

The Utility of CAHPS for Health Plans

DENISE D. QUIGLEY, DENNIS P. SCANLON,
DONNA O. FARLEY, HAN DE VRIES

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HEALTH

PREFACE

The Consumer Assessment of Health Plans Study (CAHPS®) was initiated by the Agency for Healthcare Research and Quality (AHRQ) in 1995 to establish survey and reporting products that provide consumers information on health plan and provider performance as judged by other consumers who used the health plan. It was learned during the first CAHPS development work that various stakeholders have very different perspectives and uses for CAHPS. AHRQ initiated a second CAHPS project (CAHPS® II) in 2002, working with a consortium of RAND Corporation, American Institutes for Research, the Harvard Medical School, and Westat. A goal of the CAHPS II is to address concerns expressed by health plans and health care providers that CAHPS does not provide them the information they need to improve performance in areas of importance to consumers.

RAND conducted interviews with health plans to gather information on their quality improvement activities and their perspectives about how CAHPS fits into those activities. This information from the field is helping us design a more useful CAHPS strategy and tools for quality improvement. These interviews were a component of a broader set of market research interviews conducted by the CAHPS consortium during 2003. Therefore, findings from these health plan interviews will be integrated with those from interviews with other CAHPS stakeholders.

This report presents findings from these interviews and is intended primarily for the CAHPS consortium, survey sponsors, health plans, and other stakeholders. Others also may find the information useful as they design their own consumer surveys.

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EXECUTIVE SUMMARY

The Consumer Assessment of Health Plans Study (CAHPS®) was initiated by the Agency for Healthcare Research and Quality (AHRQ) in 1995 to establish survey and reporting products that provide consumer information on health plan and provider performance as judged by other consumers who used the health plan. The primary focus of CAHPS is on providing information to help consumers make informed health plan choices. Yet it was learned during the first CAHPS development work that various stakeholders have very different perspectives and uses for CAHPS. AHRQ initiated a second CAHPS project in 2002, working with consortium of RAND Corporation, American Institute for Research, the Harvard Medical School, and Westat. One of the goals of the second CAHPS is to address concerns expressed by health plans and health care providers that CAHPS does not provide them the information they need to improve performance in areas of importance to consumers, as reflected in the CAHPS scores.

RAND's work plan specifies a coordinated strategy to strengthen the quality improvement aspects of CAHPS. We are developing and designing changes to improve the use of CAHPS in health plan quality improvement activities, including the design of the overall information gathering activities, identification of priorities for CAHPS modification, and field-testing of new methods.

PURPOSE OF THE HEALTH PLAN INTERVIEWS

To inform the efforts to maximize the usefulness of CAHPS for health plan quality improvement, our first step was to conduct interviews with health plans to gather in-depth information on their quality improvement activities and their perspectives about how CAHPS fits into those activities. The goal was to develop a better understanding of the priorities and issues of this stakeholder group, which would help us design a useful CAHPS strategy and tools for quality improvement. This report presents the findings from these interviews. The report is intended primarily for a CAHPS audience, including the CAHPS consortium, survey sponsors, health plans, and other stakeholders. Others also may find the information useful as they design their own consumer surveys.

The interview findings presented in this report describe the information obtained from the interviewed health plan representatives regarding the following topics:

- The priority placed by the plans on consumer-reported information on health plan performance,
- How health plans use consumer-reported information in their various operational functions,
- The credibility of CAHPS as a source of consumer-reported information,
- The ways in which health plans use CAHPS data, with a focus on its use in conjunction with other survey data,
- How health plans use CAHPS specifically for quality improvement activities,
- Strengths and weaknesses of CAHPS survey data for quality improvement activities, and

- Feedback from the health plans about various options that the CAHPS consortium is considering for modifying the CAHPS survey.

STUDY DESIGN AND METHODS

The use of CAHPS in quality improvement activities by health plans had not been explored in much depth, so we needed to use a data collection methodology that offered the flexibility for respondents to share their unique experiences with us. We also wanted to obtain structured feedback on specific design changes for the CAHPS survey along with open-ended responses on the usefulness of each change and suggestions for design. Therefore, we chose to conduct semi-structured interviews with health plan representatives from a purposive sample of 27 health plans.

The findings from this study are not generalizable to health plans in the United States or to all plans in the states where we conducted the study. However this design allowed us to explore the usefulness of CAHPS with health plan representatives who had considerable experience in performance measurement for quality improvement. As shown below, there was a strong consensus among these individuals regarding CAHPS and quality improvement, which allows us to use the information from the interviews to guide our development work. We would have had less confidence in applying the results if there had been a greater diversity of opinions among the respondents.

The sample of health plans we interviewed was identified in collaboration with the Blue Cross Blue Shield Association of America (BCBSA) and the National Committee for Quality Assurance (NCQA). Interviews were conducted with a total of 27 health plans. For each plan, an interview was conducted with the person responsible for management of the quality improvement (QI) function. We expected the QI managers or directors to have both operational knowledge of the CAHPS survey and an understanding of how the CAHPS data is used throughout the organization. To obtain as broad a range of viewpoints as possible, the interviews were conducted with from 4 to 5 health plans in each of the following groups:

- BCBS health plans that do not use the CAHPS survey (N=4)
- BCBS health plans that field the CAHPS survey, but do not report survey results to the NCQA Quality Compass for public reporting (N=4)
- Health plans that report survey results to the NCQA Quality Compass for public reporting, grouped based on performance on CAHPS in 2000 and 2002, as identified from survey data submitted to NCQA Quality Compass, as follows (total N=19):
 - Plans that consistently had CAHPS scores higher than average (N=5)
 - Plans that consistently had CAHPS scores lower than average (N=4)
 - Plans that had CAHPS scores that showed statistically significant improvement between 2000 and 2002 (N=5)
 - Plans that had CAHPS that showed statistically significant decline between 2000 and 2002 (N=5).

