0 being the “worst specialist possible” and 10 being the “best specialist possible.” Top-level responses were defined as those responses with a rating of 9 or 10. Figure 2-6 shows the 2013 NCQA national data for the 90th and 50th percentiles, and the 2014 Rating of Specialist Seen Most Often question summary rates for FFS, NH Healthy Families, Well Sense, and the New Hampshire Medicaid and Managed Care Program aggregates.

Figure 2-6—Rating of Specialist Seen Most Often

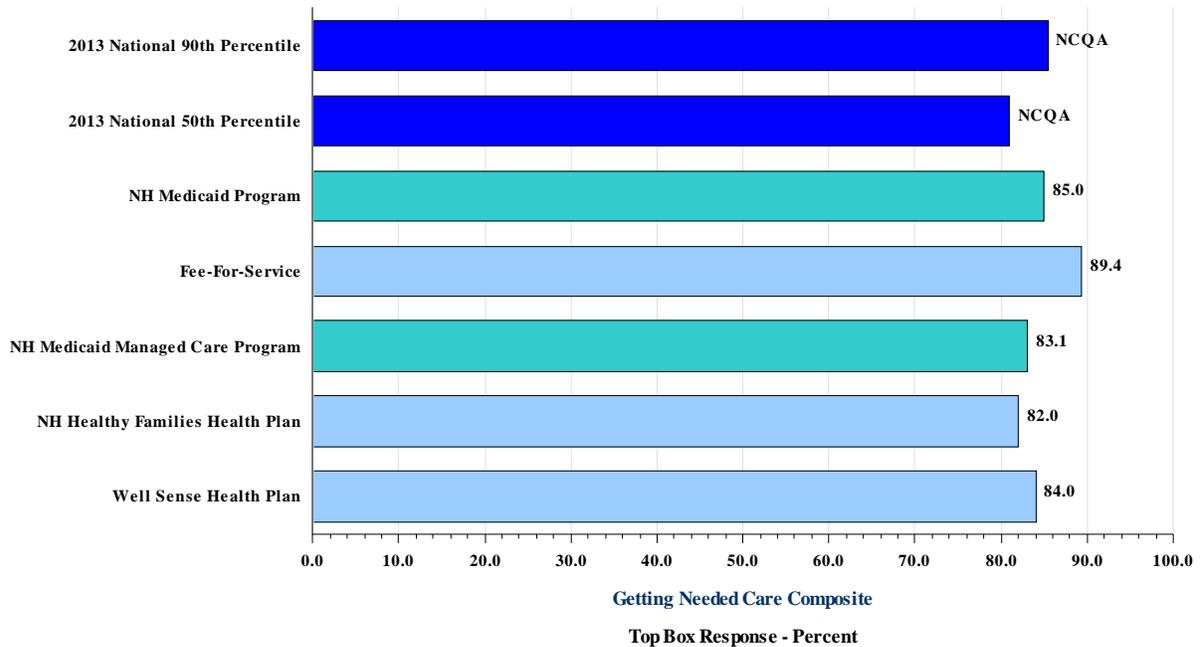


Composite Measures

Getting Needed Care

Adult members were asked two questions to assess how often it was easy to get needed care. For each of these questions (Questions 14 and 25), a top-level response was defined as a response of “Usually” or “Always.” Figure 2-7 shows the 2013 NCQA national data for the 90th and 50th percentiles, and the 2014 Getting Needed Care global proportions for FFS, NH Healthy Families, Well Sense, and the New Hampshire Medicaid and Managed Care Program aggregates.

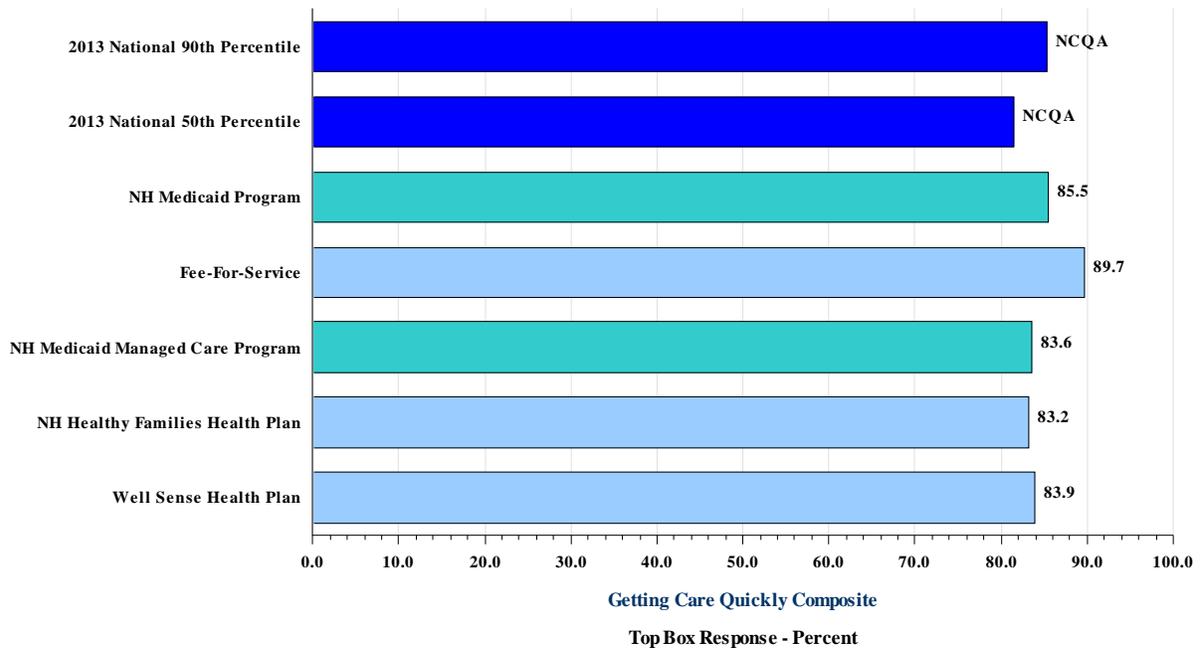
Figure 2-7—Getting Needed Care



Getting Care Quickly

Adult members were asked two questions to assess how often members received care quickly. For each of these questions (Questions 4 and 6), a top-level response was defined as a response of “Usually” or “Always.” Figure 2-8 shows the 2013 NCQA national data for the 90th and 50th percentiles, and the 2014 Getting Care Quickly global proportions for FFS, NH Healthy Families, Well Sense, and the New Hampshire Medicaid and Managed Care Program aggregates.

