Track: Improving Patients' Experiences With Care
Session: Using the CAHPS Health Plan Survey to Improve Quality for Medicaid Recipients.
Date & Time: April 21, 2010, 8:00 am
Track Number: CAHPS T2– S4-2

Accreditation of Medi-Cal, Healthy Kids and Healthy Families Program.

THINKING CAHPS®: INTERNAL AND EXTERNAL STRATEGIES TO INCREASE ACTIONABILITY IN HEALTHCARE SERVICE IMPROVEMENT

CAHPS® & SOPS User Group Meeting, April 21, 2010
Track: Improving Patients' Experiences With Care
Session: Using the CAHPS Health Plan Survey to Improve Quality for Medicaid Recipients

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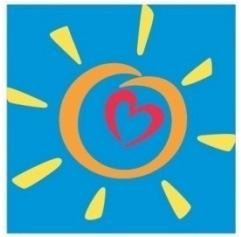


L.A. Care

Background – L.A. Care Health Plan

Large, diverse membership in Los Angeles, California:

- Mostly Medicaid, urban, 2/3rd pediatric, often Spanish-speaking.
- Roughly 22% of Medicaid managed care population in California.
- Roughly 2.2% of Medicaid managed care population in the U.S.

L.A. Care use of CAHPS Health Plan survey:

- Fielded 9 years: 1999, 2001, 2002, 2004, 2006-2010.
- Adult and Child (usually CCC); Mail+Phone; English and Spanish.

Notes:

CAHPS® is a registered trade name of the Agency for Health Research and Quality (AHRQ).
HEDIS® is a registered trade name of the National Committee on Quality Assurance (NCQA).

Overview: Improving Actionability of CAHPS®

CAHPS from the perspective of an analytic team:
How to tailor, contract, deploy, and report CAHPS to support multiple continuous quality improvement (CQI) efforts.

Part I: Strategies to Increase Analytic Value

Adding supplemental questions; administrative data.

Pooling samples to improve testability.

Part II: Overcoming Internal Barriers to Actionability

Effective survey contracting to make those strategies possible.

Avoiding pitfalls in sampling, analysis, and intervention design.

Part III: Addressing External Barriers to Actionability

Strategies for giving CAHPS users more tools and voice.

Part I. Strategies to Increase Analytic Value

A. Adding Supplemental Questions

Use Supp. Questions to *tie CAHPS to things Mgmt. cares about:*

1. Tie CAHPS to HEDIS: Ask reasons members don't get routine care.
   - Findings: *Personal reasons* far outnumber traditional access barriers.
   - **Measure member *willingness-to-comply*:** Driven by service quality?
     a. Modern illness: Member is increasingly a partner to the doctor:
        - Diet, exercise, not smoking, *self-testing, injecting meds,* dosage.
     b. **Compliance** is a route to **link CAHPS to *outcomes* and *costs***.
        HEDIS assumes compliability is *endogenous* (driven by HP & doctors). Where better to measure willingness-to-comply than explicitly in CAHPS? Then use it to rate providers and plans.
2. Synergy: Tie CAHPS to regulatory studies on access to care, etc.
3. Ask awareness of HP programs (X); correlate to satisfaction scores (Y).
   - In current budget climate, seek "two-fers": Piggyback CAHPS interventions onto programs you will be doing anyway.
4. Orphan topics (not on CAHPS) that members care about in rating us:
   Pharmacy services, language access, Medicaid dental, etc.

B. Attaching Administrative Data to CAHPS response data

CAHPS is like a report card: mainly reports *effects*, not *causes*.

Add causal variables (X) to find what drives CAHPS scores (Y):

- Member: Disease cohort; geographical location; access to services rated on CAHPS; participated in an intervention (0,1).
- Provider: Medical group (if large); specialty; Dr. received intervention (0,1).

Best source: Operational data used by health plans to manage care.

Strengths:

- Captures info the member might not know or recall accurately.
- Adds these data *without lengthening the survey.*

Limitations: Vagueness in anonymity guidelines hampers release of data.

C. Improving Precision of Tests By Pooling Over Time

Problem:

- CAHPS samples are sized to compare *whole health plans* -- not subsets of providers or members.
- Analysis rapidly runs out of sample if drilled down to actionable levels.
- Precision is too low for CQI use. Increasing sample size is expensive.

One solution: pool samples to permit meaningful testing.

- Unpooled NCQA 2008 CAHPS Medicaid average (est.): Adult n=398, Child n=429.
- Unpooled L.A. Care 2008 CAHPS with oversamples: Adult n=608, Child n=651.
- Pooled L.A. Care 2006-to-2008 CAHPS: *Adult n=**2,033**; Child n=**2,399**.*

Caveats:

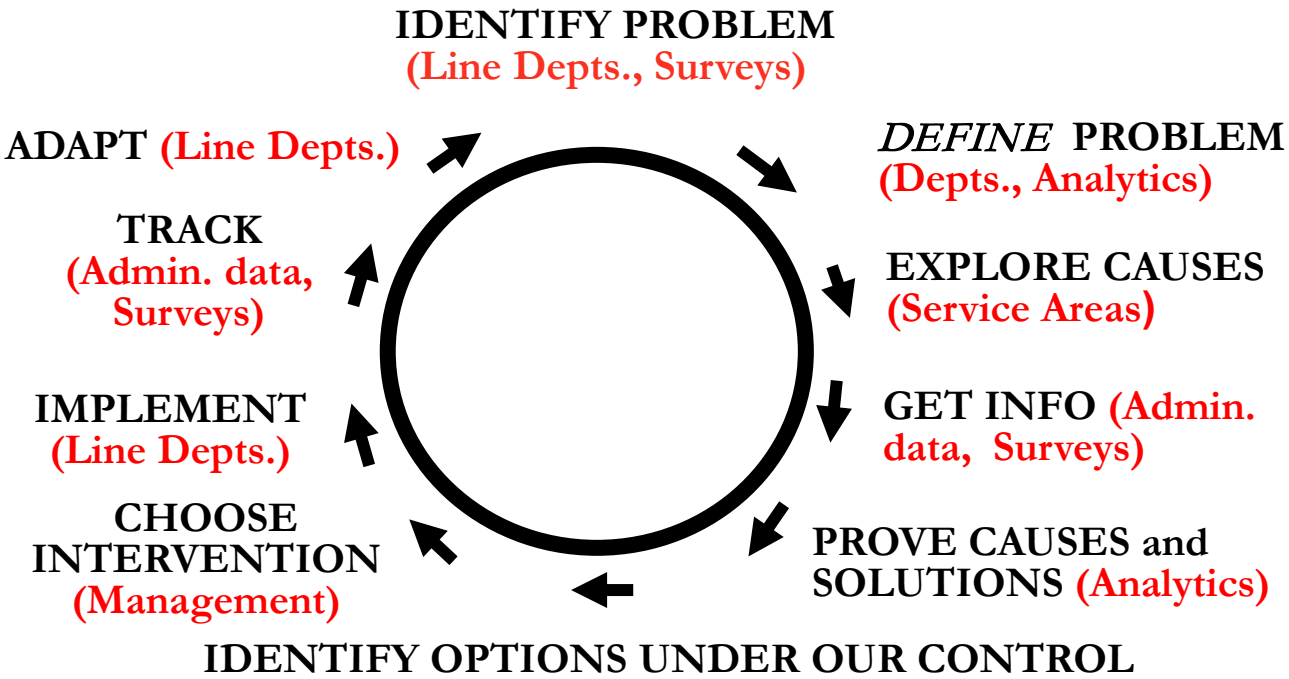
- Vendor software may lack pooled variance math so may overstate precision.
  - ***Use findings only if consistent with other independent evidence.***
- Pooling sacrifices "time" as a dimension – takes years to trend.
  - ***Only detects durable patterns*** – (which is really not a bad focus..).

Part II. Overcoming Internal Barriers to CAHPS Actionability

D. Symptoms of an incomplete CQI process

- Mere reporting, without rewards and sanctions.
- Jumping directly to implementation without root cause analysis.
- Full rollouts without pilot projects. ("Make your 1st mistakes small & cheap.")
- Juxtaposed lists (CAHPS domains vs programs) with no evidentiary link.
- "Rolling project list" -- no sustained projects evolving via lessons learned.

An ideal CQI process:



E. Effective Survey Contracting and Oversight

Actionability in CAHPS depends *heavily* on services defined in the RFP and the line items in the contract's Scope of Work:

- Extent and quality of the survey effort (callback attempts, etc.).
- Supplemental questions; open-ended questions.
- Access to administrative data with an agreed-upon anonymity protocol.
- Custom analyses to support CQI.

Boosting response rates to gain precision, lessen bias:

NCQA CAHPS nationwide response rate averages for 2008:

- Medicaid Adult: **29.5%**. (Commercial: 36%)
- Medicaid Child: **26.0%**. (Commercial: 39%)

Response rate = vendor effort *plus responsiveness of your population.*

Goal: Find a good **fit** between vendor services and your needs.

Cost is often modest if you know what to ask for:

1. Contract for **more callback attempts** beyond NCQA minimum of 3.
2. Stipulate a **longer callback window** (evenings, weekends, *in your time zone).*
3. **Monitor calls** to ensure that the contract is followed.
4. Request date/time of all calls as part of the final dataset.

Validate samples against sampling frame to avoid "de-dup disasters." 😐

F. Other Internal Impediments to Making CAHPS Actionable

Appropriately resourcing CAHPS:

1. *Analytic staff:* sufficient FTEs with appropriate skill-sets.
2. *Funds* for added questions, data, custom analyses; statistical software.
3. *Time:* Tight calendar – little time for causal analysis, reporting, etc.
4. *Exposure of findings* to decision-makers who impact service quality.

CAHPS DATA → **ANALYST NEEDED**
Start: 06/01/2010… →

SUPPLY FACTS FOR PROGRAM DESIGN:

- **Quality Improvement**
- **Utilization Management**
- **Provider Relations**
- **Member Services**
- **…**

Part III: External Barriers to CAHPS Actionability

G. Structural Impediments to Making CAHPS Actionable

1. Medicaid: Rarely see monetary incentives to improve CAHPS.

2. Purchasing survey services:
   - Uncertainty in anonymity rules limits ability to attach causal data.
   - Lack of key info to guide in custom contracting to meet CQI needs.