HEALTH PLAN USE OF CONSUMER-REPORTED INFORMATION

To best understand how health plans use CAHPS as an information source, it is important to have information on the priority placed by plans on consumer-reported information compared with other types of information on their performance. Information was gathered on the views of the plan representatives, which departments within the plans used consumer-reported information, and their views and use of CAHPS as an information source.

Use of Consumer-Reported Information in General

The first few questions addressed health plans' views about and use of consumer-reported information in general.

1. A strong majority of the health plans interviewed felt that consumer reports on their experience with care and customer service were equally or more important relative to other performance issues, such as clinical quality measures or cost information. The majority of health plan representatives also indicated that their organizations placed a high priority on measuring and improving performance based on consumer-reported measures.

Highlights:

- 41 percent of the health plans indicated that consumer reports on their health plan experiences were more important than other performance issues, such as clinical quality or cost, and another 52 percent indicated they were equally important.
 - The main reasons why consumer-reported measures were important to health plans were expectations by customers for effective service, competitive pressures to be service-driven or customer-focused, and the nature of consumer reported measures as the only way to understand what consumers think and how they interact with their health plans.
2. Use of consumer-reported measures is widely distributed throughout the health plans. The demand for consumer assessment information primarily comes from quality improvement (QI) related departments, but also from senior management, marketing, and departments overseeing accreditation preparation.

Highlights:

- 70 percent of the health plans interviewed indicated that consumer reported data, including CAHPS and other types of data, were sent to quality improvement departments, committees, and teams
 - The demand for consumer reported data within the health plans came from QI departments, committees and teams (44 percent of plans), senior management (32 percent), marketing (28 percent) and accreditation (28) percent
3. In performance reports using consumer-reported measures, health plans indicated that benchmarks and trend analysis were the two most important elements. Regional data were

more useful to their organization than local or national data when making comparisons or benchmarking.

Highlights:

- 89 percent of the health plans indicated that benchmarks were important in reporting consumer reported measures, while 70 percent also indicated trend analysis was important.
- 78 percent of the health plans compare consumer-reported measures to benchmarks.
- 85 percent of the health plans indicated that regional data was the most useful to their organization.

Health Plans' Use of CAHPS

As health plans have many types of data that they can access for improvement initiatives and assessing their performance, it is important to understand the extent to which health plans use CAHPS data and why.

4. CAHPS is an important source of consumer-reported data that has credibility with the health plans. CAHPS was reported by health plans as credible in terms of its scientific integrity and its topic areas, but a smaller percentage of health plans found CAHPS credible in terms of the specificity of information generated from the survey.

Highlights:

- 76 percent of the health plans found CAHPS credible in terms of scientific integrity.
 - 64 percent of the plans found CAHPS credible in terms of topic areas.
 - 40 percent of the plans found it credible in terms of the specificity of information generated by the survey.
5. A large majority of health plans use CAHPS consumer-reported data in conjunction with other surveys and data sources. Most often health plans use the adult CAHPS survey and analyze the data only at the plan-level.

Highlights:

- 78 percent of health plans interviewed indicated that use CAHPS in conjunction with other survey data
 - All 4 of the health plans that were selected because they “currently did not use CAHPS” indicated that they primarily did not use CAHPS because the cost of accreditation was too high and CAHPS did not fulfill their specific needs
6. Health plans reported using CAHPS data in the areas of quality improvement, credentialing and marketing. Health Plans indicated that they use CAHPS in their quality improvement efforts because it allows for benchmarking, provides valid and reliable data, and provides consumer-reported data that is not available from another source.

Highlights:

- 84 percent of health plans indicated that CAHPS was useful for quality improvement activities.
 - 44 percent of health plans indicated that CAHPS data is not actionable, 30 percent indicated that it is actionable, and 26 percent indicated that its actionability depends on the topic area addressed in the survey.
 - 85 percent of the health plans reported the data specificity was the primary barrier that restricted CAHPS from playing a more integral role in quality improvement.
7. In terms of quality improvement, CAHPS data is used most often in the area of customer service. After customer service, four areas were of similar priority – complaints and appeals, access to care, availability of providers and paperwork and claims.

Highlights:

- 25 percent of priority measures reported by health plans were in the area of Customer Service.
- After Customer Service, several areas were of equal priority in the CAHPS data: access to care, availability of providers, and paperwork and claims.

FEEDBACK ON CAHPS' STRENGTHS AND WEAKNESSES

Overall, the health plans interviewed indicated that CAHPS has various specific strengths that they value as well as weaknesses that limit its ability to support quality improvement activities. It is a good, general tool that assists health plans to compare themselves to other health plans and to do trending and benchmarking. Its usefulness stems primarily from its scientific credibility and the array of topics covered in the CAHPS survey. Plans do not appear to want to change the existing content areas of the survey, but they are interested in refining items and adding items.

8. CAHPS is used primarily for trending, benchmarking, making comparisons to other health plans, and identification of quality improvement issue areas. Moreover, health plans rated CAHPS' standardization, capability for trending, and its appropriate unit of analysis as its best features.