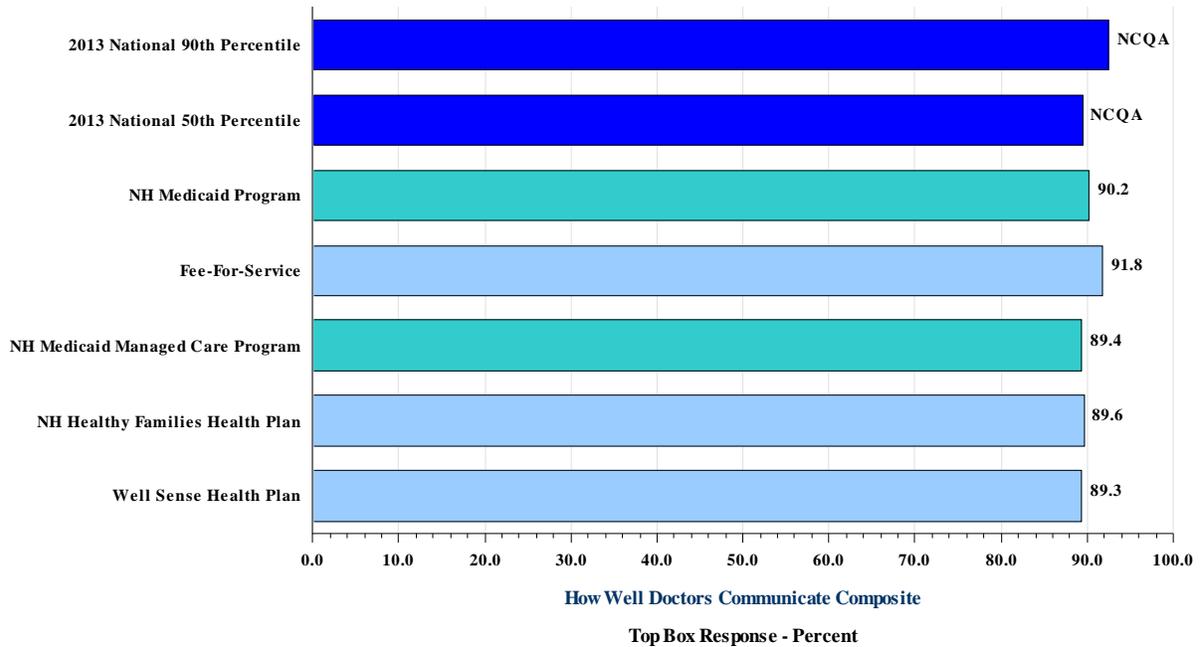
Figure 2-8—Getting Care Quickly



How Well Doctors Communicate

Adult members were asked four questions to assess how often doctors communicated well. For each of these questions (Questions 17, 18, 19, and 20), a top-level response was defined as a response of “Usually” or “Always.” Figure 2-9 shows the 2013 NCQA national data for the 90th and 50th percentiles, and the 2014 How Well Doctors Communicate global proportions for FFS, NH Healthy Families, Well Sense, and the New Hampshire Medicaid and Managed Care Program aggregates.

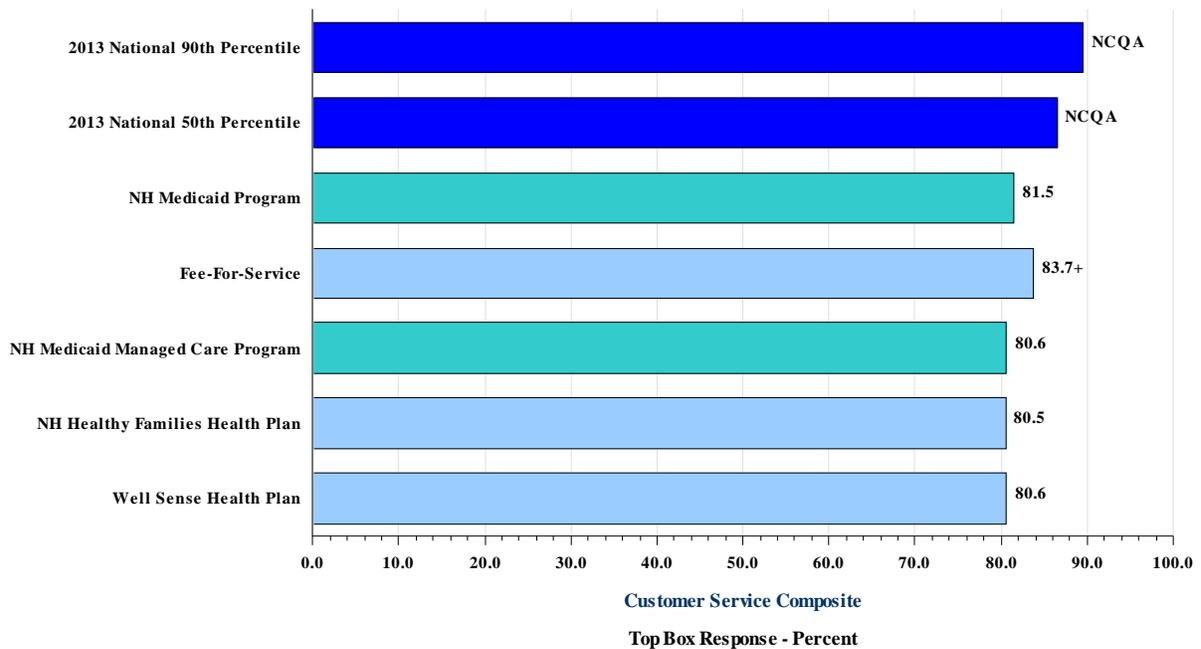
Figure 2-9—How Well Doctors Communicate



Customer Service

Adult members were asked two questions to assess how often members were satisfied with customer service. For each of these questions (Questions 31 and 32), a top-level response was defined as a response of “Usually” or “Always.” Figure 2-10 shows the 2013 NCQA national data for the 90th and 50th percentiles, and the 2014 Customer Service global proportions for FFS, NH Healthy Families, Well Sense, and the New Hampshire Medicaid and Managed Care Program aggregates.

Figure 2-10—Customer Service

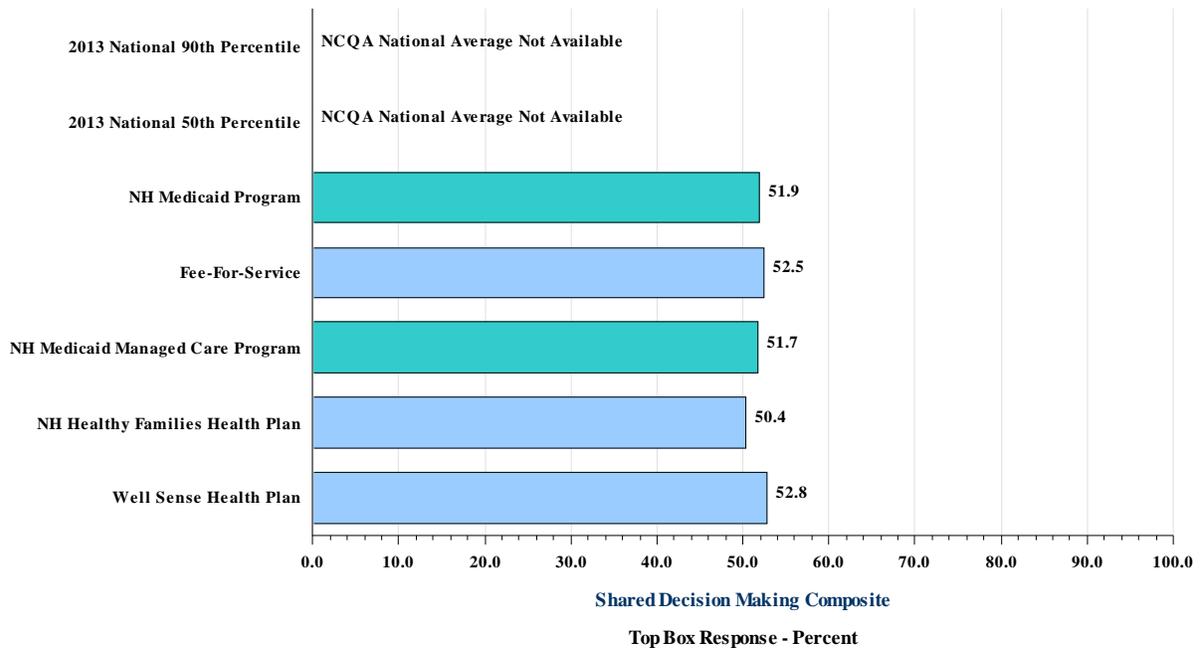


+ If the plan had fewer than 100 respondents for a measure, caution should be exercised when interpreting these results.