3. Listening to the customer -- no question on CAHPS asks members:
   "What *should* we be asking about the services you care most about?"

   CAHPS omits some categories that our members say are important:
   Language access; waiting room cleanliness; pharmacy; dental.

H. Impact of Change in the CAHPS Family of Instruments

CG CAHPS appropriately pushes focus to the provider level: the point-of-service for delivering care.

But health plan administrators may *perceive* the following:

- "Medicaid CAHPS scores are difficult to move."
- "Most of CAHPS performance is driven by providers in clinics."
- "Therefore HP CAHPS is the ***wrong survey***, at the ***wrong level***."

Coordinate CAHPS Health Plan and Clinician & Group surveys:

- How do the 2 surveys' scores *complement* & *correlate* with each other? (Reweight CG CAHPS report to popul. for comparison to HP CAHPS?)
- Help link P4P spending to show impact on NCQA Accreditation scores.

Stabilize the HP CAHPS instrument for a 4-6 year CQI cycle.

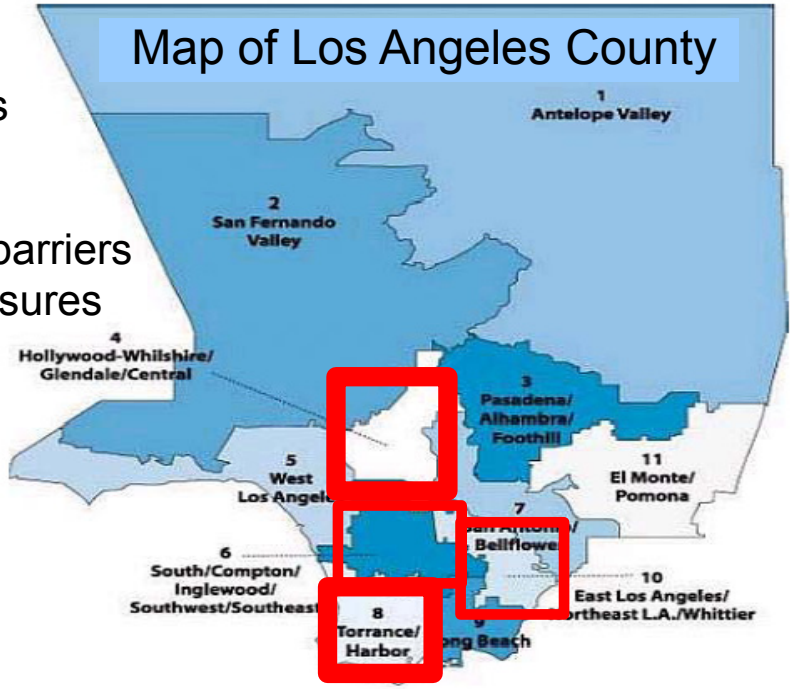
- Maintain response rates through more callbacks, not fewer questions.

Example: Loss of Language Access Questions (CAHPS 3.0 -> 4.0)

- 2008: Parents report language barriers with Child's doctor.
  - Helped focus attention toward 4 regions with greatest need.
- *2009: Unknown: Language questions were dropped from v4.0.*
  - Irony: Cuts didn't lower survey costs or increase our response rates.
  - Add as Supplemental Questions?: Means dropping other content.
  - Allow adding more questions as long as response rate >=30%.

Thick red boxes: language barriers found in 4 samples or measures)

Thin red boxes: language barriers found in 2 samples or measures



For a Healthy Life

I. Recap: Giving CAHPS Users More Tools & Voice – a Wish List

Research to lift relevance of CAHPS for Management:

1. Link CAHPS scores to other things (KPIs) health plans care about:
   - Research to tie satisfaction to *member retention* (hence revenue)?
   - Tie to *member compliance* (HEDIS visits, ER usage & costs, etc.)?
2. Research to correlate CG CAHPS to HP CAHPS and NCQA accreditation score.

Actionability:

3. Permit adding >20 Supplemental Questions if response rates stay above 30%.
4. For attaching data to CAHPS, create clearer anonymity rules based on cell size.

Transparency:

5. Disclose national Medicaid CAHPS response rates: averages, quartiles, etc.

Portability of CAHPS response data and supplemental data:

6. Standardize formats & costs to move prev. years' samples betw. CAHPS vendors.

Added voice for CAHPS users and members as customers:

7. Survey CAHPS users annually about survey needs, vendor performance, etc.
8. Survey members regularly about what they think should appear in CAHPS:
   - Ask what quality-of-service issues they care about most.
   - Ask what info from CAHPS would help them choose health plans & doctors.

(Things CAHPS users can't solve themselves that would aid actionability.)

Contact Information

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Participate in a survey of CAHPS practices (staffing, analytics, reporting, contracting, response rates, etc.), and receive a summary of the findings:

http://groups.yahoo.com/group/member_satisfaction
member_satisfaction-subscribe@yahoogroups.com