Highlights of Overall Results:

- 85 percent felt the main strength of CAHPS was trending and benchmarking for comparisons with other health plans
- 78 percent used CAHPS primarily to identify quality improvement issues
- 44 percent used CAHPS because it is required for NCQA accreditation
- 63 percent felt the topics covered by CAHPS were appropriate
- Topic areas on CAHPS that were most useful:
 - Customer service (89 percent)
 - Access to care (59 percent)

- Claims and paper work (59 percent)
- Topic area on CAHPS that was least useful – provider communication (67 percent)
- 30 percent wanted more questions on health plan customer service issues
- 19 percent disliked the negative frame on the “problem” CAHPS questions
- 22 percent felt the specialist referral questions were too focused on HMOs.

Health plans further reported that CAHPS is limited in its ability to establish specific actions and interventions in improving their health plan’s quality and performance. Reasons cited are that the CAHPS data are reported at the plan level, the contents of questions are too general, and results are not reported quickly enough back to health plans to allow for improvements and monitoring of interventions.

9. The content topic areas covered in the CAHPS survey are relevant to health plans, but within a few of the topic areas, health plans want to add more items and make some specific changes to existing items.

Highlights of Results on CAHPS Limitations:

- 74 percent identified the limited specificity of the survey as a drawback, including scope of survey items, unit of analysis (plan, group, provider), and type of health plan
- 41 percent identified poor timeliness of the survey as a drawback
- 70 percent wanted provider data aggregated at the group or individual provider level

Given these limitations, the health plans reported they tend to supplement CAHPS with other, more real-time data (i.e. claims data and operations data) that are specific to their markets and to the content areas they have been identified as having problems. In addition, by supplementing the CAHPS data with other survey data, the health plans can pinpoint more specific issues on which they need to improve, to set and establish goals, and to monitor these interventions. In this on-going process of quality improvement, health plans report that CAHPS assists primarily in identifying the general area(s) that need improving, but is not diagnostic enough to identify needed improvements solely on its own.

HEALTH PLAN VIEWS ON CAHPS DESIGN CHANGES

Overall, we found that the health plans interviewed had favorable responses to several major design changes being considered for CAHPS, as shown in Table S.1. The following changes in particular were supported strongly by the interviewed plans:

- Collecting data at the plan, group and provider level (70 percent),
- Creating a visit-specific survey (33 percent),
- Reducing administration costs (67 percent), and
- Including items for common quality improvement efforts (63 percent).

Table S.1
Percentage in Favor and Not in Favor of Suggested Design Changes to the CAHPS Survey

Design Feedback (N=27)	Percentage	Percentage	Percentage
	Yes	No	Maybe
Survey at plan, group, and provider-level (Q23A)	70	15	15
Visit-specific survey (Q23B)	33	22	45
More frequent data collection and reporting (Q23C)	48	44	8
Reduce survey administration costs (Q23D)	67	7	26
Include items for common QI efforts (Q23E)	63	15	22
Survey with non-physician providers (Q23F)	19	78	4
Change reference period (Q23G)	22	78	0

The health plans supported collecting data at the plan, group and provider level because they believed that this type of change would increase the specificity of the data and therefore increase its usefulness in QI activities, particularly in terms of identifying problem areas and pinpointing interventions. Those health plans that did not support this change mainly were worried about cost and sample size issues.

Health plans responded favorably to the general concept of creating a visit-based CAHPS survey, but when asked to specifically consider between a visit-based or a reference period for a provider-level survey, only one-third favored the visit-specific survey. A substantial percentage of the plans already had their own visit-specific survey. Those in favor of a visit-based survey believed that this change would assist them in targeting their QI interventions, potentially replace their own visit-based member surveys, and shorten the lag time of getting the data and results. Those that were undecided about the visit-based survey indicated that the appropriateness of a visit-based survey depended upon the specific content and items on such a survey. Those plans that did not support a visit-based CAHPS survey were concerned about HIPAA issues, differences in patients' recall concerning a visit-based versus a reference-period survey, and opinions that visit-specific data was better suited for provider level data.

Health plans also were in favor of reducing administration costs, but they were unclear on the best method. Almost half wanted to shorten the survey, and a few plans supported using Internet administration to cut costs. Several plans disagreed that either of these strategies would cut costs and maintain a high quality sample.

Health plans supported including items on CAHPS for common quality improvement efforts, which would assist in drilling down to specific actionable issues and would help document improvements in those areas. However many concerns were voiced about how the common QI issues would be determined. The plans that did not support this design change echoed these concerns about how to effectively define the common QI issues for the survey, and they also were worried about adding respondent burden.

Changes to CAHPS that were not supported by the health plans were a module on non-physician providers, changing the existing reference periods of the CAHPS survey, and providing more frequent data collection and reporting.

Overall, health plans supported improving the CAHPS survey to make it more useful for QI efforts. They supported changes that would enable CAHPS to assist the health plans in drilling down deeper into issues that the health plans and providers face as well as better target interventions. They expressed concerns over making these changes and not increasing costs or survey length or losing the credibility, standardization, and comparability that is now present with the CAHPS data.

ACKNOWLEDGMENTS

We are indebted to the health plans and health plan representatives whom we interviewed. They were generous with their time and participated thoughtfully in the interview process, providing us with invaluable feedback about their experiences and opinions. We are also very grateful to the National Committee on Quality Assurance (NCQA) and the Blue Cross Blue Shield Association of America (BCBSA) for their support and participation in identifying issues to be considered and for serving as liaisons with the health plans as we recruited plans for interviews and other related activities.