Shared Decision Making

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

Figure 2-11—Shared Decision Making



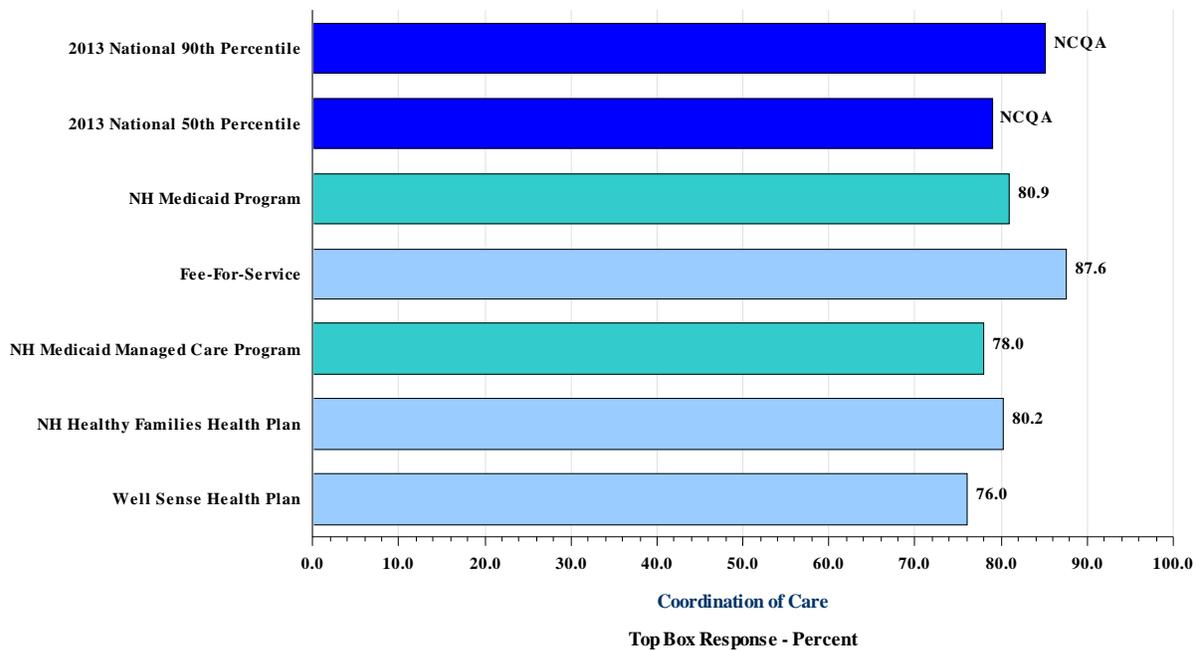
²⁻¹² As a result of the transition to the CAHPS 5.0 Adult Medicaid Health Plan Survey and changes to the Shared Decision Making composite measure, 2013 NCQA national data are not available for this CAHPS measure.

Individual Item Measures

Coordination of Care

Adult members were asked a question to assess how often their personal doctor seemed informed and up-to-date about care they had received from another doctor. For this question (Question 22), a top-level response was defined as a response of “Usually” or “Always.” Figure 2-12 shows the 2013 NCQA national data for the 90th and 50th percentiles, and the 2014 Coordination of Care question summary rates for FFS, NH Healthy Families, Well Sense, and the New Hampshire Medicaid and Managed Care Program aggregates.

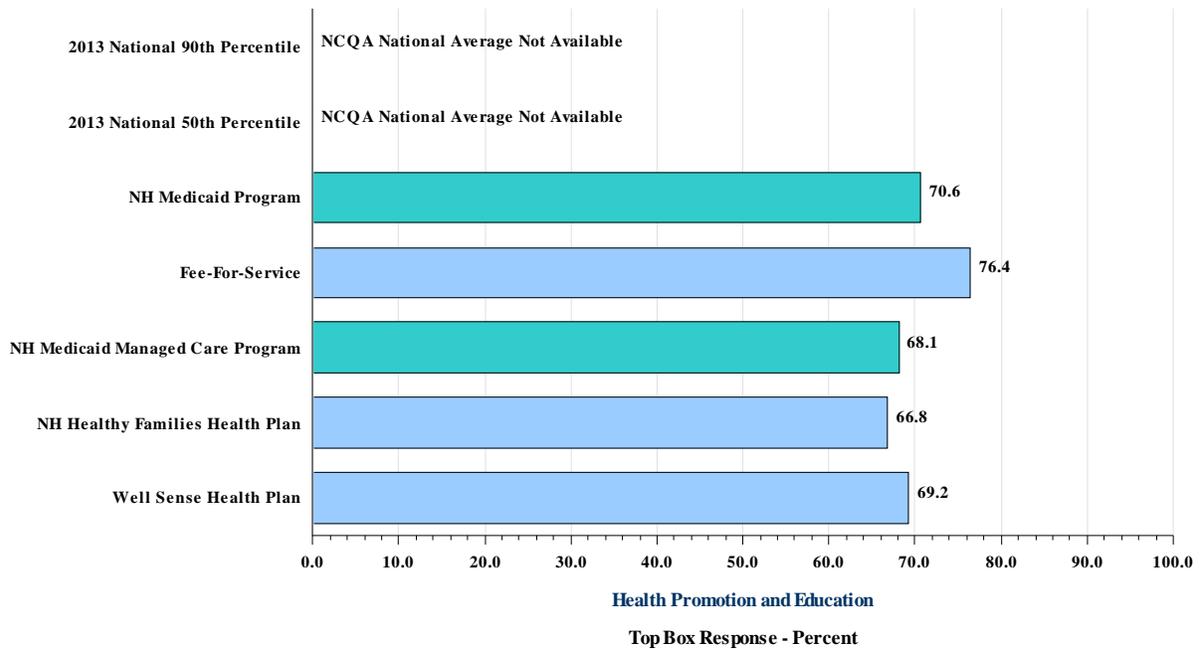
Figure 2-12—Coordination of Care



Health Promotion and Education

Adult members were asked a question to assess if their doctor talked with them about specific things they could do to prevent illness. For this question (Question 8), a top-level response was defined as a response of “Yes.” Figure 2-13 shows the 2014 Health Promotion and Education question summary rates for FFS, NH Healthy Families, Well Sense, and the New Hampshire Medicaid and Managed Care Program aggregates.²⁻¹³

Figure 2-13—Health Promotion and Education



²⁻¹³ As a result of the transition to the CAHPS 5.0 Adult Medicaid Health Plan Survey and changes to the Health Promotion and Education individual item measure, 2013 NCQA national data are not available for this CAHPS measure.

Statewide Comparisons

In order to identify performance differences in member satisfaction, the FFS population and two participating MCOs were compared to the New Hampshire Medicaid Program average using standard tests for statistical significance.²⁻¹⁴ For purposes of this comparison, results were case-mix adjusted. Case-mix refers to the characteristics of respondents used in adjusting the results for comparability among the FFS population and MCOs. Results were case-mix adjusted for general health status, educational level, and age of the respondent.²⁻¹⁵ Given that differences in case-mix can result in differences in ratings between FFS and the two MCOs that are not due to differences in quality, the data were adjusted to account for disparities in these characteristics. The case-mix adjustment was performed using standard regression techniques (i.e., covariance adjustment). For additional information, please refer to the Reader's Guide Section beginning on page 4-8.

The scoring of the global ratings, composite measures, and individual item measures involved assigning top-level responses a score of one, with all other responses receiving a score of zero. After applying this scoring methodology, the percentage of top-level responses was calculated in order to determine the question summary rates and global proportions. For additional detail, please refer to the *NCQA HEDIS 2014 Specifications for Survey Measures, Volume 3*.

Statistically significant differences are noted in the tables by arrows. If the population/plan performed statistically *better* than the New Hampshire Medicaid Program average, this is denoted with an upward (↑) arrow. Conversely, if the population/plan performed statistically *worse* than the New Hampshire Medicaid Program average, this is denoted with a downward (↓) arrow. If the population's/plan's score is not statistically different than the New Hampshire Medicaid Program average, this is denoted with a horizontal (↔) arrow.

Table 2-10, on the following page, shows the results of the Statewide Comparisons analysis. **NOTE: These results may differ from those presented in the rates and proportions figures because they have been adjusted for differences in case mix (i.e., the percentages presented have been case-mix adjusted).**

²⁻¹⁴ Caution should be exercised when evaluating the statewide comparisons, given that the FFS population's and MCOs' differences may impact CAHPS results.

²⁻¹⁵ Agency for Healthcare Research and Quality. *CAHPS Health Plan Survey and Reporting Kit 2008*. Rockville, MD: US Department of Health and Human Services, July 2008.

Table 2-10 Statewide Comparisons			
	Fee-for-Service	NH Healthy Families Health Plan	Well Sense Health Plan
Global Rating			
Rating of Health Plan	51.5% ↑	43.7% ↔	45.9% ↔
Rating of All Health Care	54.3% ↑	46.8% ↔	45.3% ↔
Rating of Personal Doctor	67.1% ↔	64.8% ↔	64.2% ↔
Rating of Specialist Seen Most Often	67.6% ↔	67.2% ↔	58.9% ↔
Composite Measure			
Getting Needed Care	88.7% ↑	82.2% ↔	84.5% ↔
Getting Care Quickly	89.8% ↑	83.2% ↔	83.9% ↔
How Well Doctors Communicate	92.6% ↔	89.2% ↔	88.9% ↔
Customer Service	81.8% ⁺ ↔	80.9% ↔	82.1% ↔
Shared Decision Making	53.8% ↔	49.9% ↔	52.0% ↔
Individual Item Measure			
Coordination of Care	87.6% ↑	80.2% ↔	76.1% ↔
Health Promotion and Education	75.4% ↑	67.4% ↔	69.6% ↔
↑ Indicates the score is statistically better than the New Hampshire Medicaid Program average. ↔ Indicates the score is not statistically different than the New Hampshire Medicaid Program average. ↓ Indicates the score is statistically worse than the New Hampshire Medicaid Program average.			
<i>Please note: Scores with fewer than 100 respondents are denoted with a cross (+). If there are fewer than 100 respondents for a measure, caution should be exercised when interpreting the results.</i>			

Summary of Statewide Comparisons Results

The Statewide Comparisons revealed the following statistically significant results.

- ◆ FFS scored statistically better than the New Hampshire Medicaid Program average on six CAHPS measures: Rating of Health Plan, Rating of All Health Care, Getting Needed Care, Getting Care Quickly, Coordination of Care, and Health Promotion and Education.
- ◆ NH Healthy Families did not score statistically better or worse than the New Hampshire Medicaid Program average on any of the CAHPS measures.
- ◆ Well Sense did not score statistically better or worse than the New Hampshire Medicaid Program average on any of the CAHPS measures.

Supplemental Items

DHHS elected to add 14 supplemental items to the standard CAHPS 5.0 Adult Medicaid Health Plan Survey. Table 2-11 details the survey language and response options for each of the supplemental items. Table 2-12 through Table 2-25 show the results for each supplemental item. For these supplemental items, the number and percentage of responses for each item are presented for the FFS population, NH Healthy Families, and Well Sense.

Table 2-11 Supplemental Items	
Question	Response Options
Q14a. In the last 6 months, did you have a health problem for which you needed special medical equipment, such as a cane, a wheelchair, or oxygen equipment?	Yes No
Q14b. In the last 6 months, how often was it easy to get the medical equipment you needed through your health plan?	Never Sometimes Usually Always
Q14c. In the last 6 months, did you have any health problems that needed special therapy, such as physical, occupational, or speech therapy?	Yes No
Q14d. In the last 6 months, how often was it easy to get the special therapy you needed through your health plan?	Never Sometimes Usually Always
Q14e. Home health care or assistance means home nursing, help with bathing or dressing, and help with basic household tasks. In the last 6 months, did you need someone to come into your home to give you home health care or assistance?	Yes No
Q14f. In the last 6 months, how often was it easy to get home health care or assistance through your health plan?	Never Sometimes Usually Always
Q14g. In the last 6 months, did you need any treatment or counseling for a personal or family problem?	Yes No
Q14h. In the last 6 months, how often was it easy to get the treatment or counseling you needed through your health plan?	Never Sometimes Usually Always
Q22a. In the last 6 months, did anyone from your health plan, doctor's office, or clinic help coordinate your care among these doctors or other health providers?	Yes No

Table 2-11 Supplemental Items		
Question		Response Options
Q22b.	In the last 6 months, who helped to coordinate your care? Mark one or more.	Someone from your health plan Someone from your doctor's office or clinic Someone from another organization A friend or family member You
Q22c.	How satisfied are you with the help you received to coordinate your care in the last 6 months?	Very dissatisfied Dissatisfied Neither dissatisfied nor satisfied Satisfied Very satisfied
Q31a.	Were any of the following a reason you did not get the information or help you needed from your health plan's customer service? Mark one or more.	You had to call several times before you could speak with someone The information customer service gave you was not correct Customer service did not have the information you needed You waited too long for someone to call you back No one called you back Some other reason
Q35a.	Some health plans help with transportation to doctors' offices or clinics. This help can be a shuttle bus, tokens or vouchers for a bus or taxi, or payments for mileage. In the last 6 months, did you phone your health plan to get help with transportation?	Yes No
Q35b.	In the last 6 months, when you phoned to get help with transportation from your health plan, how often did you get it?	Never Sometimes Usually Always

Special Medical Equipment

Adult members were asked if they had a health problem for which they needed special medical equipment, such as a cane, a wheelchair, or oxygen equipment (Question 14a). Table 2-12 displays the responses for this question.

Table 2-12 Needed Special Medical Equipment				
Plan Name	Yes		No	
	N	%	N	%
Fee-for-Service	173	30.1%	402	69.9%
NH Healthy Families Health Plan	78	16.6%	393	83.4%
Well Sense Health Plan	54	13.5%	346	86.5%
<i>Please note: Percentages may not total 100% due to rounding.</i>				

Adult members were asked to assess how often it was easy to get medical equipment they needed through their health plan (Question 14b). Table 2-13 displays the responses for this question.

Table 2-13 Access to Special Medical Equipment								
Plan Name	Never		Sometimes		Usually		Always	
	N	%	N	%	N	%	N	%
Fee-for-Service	15	9.5%	18	11.4%	34	21.5%	91	57.6%
NH Healthy Families Health Plan	10	15.6%	9	14.1%	18	28.1%	27	42.2%
Well Sense Health Plan	12	24.5%	6	12.2%	12	24.5%	19	38.8%
<i>Please note: Percentages may not total 100% due to rounding.</i>								

Special Therapy

Adult members were asked if they had a health problem for which they needed special therapy, such as a physical, occupational, or speech therapy (Question 14c). Table 2-14 displays the responses for this question.

Table 2-14 Needed Special Therapy				
Plan Name	Yes		No	
	N	%	N	%
Fee-for-Service	151	26.5%	419	73.5%
NH Healthy Families Health Plan	94	20.2%	372	79.8%
Well Sense Health Plan	70	17.5%	329	82.5%
<i>Please note: Percentages may not total 100% due to rounding.</i>				

Adult members were asked to assess how often was it easy to get the special therapy they needed through their health plan (Question 14d). Table 2-15 displays the responses for this question.

Table 2-15 Access to Special Therapy								
Plan Name	Never		Sometimes		Usually		Always	
	N	%	N	%	N	%	N	%
Fee-for-Service	9	6.6%	8	5.8%	37	27.0%	83	60.6%
NH Healthy Families Health Plan	9	9.9%	22	24.2%	26	28.6%	34	37.4%
Well Sense Health Plan	4	6.2%	12	18.5%	16	24.6%	33	50.8%
<i>Please note: Percentages may not total 100% due to rounding.</i>								

Home Health Care or Assistance

Adult members were asked if they needed someone to come to their home for home health care or assistance with bathing or dressing, and other basic household tasks (Question 14e). Table 2-16 displays the responses for this question.

Table 2-16 Needed Home Health Care or Assistance				
Plan Name	Yes		No	
	N	%	N	%
Fee-for-Service	184	32.3%	386	67.7%
NH Healthy Families Health Plan	43	9.1%	427	90.9%
Well Sense Health Plan	36	9.2%	354	90.8%

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

Adult members were asked to assess how often was it easy to get home health care or assistance they needed through their health plan (Question 14f). Table 2-17 displays the responses for this question.

Table 2-17 Access to Home Health Care or Assistance								
Plan Name	Never		Sometimes		Usually		Always	
	N	%	N	%	N	%	N	%
Fee-for-Service	10	6.1%	3	1.8%	31	19.0%	119	73.0%
NH Healthy Families Health Plan	6	15.8%	1	2.6%	8	21.1%	23	60.5%
Well Sense Health Plan	6	17.1%	4	11.4%	8	22.9%	17	48.6%

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

Treatment or Counseling

Adult members were asked if they needed treatment or counseling for a personal or family problem (Question 14g). Table 2-18 displays the responses for this question.