A number of other individuals made important contributions to the development of this work. For their valuable input, we would like to thank Marc Elliott, Marla Haims, Harry Holt, and Ron Hays, all of whom are colleagues on the RAND CAHPS team.

1. PURPOSE AND METHODS

The Consumer Assessment of Health Plans Study (CAHPS®) was initiated by the Agency for Healthcare Research and Quality (AHRQ) in 1995 to establish survey and reporting products that provide consumers information on health plan and provider performance, as judged by other consumers who used the health plans. For the initial development, testing, and refinement of these CAHPS® products, AHRQ worked with a research consortium consisting of the RAND Corporation, Research Triangle Institute, Harvard Medical School, and Westat. The primary focus of CAHPS is on providing information to help consumers make informed health plan choices.

The CAHPS survey measures health plan performance on several dimensions including global rating (e.g., ratings of health plan, primary doctors or nurse, specialty care) and reports of experiences with using a health plan (e.g., doctor or nurse listened and showed respect, could get an appointment when needed, got specialty referral when needed, plan responded to concerns or questions). The ratings are individual items using response scales ranging from 0 to 10. The reports of experiences are composite scores that are averages of responses to sets of individual items using four-category response options (Agency for Healthcare Research and Quality, 1999).

It was learned during the first CAHPS development work that various stakeholders have very different perspectives and uses for CAHPS. (Carman et al., 1999; Fox et al., 2001; Spranca et al., 2000; Kanouse et al., 2001; Farley, et al., 2002a; Farley et al., 2002b).

AHRQ initiated a second CAHPS project in 2002 (CAHPS® II), working with consortium of RAND Corporation, American Institutes for Research, the Harvard Medical School, and Westat. One of the goals of the second CAHPS work was to address concerns expressed by health plans and providers that CAHPS does not provide them the information they need to improve their performance in areas important to consumers.

RAND's work plan specifies a coordinated strategy to strengthen the quality improvement aspects of CAHPS. Both the National Committee on Quality Assurance (NCQA) and the Blue Cross Blue Shield Association (BCBSA) had received feedback from their constituent health plans regarding these concerns. We are partnering with NCQA and BCBSA to study the use of CAHPS in health plan quality improvement activities, including the design of the overall information gathering activities, identification of priority areas for CAHPS modification, and field-testing of new methods.

Interviews were conducted with representatives of 27 health plans in the summer of 2003 with the goal of gaining a better understanding about their perspectives on consumer-reported measures and CAHPS information. The information obtained from the interviews has helped to guide work on development of additional items for the CAHPS survey as well as other tools to support use of CAHPS in health plan quality improvement processes.

PURPOSE OF THE HEALTH PLAN INTERVIEWS

To inform efforts to maximize the usefulness of CAHPS for health plan quality improvement, our first step was to conduct interviews with health plans to gather in-depth information on their quality improvement activities and their perspectives about how CAHPS fits into those activities. The goal was to develop a better understanding of the priorities and issues of this stakeholder group, to help us design a useful CAHPS strategy and tools for quality improvement. This report presents the findings from these interviews addressing health plans views regarding general aspects of CAHPS and specific options being considered by the CAHPS development team from modification of the CAHPS survey. The report is intended primarily for a CAHPS audience, including the CAHPS consortium, survey sponsors, health plans, and other stakeholders. Others also may find the information useful as they design their own consumer surveys.

The presentation of interview results is organized into three sections that outline health plans' use of CAHPS and their opinions on the strengths and weaknesses of CAHPS data overall and in their quality improvement activities. Section 2 provides the health plans' views of the importance of consumer reported measures and their overall use of CAHPS. Section 3 reports feedback from the plans concerning the strengths and weaknesses of CAHPS. Section 4 lays out a detailed questions-by-question analysis of specific re-design issues under consideration for CAHPS by the CAHPS development team to improve its usefulness in quality improvement activities.

STUDY DESIGN AND METHODS

Some work has been undertaken to document how health plans have used CAHPS in quality improvement activities, but by health plans' use of CAHPS is multifaceted and we are only beginning to understand the patterns of use and related issues. Thus, we needed to use a data collection methodology that offered the flexibility for respondents to share their unique experiences with us. We also wanted to obtain structured feedback on specific design changes for the CAHPS survey along with open-ended responses on the utility of each change and suggestions for design. Therefore, we chose to conduct semi-structured interviews with health plan representatives from a purposive sample of 27 health plans.

The findings from this study are not generalizable to health plans in the United States or to all plans in the states where we conducted the study. However this design allowed us to explore the usefulness of CAHPS with health plan representatives who had considerable experience in performance measurement for quality improvement. As shown below, there was a strong consensus among these individuals regarding CAHPS and quality improvement, which allows us to use the information from the interviews to guide our development work. We would have had less confidence in applying the results if there had been a greater diversity of opinions among the respondents.

Protocol Content

A standard protocol was developed to guide the health plan interviews. We developed and pilot tested an interview protocol with a one-page pre-interview survey. The health plan interview protocol is provided in Appendix A along with the pre-interview survey. Each interview took approximately one hour. The protocol was designed to allow us to:

- Gain an understanding of the importance of consumer measures for health plans,
- Identify how the health plans are using CAHPS in general and specifically for quality improvement activities,
- Obtain feedback on the value and limitations of CAHPS for quality improvement,
- Identify topics that are important to health plans that could provide more actionable data from CAHPS.