Table 2-18 Needed Treatment or Counseling				
Plan Name	Yes		No	
	N	%	N	%
Fee-for-Service	124	21.7%	447	78.3%
NH Healthy Families Health Plan	112	24.0%	354	76.0%
Well Sense Health Plan	105	26.4%	293	73.6%

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

Adult members were asked to assess how often was it easy to get the treatment or counseling they needed through their health plan (Question 14h). Table 2-19 displays the responses for this question.

Table 2-19 Access to Treatment or Counseling								
Plan Name	Never		Sometimes		Usually		Always	
	N	%	N	%	N	%	N	%
Fee-for-Service	6	5.3%	8	7.0%	32	28.1%	68	59.6%
NH Healthy Families Health Plan	16	15.4%	14	13.5%	21	20.2%	53	51.0%
Well Sense Health Plan	8	8.4%	7	7.4%	26	27.4%	54	56.8%

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

Care Coordination Among Doctors or Other Health Providers

Adult members were asked if anyone from their health plan, personal doctor’s office, or clinic helped coordinate their care among doctors or other health providers (Question 22a). Table 2-20 displays the responses for this question.

Table 2-20 Received Help Coordinating Care Among Doctors or Other Health Providers				
Plan Name	Yes		No	
	N	%	N	%
Fee-for-Service	166	64.3%	92	35.7%
NH Healthy Families Health Plan	124	66.7%	62	33.3%
Well Sense Health Plan	98	59.0%	68	41.0%

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

Adult members were asked who helped coordinate their care among these doctors or other health providers (Question 22b). Table 2-21 displays the responses for this question.

Table 2-21 Who Helped Coordinate Care		
Response/Plan Name	Yes	
Someone from Member’s Health Plan	N	%
Fee-for-Service	19	7.3%
NH Healthy Families Health Plan	24	13.3%
Well Sense Health Plan	22	15.5%
Someone from Member’s Doctor’s Office or Clinic	N	%
Fee-for-Service	108	41.2%
NH Healthy Families Health Plan	99	55.0%
Well Sense Health Plan	71	50.0%
Someone from Another Organization	N	%
Fee-for-Service	36	13.7%
NH Healthy Families Health Plan	19	10.6%
Well Sense Health Plan	21	14.8%
A Friend or Family Member	N	%
Fee-for-Service	43	16.4%
NH Healthy Families Health Plan	27	15.0%
Well Sense Health Plan	25	17.6%

Table 2-21 Who Helped Coordinate Care		
Response/Plan Name	Yes	
You (i.e., Member)	N	%
Fee-for-Service	44	16.8%
NH Healthy Families Health Plan	39	21.7%
Well Sense Health Plan	25	17.6%
<i>Please note: Respondents may have marked more than one response option; therefore, percentages will not total 100%.</i>		

Adult members were asked how satisfied they were with the help they received to coordinate care among doctors or other health providers in the last 6 months (Question 22c). Table 2-22 displays the responses for this question.

Table 2-22 Satisfied with Help Coordinating Care										
Plan Name	Very dissatisfied		Dissatisfied		Neutral		Satisfied		Very satisfied	
	N	%	N	%	N	%	N	%	N	%
Fee-for-Service	6	3.7%	5	3.1%	11	6.8%	59	36.4%	81	50.0%
NH Healthy Families Health Plan	3	2.5%	6	5.0%	11	9.1%	48	39.7%	53	43.8%
Well Sense Health Plan	2	2.1%	1	1.1%	12	12.8%	36	38.3%	43	45.7%
<i>Please note: Percentages may not total 100% due to rounding.</i>										

Access to Customer Service

Adult members were asked about the reason(s) they did not get the information or help needed from their health plan’s customer service (Question 31a). Table 2-23 displays the responses for this question.²⁻¹⁶

Table 2-23 Access to Customer Service		
Response/Plan Name	Yes	
	N	%
Member Had to Call Several Times Before Speaking with Someone		
Fee-for-Service	7	9.1%
NH Healthy Families Health Plan	15	17.0%
Well Sense Health Plan	12	14.5%
Information Customer Service Gave was Not Correct		
Fee-for-Service	4	5.2%
NH Healthy Families Health Plan	14	15.9%
Well Sense Health Plan	11	13.3%
Customer Service Did Not Have the Information Member Needed		
Fee-for-Service	10	13.0%
NH Healthy Families Health Plan	15	17.0%
Well Sense Health Plan	10	12.0%
Member Waited too Long for Someone to Call Back		
Fee-for-Service	5	6.5%
NH Healthy Families Health Plan	10	11.4%
Well Sense Health Plan	6	7.2%
No One Called Back		
Fee-for-Service	6	7.8%
NH Healthy Families Health Plan	3	3.4%
Well Sense Health Plan	3	3.6%
Some Other Reason		
Fee-for-Service	9	11.7%
NH Healthy Families Health Plan	19	21.6%
Well Sense Health Plan	28	33.7%
<i>Please note: Respondents may have marked more than one response option; therefore, percentages will not total 100%.</i>		

²⁻¹⁶ Please note, the results presented in Table 2-23 represent the proportions of members that had valid responses to the preceding gateway questions (i.e., Questions 30 and 31) and, as a result, were asked to select one or more applicable response options describing the reasons they did not get the information or help needed from their health plan’s customer service. In some instances, a member could have not selected any of the possible response options listed for this supplemental question.

Transportation

Adult members were asked if they phoned their health plan to get help with transportation (Question 35a). Table 2-24 displays the responses for this question.

Table 2-24 Needed Help with Transportation				
Plan Name	Yes		No	
	N	%	N	%
Fee-for-Service	49	8.8%	508	91.2%
NH Healthy Families Health Plan	33	7.4%	413	92.6%
Well Sense Health Plan	43	11.0%	347	89.0%
<i>Please note: Percentages may not total 100% due to rounding.</i>				

Adult members were asked to assess, when they phoned to get help with transportation from their health plan, how often they received help (Question 35b). Table 2-25 displays the responses for this question.

Table 2-25 Access to Transportation								
Plan Name	Never		Sometimes		Usually		Always	
	N	%	N	%	N	%	N	%
Fee-for-Service	7	14.6%	7	14.6%	9	18.8%	25	52.1%
NH Healthy Families Health Plan	2	6.5%	6	19.4%	7	22.6%	16	51.6%
Well Sense Health Plan	4	9.5%	5	11.9%	5	11.9%	28	66.7%
<i>Please note: Percentages may not total 100% due to rounding.</i>								

3. Recommendations

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

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

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

Priority Assignments

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

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

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

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

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

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

Key Drivers of Satisfaction Priority Assignments

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

The key drivers of satisfaction analysis focuses on the top and high priorities. Table 3-3 displays the priority areas identified for analysis and the priority assignment for the New Hampshire Medicaid Program.

Table 3-3 Key Drivers of Satisfaction—Priority Areas	
Priority Areas	Priority Assignment
Customer Service	Top
Rating of Health Plan	Top
Rating of All Health Care	High

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

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

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

Table 3-4 Key Drivers of Satisfaction	
Customer Service	
	Respondents reported that the written materials or the Internet did not provide them with the information they needed about how their health plan works.
	Respondents reported that their health plan’s customer service did not always give them the information or help they needed.
Rating of Health Plan	
	Respondents reported that their personal doctor did not always seem informed and up-to-date about the care they received from other doctors or health providers.
	Respondents reported that the written materials or the Internet did not provide them with the information they needed about how their health plan works.
	Respondents reported that their health plan’s customer service did not always give them the information or help they needed.
	Respondents reported that forms from their health plan were often not easy to fill out.
Rating of All Health Care	
	Respondents reported that their personal doctor did not always seem informed and up-to-date about the care they received from other doctors or health providers.
	Respondents reported that the written materials or the Internet did not provide them with the information they needed about how their health plan works.

Recommendations for Quality Improvement

Based on the results of the key drivers of satisfaction analysis, the following are general recommendations based on the most up-to-date information in the CAHPS literature. The New Hampshire Medicaid Program and plans should evaluate these general recommendations in the context of its own operational and QI activities. For additional information, please refer to the QI references beginning on page 4-13.