This protocol was a component of a more general interview protocol that the CAHPS consortium used for broader market research interviews conducted during 2003. Therefore, findings from our health plan interviews can be integrated with those from interviews with other CAHPS stakeholders.

Sample of Health Plans

The sample of health plans we interviewed was identified in collaboration with the BCBS Association and the NCQA. To obtain as broad a range of viewpoints as possible, we selected health plans to interview from three categories—plans that did not field CAHPS, plans that fielded CAHPS but did not publicly report CAHPS results in the NCQAs Quality Compass product, and plans that did publicly report CAHPS results in Quality Compass. Within the group of health plans that report their CAHPS results to Quality Compass, we selected plans with a range of performance levels on the CAHPS survey. Within each of the three sample groups, we attempted to select plans from across the regions of the US (North, South, East, West, and Midwest).

Interviews were conducted with personnel in a total of 27 health plans. For each plan, an interview was conducted with the person responsible for management of the quality improvement (QI) function. We expected the QI managers or directors to have both operational knowledge of the CAHPS survey and an understanding of how the CAHPS data is used throughout the organization. The interviews were with the QI managers from health plans in each of the following groups:

- BCBS health plans that do not use the CAHPS survey (N=4)
- BCBS health plans that field the CAHPS survey, but do not report survey results to the NCQA Quality Compass for public reporting (N=4)
- Health plans that report survey results to the NCQA Quality Compass for public reporting, grouped based on performance on CAHPS in 2000 and 2002, as identified from survey data submitted to NCQA Quality Compass, as follows (total N=19):
 - NCQA-1: Plans that consistently had CAHPS scores higher than average (N=5)

- NCQA-2: Plans that consistently had CAHPS scores lower than average (N=4)
- NCQA-3: Plans with mixed performance on CAHPS (Not included in interviews)
- NCQA-4: Plans that had CAHPS scores that showed statistically significant improvement between 2000 and 2002 (N=5)
- NCQA-5: Plans that had CAHPS scores that showed statistically significant decline between 2000 and 2002 (N=5).

Health Plan Recruitment and Participation

We collaborated with the BCBS Association in the recruitment of BCBS health plans to participate in the interviews. To initiate the process, the BCBS Association fielded a web-based survey to its member health plans, in which it gathered basic descriptive information on the plans' quality improvement activities and if and how they were using CAHPS. It also asked them to indicate whether they were willing to be interviewed by RAND to obtain their views on CAHPS.

A total of 24 BCBS health plans responded to the BCBS Association survey out of 42, and 23 plans stated their willingness to participate in the RAND interviews. All of the BCBS health plans identified through the BCBS web-based survey were using CAHPS. Of these 23 health plans, 17 plans did not report their CAHPS results to the NCQA Quality Compass. We identified 9 of the 17 plans for possible interviews, selecting plans located in a variety of geographic regions. From this list, 4 plans were interviewed, 3 plans did not respond to calls, and 2 plans were not contacted because an interview already had been scheduled with another plan in their region.

The BCBS Association also provided us with the names of the 8 plans that they knew of that did not use CAHPS at all. From this list, 4 plans participated in the interviews, 2 plans did not respond, and 2 plans chose not to participate.

Rand with the analytic support of NCQA undertook the selection of health plans that reported CAHPS results publicly to NCQA Quality Compass. Quality Compass is a database of health plans that allows NCQA to publicly release their results. This subset of health plans was used for this RAND CAHPS study. The first step, which was an analysis of the CAHPS performance, was guided by a written analysis plan prepared jointly by RAND and NCQA. NCQA provided the RAND team with health plan-level summary CAHPS survey data for the years 2000 and 2002. A crosswalk was also provided to match the plans that reported results to Quality Compass for all three years. Data for a total of 245 health plans in 2002 was available. For a subset of 154 plans that had three years of data, the data were matched and trended from 2000 to 2002. The CAHPS 2.0H performance of each plan was indexed using the standardized difference of the plan's scores from the means of the group. These standardized scores were based on raw scores pre-calculated by NCQA using its standard methods, as documented in the detailed instructions presented in HEDIS® 2002 Volume 3: Specification for Survey Measures (NCQA, 2002)

Working with the results of the analysis, the RAND team prepared a list of the health plans that were candidates for interviews, which included 5 to 10 plans in each of the four performance categories described above: consistent improvers, improvers, decliners, consistent decliners. NCQA sent an introductory letter to those plans, informing them about the purpose of the interviews and delineating informed consent provisions. These 30 health plans were asked to contact NCQA if they did not wish to participate.

The NCQA provided RAND with contact information for 27 health plans that did not decline to participate in the interviews. Of these health plans, 19 plans were interviewed, 7 plans across the four performance levels were not contacted because interviews were scheduled with 5 other plans with the same performance level, and 1 plan refused to participate.

A member of the RAND research team conducted each interview by telephone. In some cases, multiple respondents from the same health plan participated, and they were interviewed as a group¹. We used the informed consent procedure to confirm the earlier consent given by BCBS health plans and to obtain oral consent from the non-BCBS/NCQA health plans. The interviews were audio taped, and the results of each interview were written up based on notes taken during the interview and information from the tapes.

Overall, 44 health plans were recruited, of which 27 plans were interviewed, five plans did not respond, nine plans were not contacted because the number of health plans needed by region was reached, and three plans refused the interview. On average, the primary interviewees had an average of 4.7 years of experience in their current position and held the positions and job titles listed in Table 1.1. In addition to the primary interviewees, 40 percent (N=11) reported to a vice president, 37 percent (N=10) reported to a Director, 11 percent (N=3) reported to a chief Medical officer, two reported to other positions, and information was missing for one respondent.

In terms of the health plans interviewed, the health plans were primarily mixed or a network model. Tables 1.2 and 1.3 provide self-reported health plan information about total enrollment (including commercial, Medicare, Medicaid, etc.), model type, and region of the health plans that were interviewed.

¹ In some of the interviews, we interviewed more than one person. In 18 of the interviews, we interviewed only one person, the primary contact person. In the remaining 9 interviews, we interviewed multiple people at a time. In five of the interviews we interviewed two people together, in one interview there were 3 people, in two interviews there were 4 people and in one interview there were 5 people. In each interview, however, the main contact person was considered the primary interviewee.

Table 1.1
Distribution of People Interviewed by Type of Position Held

Position Title	Number Interviewed	Percentage of Total
Director - QI/Accreditation	3	11
Director - Research/ consulting	3	15
Director - Medical related dept	2	7
Associate/ Assistant Director	2	7
Project leader/ manager - QI	4	15
Project leader/ Manager Market Research	4	15
Project leader/ Manager other dept	2	7
Analyst/ consultant	6	22
Missing	1	<1

Table 1.2 Total Enrollment Sizes of the Health Plans Interviewed

Group	Health Plan Enrollments		
	Mean	Minimum	Maximum
NCQA – 1 (N=5)	373,250	30,000	1,300,000
NCQA – 2 (N=4)	957,600	63,000	2,200,000
NCQA – 4 (N=5)	936,459	200,000	2,574,836
NCQA – 5 (N=5)	3,485,400	217,000	13,400,000
Field CAHPS, Don't Report(N=4)	1,400,000	300,000	3,500,000
Don't field CAHPS (N=4)	1,372,500	600,000	3,000,000

Source: Self-reported data from the health plans.

Table 1.3 Distribution of Model Types for the Health Plans Interviewed

Group	Health Plan Model Type					Total
	IPA	Mixed	Network	Staff	Other	
NCQA - 1	-	1	2	1	-	4
NCQA - 2	-	2	2	-	1	5
NCQA - 4	1	2	2	-	-	5
NCQA - 5	2	2	-	-	1	5
Field CAHPS, no public reports	1	2	1	-	-	4
Don't Field CAHPS	1	2	1	-	-	4
Total	5	11	8	1	2	27

Source: Self-reported data from the health plans. Those listed as “other” did not specify their health plan model.

Analysis of the Interview Data

The interviewers drafted notes from the tape recordings of the interviews, and these notes were given to another team member. Working with the drafted notes and the tape, the other team member transcribed a draft document of the interview. The interviewer then reviewed the draft interview for accuracy and finalized the transcription notes. The final notes were used to create a detailed spreadsheet entry for each interview. The spreadsheet allowed us to do frequency counts and calculations for quantifiable data and aided in sorting and grouping interviews for qualitative analysis. The counts were also disaggregated according to the sample selection criteria (i.e., do not field CAHPS, do not report CAHPS publicly, and publicly reporting plans grouped by the four performance categories) to identify whether answers clustered according to these selection characteristics. All interview data was analyzed and included in this report. The interview protocol is in Appendix A. The main interview questions that were analyzed are listed below.

Main interview questions were the following:

- B1-Q3 What is your organization most interested in knowing from consumers or patients about their experiences with their health care and customer service? Why? What drives them?
- B2-Q1 What surveys do you use to collect consumer experience with care? CAHPS? Others? Can you tell me a little about the survey that you use? Audience? Reference period? Frequency of administration? Unit of analysis?
- B2-Q3. Are CAHPS or your other survey(s) useful for quality improvement activities of health plans or providers?
- B2-Q4 Now thinking about the content of the surveys, what do you find *most useful* about the content of the surveys you use? *Least Useful*?
- B2-Q5 To people important to you and your organization, is {CAHPS/your current survey} credible with respect to: a. Scientific integrity of the survey instrument; b. Topic areas addressed by the survey; c. specificity of the information generated from the survey? Y/N, Why?
- B2-Q6 Does the {CAHPS/your survey/both} measure processes of care or service issues that you think are important? *IF YES*, which ones? *IF NO*, why not? What could be improved or added?
- B2-Q7 Does the {CAHPS/your survey/both} provide you with actionable data? *IF YES*, in what areas? How most commonly used? *IF NO*, what would you like to see produced by the CAHPS development team that would make it actionable? (Probe: specific changes or different measures)
- D-Q6 What data is most useful to your organization for benchmarking or for making comparisons? PROBE: Local? Regional? National? Other, e.g. by Specialty? Group size? Urban? Rural?)?

- D-Q7 Are data from the consumer assessment surveys compared to benchmarks such as NCBD or the NCQA Quality Compass data?
- E-Q6 What aspects of the CAHPS survey or methods are useful for QI?
- E-Q7 How do you use CAHPS for QI? For example: benchmark, to identify problem areas, to establish improvement goals, to develop specific interventions, to monitor intervention effectiveness...
- E-Q16 What do you think are the key barriers for using CAHPS data for quality improvement?