Customer Service

Service Recovery

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

Employee Training and Empowerment

Employees who have the necessary skills and tools to appropriately communicate with members and answer their questions and/or complete their requests are more likely to provide exceptional customer service. Therefore, it is important for health programs, plans, and providers to ensure that staff have adequate training on all pertinent business processes. Furthermore, staff members should feel empowered to resolve most issues a member might have. This will eliminate transferring members to multiple employees and will help to resolve a complaint in a more timely manner.

Call Centers

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

Creating an Effective Customer Service Training Program

The program's and health plans' efforts to improve customer service should include implementing a training program to meet the needs of their unique work environments. Direct patient feedback should be disclosed to employees to emphasize why certain changes need to be made. Additional recommendations from employees, managers, and business administrators should be provided to

serve as guidance when constructing the training program. It is important that employees receive direction and feel comfortable putting new skills to use before applying them within the work place.

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

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

Rating of Health Plan

Alternatives to One-on-One Visits

To achieve improved quality, timeliness, and access to care, health plans/programs should engage in efforts that assist providers in examining and improving their systems' abilities' to manage patient demand. As an example, health plans/programs 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/programs can assist in improving physician availability and ensuring patients receive immediate medical care and services.

Health Plan Operations

It is important for health plans/programs 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/program'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 and program 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 or program.

Online Patient Portal

A secure online patient portal allows members easy access to a wide array of health plan/program and health care information and services that are particular to their needs and interests. To help increase members' satisfaction with their health plan/program, health plans/programs 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/program 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/programs 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 and program 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/program organization, establishing plan-level/program-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 and programs can assess whether QI initiatives have been effective in improving the quality of care delivered to members.

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

Rating of All Health Care

Access to Care

Health plans and programs 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/program 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/programs 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 and Advisory Councils

Since both patients and families have the direct experience of an illness or health care system, their perspectives can provide significant insight when performing an evaluation of health care processes. Therefore, health plans and programs 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/program and its members. The councils' roles within a health plan/program 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.

Accountability and Improvement of Care

Although the administration of the CAHPS survey takes place at the program/health plan level, the accountability for the performance lies at both the program/plan and provider network levels. Table 3-5 provides a summary of the responsible parties for various aspects of care.³⁻²

Table 3-5—Accountability for Areas of Care			
Domain	Composite	Who Is Accountable?	
		Program/Plan	Provider Network
Access	Getting Needed Care	✓	✓
	Getting Care Quickly		✓
Interpersonal Care	How Well Doctors Communicate		✓
	Shared Decision Making		✓
Plan Administrative Services	Customer Service	✓	
Personal Doctor			✓
Specialist			✓
All Health Care		✓	✓
Health Plan		✓	

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

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

- ◆ Drawing on the analysis of population sub-groups (e.g., health status, race, age) to determine if there are member groups that tend to have lower levels of satisfaction (see HyperText Markup Language [HTML] output of detailed CAHPS survey results).
- ◆ Using other indicators to supplement CAHPS data such as member complaints/grievances, feedback from staff, and other survey data.
- ◆ Conducting focus groups and interviews to determine what specific issues are causing low satisfaction ratings.

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

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

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

Survey Administration

Survey Overview

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

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

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

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

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

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

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

The CAHPS 5.0 Adult Medicaid Health Plan Survey with the HEDIS supplemental item set includes 58 core questions that yield 11 measures of satisfaction. These measures include four global rating questions, five composite measures, and two individual item measures. The global measures (also referred to as global ratings) reflect overall satisfaction with the health plan, health care, personal doctors, and specialists. The composite measures are sets of questions grouped together to address different aspects of care (e.g., “Getting Needed Care” or “Getting Care Quickly”). The individual item measures are individual questions that look at a specific area of care (i.e., “Coordination of Care” and “Health Promotion and Education”).

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

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

Sampling Procedures

The members eligible for sampling included those who were FFS, NH Healthy Families, or Well Sense members at the time the sample was drawn and who were continuously enrolled for at least five of the last six months of the measurement period (November 1, 2013 through April 30, 2014). The members eligible for sampling included those who were age 18 or older (as of April 30, 2014).

A random sample of 1,350 adult members was selected from FFS’, NH Healthy Families’, and Well Sense’s eligible populations. Oversampling was not performed on the adult population.

Survey Protocol

The CAHPS 5.0 Health Plan Survey process allowed members two methods by which they could complete a survey. The first phase, or mail phase, consisted of a survey being mailed to all sampled members. For FFS, NH Healthy Families, and Well Sense all sampled members received an English version of the survey. A reminder postcard was sent to all non-respondents, followed by a second survey mailing and reminder postcard. The second phase, or telephone phase, consisted of CATI of sampled members who had not mailed in a completed survey. A series of up to three CATI calls was made to each non-respondent. It has been shown that the addition of the telephone phase aids in the reduction of non-response bias by increasing the number of respondents who are more demographically representative of a plan's/program's population.⁴⁻⁶

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

- ◆ Were age 18 or older as of April 30, 2014.
- ◆ Were currently enrolled in FFS, NH Healthy Families, or Well Sense.
- ◆ Had been continuously enrolled for at least five of the last six months of the measurement period (November 1, 2013 through April 30, 2014).
- ◆ Had Medicaid as a payer.

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

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

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

Table 4-2 shows the standard mixed mode (i.e., mail followed by telephone follow-up) CAHPS timeline used in the administration of the New Hampshire CAHPS 5.0 Adult Medicaid Health Plan Surveys. This timeline is based on NCQA HEDIS Specifications for Survey Measures.^{4,7}

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

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

Methodology

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

Response Rates

The administration of the CAHPS 5.0 Adult Medicaid Health Plan Survey is comprehensive and is designed to achieve the highest possible response rate. The response rate is defined as the total number of completed surveys divided by all eligible members of the sample.⁴⁻⁸ A member's survey was assigned a disposition code of "completed" if at least one question was answered within the survey. Eligible members include the entire random sample minus ineligible members. Ineligible members of the sample met one or more of the following criteria: were deceased, were invalid (did not meet criteria described on page 4-3), were mentally or physically unable to complete the survey, or had a language barrier.

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

Respondent Demographics

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

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

NCQA Comparisons

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

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

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

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

Table 4-3—Overall Adult Medicaid Member Satisfaction Ratings Crosswalk				
Measure	90th Percentile	75th Percentile	50th Percentile	25th Percentile
Rating of Health Plan	2.54	2.46	2.40	2.32
Rating of All Health Care	2.42	2.38	2.32	2.27
Rating of Personal Doctor	2.57	2.53	2.50	2.43
Rating of Specialist Seen Most Often	2.59	2.56	2.51	2.48
Getting Needed Care	2.46	2.41	2.37	2.31
Getting Care Quickly	2.49	2.45	2.41	2.37
How Well Doctors Communicate	2.64	2.58	2.54	2.48
Customer Service	2.61	2.58	2.54	2.48

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

Rates and Proportions

For purposes of this analysis, question summary rates were calculated for each global rating and individual item measure, and global proportions were calculated for each composite measure. Both the question summary rates and global proportions were calculated following NCQA HEDIS Specifications for Survey Measures.⁴⁻¹¹ The scoring of the global ratings, composite measures, and individual item measures involved assigning top-level responses a score of one, with all other responses receiving a score of zero. After applying this scoring methodology, the percentage of top-level responses was calculated in order to determine the question summary rates and global proportions. For additional detail, please refer to the *NCQA HEDIS 2014 Specifications for Survey Measures, Volume 3*.

Weighting

Both a weighted New Hampshire Medicaid Program rate and a weighted New Hampshire Medicaid Managed Care Program rate were calculated. Results were weighted based on the total eligible population for each adult population (i.e., FFS and/or MCOs). The New Hampshire Medicaid Program aggregate includes results from the FFS population and two participating MCOs. The New Hampshire Medicaid Managed Care Program aggregate is limited to the result of the MCOs (i.e., the FFS population is not included).

Statewide Comparisons

Statewide comparisons were performed to identify member satisfaction differences that were statistically different between the FFS population, NH Healthy Families, and Well Sense. Given that differences in case-mix can result in differences in ratings between the FFS population and MCOs that are not due to differences in quality, the data were adjusted to account for disparities in these characteristics. Case-mix refers to the characteristics of members and respondents used in adjusting the results for comparability among FFS and the MCOs. Results for the FFS population and MCOs were case-mix adjusted for respondent general health status, education level, and age.