2. THE IMPORTANCE OF CONSUMER REPORTED MEASURES AND HEALTH PLAN'S USE OF CAHPS

Managed care organizations use performance measures for quality improvement in various degrees and level of sophistication (Scanlon et al, 2001). Few studies have broadly examined the importance of consumer reported measures and how health plans incorporate performance measures into their quality improvement programs. Most of the existing studies discuss specific quality improvement initiatives, focusing primarily on impetus and design rather than the usage and utility of the measure (Goverman 1994; Kinney and Gift, 1997). Published literature that systematically examines the role and value of HEDIS and CAHPS for purposes of quality improvement is also scarce. Again this literature is more focused on best practices (NCQA, 1999; Gustafson, et al., 1997; Hillman and Goldfarb, 1995; Long, et al., 2001), reporting (Smith, et al. 2001; McCormick, et al., 2002) or identifying QI issues (Landon, Tobias, and Epstein, 1998), but not on actual improvement or the specific use of measures. One study found that managed care organizations use performance measures for quality improvement in various degrees and levels of sophistication (Scanlon et al, 2001).

Two additional studies hypothesize that key drivers, both internal and external to the organization, significantly influence the degree to which managed care organizations engage in QI activities (Bodenheimer and Casalino, 1999; Parisi, 1997). They suggest that voluntary regulatory bodies, such as NCQA and the Joint Commission on Accreditation of Healthcare Organizations, and purchasers, such as private employers, Medicare, and Medicaid, dictate plan QI activity through their various requirements. Some argue that such influence can be counterproductive if it narrows the focus of quality to a small number of measures, some of which might not be applicable to the populations served by particular plans (Bodenheimer and Casalino, 1999). Others argue that requirements of external drivers can serve as catalysts for achieving provider participation, securing budgetary resources for QI initiatives, and refocusing and building organizational structures and technical capacity for QI (Scanlon et al, 2000; Galvin and McGlynn, 2003).

We found that health plans have many types of data that they access for improvement initiatives and assessing their performance. As stated by one plan, they have “consumer-reported measures alongside HEDIS, internal member satisfaction surveys, Touch point reports or indicators, BCBS standards, claims and complaints data, etc.”. For CAHPS to be useful in Quality Improvement (QI) activities, it is helpful to understand what importance health plans give to consumer-reported measures vs. other performance measures (and why) as well as to understand how they use the CAHPS data. This section addresses these two issues.

The CAHPS survey measures health plan performance on several dimensions including global rating (e.g., ratings of health plan, primary doctors or nurse, specialty care) and reports of experiences with using a health plan (e.g., doctor or nurse listened and showed respect, could get an appointment when needed, got specialty referral when needed, plan responded to concerns or questions). The ratings are individual items using response scales ranging from 0 to 10. The reports of experiences are composite scores that are averages of responses to sets of individual

items using three- or four-category response options (Agency for Healthcare Research and Quality, 1999).

For CAHPS to be useful in quality improvement (QI) activities it is important to understand what importance health plans give to consumer-reported measures versus other performance measures and why, as well as to understand how they use the CAHPS data. This section addresses these two issues. First we report interview results regarding how health plans view consumer-reported measures in general, and how they use them for various activities, including marketing, competitive positioning, and quality improvement. Then we report interview results regarding how health plans use CAHPS as one source of consumer-reported measures. (Refer to Section 3 for assessments by the interviewed health plans of the specific strengths and weaknesses of CAHPS as an information source.)

IMPORTANCE OF CONSUMER-REPORTED MEASURES IN GENERAL

We report here the opinions of the interviewed health plans regarding consumer-reported measures as well as information about which departments within health plans receive or demand consumer assessment information.

- 1. The majority of the health plans interviewed felt that consumer reports on their experience with care and customer service were equally or more important relative to other performance issues, such as clinical quality measures or cost information. The majority of health plan representatives also indicated that their organizations placed a high priority on measuring and improving performance based on consumer-reported measures.**

Highlights:

- 41 percent of the health plans indicated that consumer reports on their health plan experiences were more important than other performance issues, such as clinical quality or cost, and another 52 percent indicated they were equally important.*
- The main reasons why consumer-reported measures were important to health plans were expectations by customers for effective service, competitive pressures to be service-driven or customer-focused, and the nature of consumer reported measures as the only way to understand what consumers think and how they interact with their health plans.*

Of the 27 interviews conducted, 30 percent of the plans indicated that consumer reports were more important than clinical measures, and an additional 11 percent indicated that it was their top priority and extremely important relative to other measures. Another 52 percent of the health plans indicated that consumer reports on their experience were equally important relative to other performance issues, such as clinical quality or cost. Only 7 percent (two plans) indicated that consumer reports were not more important than other performance issues.

Of the 11 health plans who believed consumer reported measures were extremely important (3 plans) or more important than other measures (8 plans), 3 plans indicated that their health plans are service-driven and 3 other plans indicated that they must be customer-focused

because of competition. The other 5 health plans indicated that consumer reported measures were the only way to understand what the consumer thinks and to understand their reality of interacting with the health plan. As indicated by one health plan:

“The voice of the customer adds context and provides an understanding and an insight into the hard data that is collected on the behavioral data that utilization management or quality assurance provides. It is very important to match the behavioral data with the context of the customer. The attitudinal opinions of our members need to be compared with the hard behavioral data to provide a balance and counterweight.”

Of the 14 health plans indicating that consumer reports were equally as important as clinical quality and cost performance issues, 9 plans indicated that it was important to understand consumer-reported measures because of customer service and customer satisfaction demands. Two of the plans cited accreditation requirements as a motivating force. Three of the plans had various other explanations, such as their importance in choosing an insurance company.