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

Two types of hypothesis tests were applied to the statewide comparative results. First, a global *F* test was calculated, which determined whether the difference between the FFS population and MCOs scores was significant.

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

The score was:

$$\hat{\mu} = \left(\sum_p \hat{\mu}_p / \hat{V}_p \right) / \left(\sum_p 1 / \hat{V}_p \right)$$

The *F* statistic was determined using the formula below:

$$F = (1/(P-1)) \sum_p (\hat{\mu}_p - \hat{\mu})^2 / \hat{V}_p$$

The *F* statistic, as calculated above, had an *F* distribution with (*P* - 1, *q*) degrees of freedom, where *q* was equal to *n/P* (i.e., the average number of respondents in the FFS population/MCO). Due to these qualities, this *F* test produced *p*-values that were slightly larger than they should have been; therefore, finding significant differences between FFS/MCOs was less likely.⁴⁻¹² An alpha-level of 0.05 was used. If the *F* test demonstrated FFS/MCO-level differences (i.e., *p* < 0.05), then a *t*-test was performed for FFS/each MCO.

The *t*-test determined whether FFS or the MCO's score was significantly different from the overall results of the New Hampshire Medicaid Program. The equation for the differences was as follows:

$$\Delta_p = \hat{\mu}_p - (1/P) \sum_{p'} \hat{\mu}_{p'} = ((P-1)/P) \hat{\mu}_p - \sum_{p'}^* (1/P) \hat{\mu}_{p'}$$

In this equation, \sum^* was the sum of all health plans except program/plan *p*.

The variance of Δ_p was:

$$\hat{V}(\Delta_p) = [(P-1)/P]^2 \hat{V}_p + 1/P^2 \sum_{p'} \hat{V}_{p'}$$

The *t* statistic was $\Delta_p / \hat{V}(\Delta_p)^{1/2}$ and had a *t* distribution with (*n_p* - 1) degrees of freedom. This statistic also produced *p*-values that were slightly larger than they should have been; therefore, finding significant differences between each reporting unit *p* and the results of all other reporting units was less likely.

⁴⁻¹² Please note “these qualities” refers to the usage of the formula *q* = *n/P* used to obtain the denominator degrees of freedom. As documented in the CAHPS® Health Plan Survey and Reporting Kit 2008, published by AHRQ, it has been found in simulations that *q* = *n/P* (the average sample size per entity) makes the *F* test at worst slightly conservative with typical sample size and response distributions. In other words, the reported *p*-values from the test are slightly larger than they should be, so significant differences are less likely to be declared.

Key Drivers of Satisfaction Analysis

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

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

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

Table 4-4—Correlation Matrix								
Question Number	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service
Q4	✓	✓	✓	✓	✓	✓		
Q6	✓	✓	✓	✓	✓	✓		
Q8	✓	✓	✓	✓			✓	
Q9	✓	✓	✓	✓	✓		✓	
Q10	✓	✓	✓	✓	✓		✓	
Q11	✓	✓	✓	✓			✓	
Q12	✓	✓	✓	✓	✓		✓	
Q14	✓	✓	✓	✓	✓	✓		✓
Q17	✓	✓	✓				✓	
Q18	✓	✓	✓				✓	
Q19	✓	✓	✓				✓	
Q20	✓	✓	✓		✓		✓	
Q22	✓	✓	✓				✓	
Q25	✓	✓		✓	✓	✓		
Q29	✓	✓						✓
Q31	✓	✓						✓
Q32	✓	✓						✓
Q34	✓	✓						✓

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

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

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

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

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

Correlation

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

The correlation can range from -1 to 1, with negative values indicating a negative relationship between overall satisfaction and a particular survey item. However, the correlation analysis conducted is not focused on the direction of the correlation, but rather on the degree of correlation. Therefore, the absolute value of r is used in the analysis, and the range for r is 0 to 1. An r of zero indicates no relationship between the response to a question and satisfaction. As r increases, the importance of the question to the respondent’s satisfaction increases.

Limitations and Cautions

The findings presented in the 2014 New Hampshire Adult Medicaid Member Satisfaction CAHPS Report are subject to some limitations in the survey design, analysis, and interpretation. These limitations should be considered carefully when interpreting or generalizing the findings. These limitations are discussed below.

Case-Mix Adjustment

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

Non-Response Bias

The experiences of the survey respondent population may be different than that of non-respondents with respect to their health care services and may vary by program/plan. 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 FFS program or health plan. These analyses identify whether members give different ratings of satisfaction with their program/health plan. The survey by itself does not necessarily reveal the exact cause of these differences.

Baseline Results

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

Quality Improvement References

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

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

AHRQ Health Care Innovations Exchange Web site. *Interactive Workshops Enhance Access to Health Education and Screenings, Improve Outcomes for Low-Income and Minority Women*. Available at: <https://innovations.ahrq.gov/profiles/interactive-workshops-enhance-access-health-education-and-screenings-improve-outcomes-low>. Accessed on: December 1, 2014.

AHRQ Health Care Innovations Exchange Web site. *Online Tools and Services Activate Plan Enrollees and Engage Them in Their Care, Enhance Efficiency, and Improve Satisfaction and Retention*. Available at: <https://innovations.ahrq.gov/profiles/online-tools-and-services-activate-plan-enrollees-and-engage-them-their-care-enhance>. Accessed on: December 1, 2014.

AHRQ Health Care Innovations Exchange Web site. *Health Plan's Comprehensive Strategy Involving Physician Incentives and Targeted Recruitment Enhances Patient Access to Language-Concordant Physicians*. Available at: <https://innovations.ahrq.gov/profiles/health-plans-comprehensive-strategy-involving-physician-incentives-and-targeted-recruitment>. Accessed on: December 1, 2014.

American Academy of Pediatrics Web site. *Quality Improvement: Open Access Scheduling*. Available at: <http://www.aap.org/en-us/professional-resources/practice-support/quality-improvement/Pages/Quality-Improvement-Open-Access-Scheduling.aspx>. Accessed on: December 1, 2014.

Backer LA. Strategies for better patient flow and cycle time. *Family Practice Management*. 2002; 9(6): 45-50. Available at: <http://www.aafp.org/fpm/20020600/45stra.html>. Accessed on: December 1, 2014.

Barrier PA, Li JT, Jensen NM. Two Words to Improve Physician-Patient Communication: What Else? *Mayo Clinic Proceedings*. 2003; 78: 211-214. Available at: <http://download.journals.elsevierhealth.com/pdfs/journals/0025-6196/PIIS0025619611625524.pdf>. Accessed on: December 1, 2014.

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

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

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

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

Flores G. Language barriers to health care in the United States. *The New England Journal of Medicine*. 2006; 355(3): 229-31.

Fong Ha J, Longnecker N. Doctor-patient communication: a review. *The Ochsner Journal*. 2010; 10(1): 38-43. Available at: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3096184/pdf/i1524-5012-10-1-38.pdf>. Accessed on: December 1, 2014.

Fottler MD, Ford RC, Heaton CP. *Achieving Service Excellence: Strategies for Healthcare (Second Edition)*. Chicago, IL: Health Administration Press; 2010.

Fraenkel L, McGraw S. What are the Essential Elements to Enable Patient Participation in Decision Making? *Society of General Internal Medicine*. 2007; 22: 614-619.

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

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

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

Houck S. *What Works: Effective Tools & Case Studies to Improve Clinical Office Practice*. Boulder, CO: HealthPress Publishing; 2004.

Institute for Healthcare Improvement Web site. *Decrease Demand for Appointments*. Available at: <http://www.ihl.org/knowledge/Pages/Changes/DecreaseDemandforAppointments.aspx>. Accessed on: December 1, 2014.

Institute for Healthcare Improvement Web site. *Office Visit Cycle Time*. Available at: <http://www.ihl.org/knowledge/Pages/Measures/OfficeVisitCycleTime.aspx>. Accessed on: December 1, 2014.

Institute for Healthcare Improvement Web site. *Reduce Scheduling Complexity: Maintain Truth in Scheduling*. Available at: <http://www.ihl.org/resources/Pages/Changes/ReduceSchedulingComplexity.aspx>. Accessed on: December 1, 2014.

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

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

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

Landro L. The Talking Cure for Health Care. *The Wall Street Journal*. 2013. Available at: <http://online.wsj.com/article/SB10001424127887323628804578346223960774296.html>. Accessed on: December 1, 2014.

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

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

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

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

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

Murray M. Reducing waits and delays in the referral process. *Family Practice Management*. 2002; 9(3): 39-42. Available at: <http://www.aafp.org/fpm/2002/0300/p39.html>. Accessed on: December 1, 2014.

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

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

Quigley D, Wiseman S, Farley D. Improving Performance For Health Plan Customer Service: A Case Study of a Successful CAHPS Quality Improvement Intervention. Rand Health Working Paper; 2007. Available at: http://www.rand.org/pubs/working_papers/WR517. Accessed on: December 1, 2014.

Reinertsen JL, Bisognano M, Pugh MD. *Seven Leadership Leverage Points for Organization-Level Improvement in Health Care (Second Edition)*. Cambridge, MA: Institute for Healthcare Improvement; 2008.

Schaefer J, Miller D, Goldstein M, et al. *Partnering in Self-Management Support: A Toolkit for Clinicians*. Cambridge, MA: Institute for Healthcare Improvement; 2009. Available at: http://www.improvingchroniccare.org/downloads/selfmanagement_support_toolkit_for_clinicians_2012_update.pdf. Accessed on: December 1, 2014.

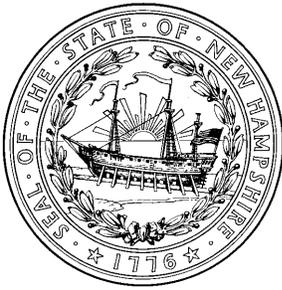
Spicer J. Making patient care easier under multiple managed care plans. *Family Practice Management*. 1998; 5(2): 38-42, 45-8, 53.

Stevenson A, Barry C, Britten N, et al. Doctor-patient communication about drugs: the evidence for shared decision making. *Social Science & Medicine*. 2000; 50: 829-840.

Wasson JH, Godfrey MM, Nelson EC, et al. Microsystems in health care: Part 4. Planning patient-centered care. *Joint Commission Journal on Quality and Safety*. 2003; 29(5): 227-237. Available at: <http://howyourhealth.com/html/CARE.pdf>. Accessed on: December 1, 2014.

5. Survey Instrument

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



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

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

If you want to know more about this study, please call 1-877-455-7156.

SURVEY INSTRUCTIONS

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

Correct Mark 

Incorrect Marks   

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

Yes ➔ *Go to Question 1*
 No

↓ **START HERE** ↓

1. Our records show that you are now in [HEALTH PLAN NAME]. Is that right?

Yes ➔ *Go to Question 3*
 No

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



YOUR HEALTH CARE IN THE LAST 6 MONTHS

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

3. In the last 6 months, did you 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 you needed care right away, how often did you get care as soon as you needed?
- Never
 Sometimes
 Usually
 Always
5. In the last 6 months, did you make any appointments for a check-up or routine care at a doctor's office or clinic?
- Yes
 No → *Go to Question 7*
6. In the last 6 months, how often did you get an appointment for a check-up or routine care at a doctor's office or clinic as soon as you needed?
- Never
 Sometimes
 Usually
 Always

7. In the last 6 months, not counting the times you went to an emergency room, how many times did you go to a doctor's office or clinic to get health care for yourself?
- None → *Go to Question 14a*
 1 time
 2
 3
 4
 5 to 9
 10 or more times
8. In the last 6 months, did you and a doctor or other health provider talk about specific things you could do to prevent illness?
- Yes
 No
9. In the last 6 months, did you and a doctor or other health provider talk about starting or stopping a prescription medicine?
- Yes
 No → *Go to Question 13*
10. When you talked about starting or stopping a prescription medicine, how much did a doctor or other health provider talk about the reasons you might want to take a medicine?
- Not at all
 A little
 Some
 A lot
11. When you talked about starting or stopping a prescription medicine, how much did a doctor or other health provider talk about the reasons you might not want to take a medicine?
- Not at all
 A little
 Some
 A lot

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

- Yes
 No

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

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

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

- Never
 Sometimes
 Usually
 Always

14a. In the last 6 months, did you have a health problem for which you needed special medical equipment, such as a cane, a wheelchair, or oxygen equipment?

- Yes
 No -> Go to Question 14c

14b. In the last 6 months, how often was it easy to get the medical equipment you needed through your health plan?

- Never
 Sometimes
 Usually
 Always

14c. In the last 6 months, did you have any health problems that needed special therapy, such as physical, occupational, or speech therapy?

- Yes
 No -> Go to Question 14e

14d. In the last 6 months, how often was it easy to get the special therapy you needed through your health plan?

- Never
 Sometimes
 Usually
 Always

14e. Home health care or assistance means home nursing, help with bathing or dressing, and help with basic household tasks. In the last 6 months, did you need someone to come into your home to give you home health care or assistance?

- Yes
 No -> Go to Question 14g

14f. In the last 6 months, how often was it easy to get home health care or assistance through your health plan?

- Never
 Sometimes
 Usually
 Always

14g. In the last 6 months, did you need any treatment or counseling for a personal or family problem?

- Yes
 No -> Go to Question 15

14h. In the last 6 months, how often was it easy to get the treatment or counseling you needed through your health plan?

- Never
 Sometimes
 Usually
 Always



YOUR PERSONAL DOCTOR

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

- Yes
- No → **Go to Question 24**

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

- None → **Go to Question 23**
- 1 time
- 2
- 3
- 4
- 5 to 9
- 10 or more times

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

- Never
- Sometimes
- Usually
- Always

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

- Never
- Sometimes
- Usually
- Always

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

- Never
- Sometimes
- Usually
- Always

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

- Never
- Sometimes
- Usually
- Always

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

- Yes
- No → **Go to Question 23**

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

- Never
- Sometimes
- Usually
- Always

22a. In the last 6 months, did anyone from your health plan, doctor's office, or clinic help coordinate your care among these doctors or other health providers?

- Yes
- No → **Go to Question 23**

22b. In the last 6 months, who helped to coordinate your care? Mark one or more.

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

22c. How satisfied are you with the help you received to coordinate your care in the last 6 months?

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

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

0 1 2 3 4 5 6 7 8 9 10

Worst Personal Doctor Possible Personal Doctor Possible Best

GETTING HEALTH CARE FROM SPECIALISTS

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

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

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

- Yes
 No → *Go to Question 28*

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

- Never
 Sometimes
 Usually
 Always

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

- None → *Go to Question 28*
 1 specialist
 2
 3
 4
 5 or more specialists

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

0 1 2 3 4 5 6 7 8 9 10

Worst Specialist Possible Best Specialist Possible

YOUR HEALTH PLAN

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

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

- Yes
 No → *Go to Question 30*

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

- Never
 Sometimes
 Usually
 Always

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

- Yes
 No → *Go to Question 33*

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

- Never
 Sometimes
 Usually
 Always

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

- Every day
- Some days
- Not at all → **Go to Question 43**
- Don't know → **Go to Question 43**

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

- Never
- Sometimes
- Usually
- Always

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

- Never
- Sometimes
- Usually
- Always

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

- Never
- Sometimes
- Usually
- Always

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

- Yes
- No
- Don't know

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

- Yes
- No
- Don't know

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

- Yes
- No

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

- High cholesterol
- High blood pressure
- Parent or sibling with heart attack before the age of 60

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

- A heart attack
- Angina or coronary heart disease
- A stroke
- Any kind of diabetes or high blood sugar

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

- Yes
- No → **Go to Question 50**

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

- Yes
- No

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

- Yes
- No → **Go to Question 52**



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

- Yes
- No

52. What is your age?

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

53. Are you male or female?

- Male
- Female

54. 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

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

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

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

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

57. Did someone help you complete this survey?

- Yes → **Go to Question 58**
- No → **Thank you. Please return the completed survey in the postage-paid envelope.**

58. 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

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