The two health plans that indicated that consumer-reported measures were not more important than other performance measures had varying views. One plan indicated that consumer reported measures were “much less important than clinical measures because many things can affect people’s perceptions, including what they read in the media, without a lot of actual experience”. The other health plan indicated that consumer-reported measures are not important because they are “not received in a timely manner and therefore are not used in improvement initiatives”.

Interview responses indicate that health plans act on these views about consumer-reported measures, with 59 percent of the plan representatives interviewed indicating that their organization placed a high priority on measuring and improving performance on consumer-reported measures. An additional 15 percent of the plans indicated that use of consumer reported measures was medium to high priority while 22 percent indicated that it was medium priority. None of the plans reported that it was a low priority to their organization.

The high priority placed on these measures is revealed in many ways. Four plans indicated that consumer-reported measures and service projects have been assigned high priority explicitly and given visibility within the company. Three plans indicated that substantial numbers of projects and budget have been designated for collecting, analyzing and using consumer reported measures. Three plans pointed to use of these measures in performance guarantees, while two plans indicated they were used in strategic planning and identifying key drivers of performance. One health plan reported that consumer-reported data were reported publicly and also used for marketing and sales. Another plan mentioned, “The activities involved in supporting the NCQA accreditation process are strong”.

- 2. Use of consumer-reported measures is widely distributed throughout the health plans. The demand for consumer assessment information primarily comes from quality improvement (QI) related departments, but also from senior management, marketing, and departments overseeing accreditation preparation.**

Highlights:

- *70 percent of the health plans interviewed indicated that consumer reported data, including CAHPS and other types of data, were sent to quality improvement departments, committees, and teams*
- *The demand for consumer reported data within the health plans came from QI departments, committees and teams (44 percent of plans), senior management (32 percent), marketing (28 percent) and accreditation (28) percent*

Consumer-reported data are used widely throughout health plans. The majority (70 percent) of the health plans interviewed indicated that consumer reported CAHPS results are sent to quality improvement departments, committees, and teams. Almost half of the health plans (48 percent) indicated that consumer reported data were sent to directors, executives and senior management. One third of the health plans (37 percent) indicated that consumer reported results were sent to marketing, market strategy, sales, and product development. Other recipients of the consumer reported data were other departments or business segments/units (30 percent of plans), the Board of Directors (15 percent); health services research functions (7 percent), research, decision support, and business intelligence units (15 percent), the entire organization (11 percent), and outside advisors (7 percent).

The demand for consumer assessment information and data within the health plans comes primarily from QI related departments, committees and teams, as reported by 44.0 percent of the health plans. One third of the plans (32 percent) reported they had demand for consumer assessment information from directors, senior management and executives. Other sources of demand were marketing, sales and product development functions (28 percent) the accreditation function (28 percent), and the customer service function (20 percent).

3. In performance reports using consumer-reported measures, health plans indicated that benchmarks and trend analysis were the two most important elements. Regional data were more useful to their organization than local or national data when making comparisons or benchmarking.

Highlights:

- *89 percent of the health plans indicated that benchmarks were important in reporting consumer reported measures, while 70.4 percent also indicated trend analysis was important.*
- *78 percent of the health plans compare consumer-reported measures to benchmarks.*
- *85 percent of the health plans indicated that regional data was the most useful to their organization.*

Given the importance placed by health plans on information reported by consumers regarding their health care experiences and customer service, and the widespread use of consumer-reported measures by plans, it is useful to understand how plans report consumer-reported measures. Health plan representatives were asked which measurement and reporting features were most important to them in a report containing consumer-reported measures. As

shown in Table 2.1, benchmarks and trend analysis were identified as important report features by 89 percent and 70 percent of health plans, respectively. The next most important features were identified by far fewer health plans. The unit of analysis was identified by only 30 percent of the plans, and type of scoring was identified by only 26 percent of the plans.

Table 2.1
Features of Plan Performance Reports That Are Important to Health Plans

Report Feature	Identified as Important by Plans	
	Number	Percentage
Benchmarks	24	89%
Type of scoring	7	26
Trend analysis	19	70
Unit of analysis	8	30
Additional types of performance data	5	19
Reporting to various audiences	5	19
Did not respond	1	4

When asked whether they compare their consumer-reported data to benchmarks, 78 percent of the health plans indicated that they do and 22 percent indicated that they do not make these comparisons. When making benchmark comparisons, 85 percent of the health plans reported that regional data were useful to their organization, while 59 percent reported that national data was important and only 22 percent indicated that local data were important.

The majority of health plans (67 percent) indicated that consumer-reported measures and quality data were available in their state. Three health plans (11 percent) indicated that consumer reported measures and quality data were available in only some—but not *all*—of the states in their regions. Five health plans indicated that benchmark consumer-reported quality data were not available to them, and one health plan representative did not know.

4. CAHPS is an important source of consumer-reported data that has credibility with the health plans. CAHPS was reported by health plans as credible in terms of its scientific integrity and its topic areas, but a smaller percentage of health plans found CAHPS credible in terms of the specificity of information generated from the survey.

Highlights:

- 76 percent of the health plans found CAHPS credible in terms of scientific integrity.
- 64 percent of the plans found CAHPS credible in terms of topic areas.
- 40 percent of the plans found it credible in terms of the specificity of information generated by the survey.

When asked specifically about CAHPS consumer reported measures, health plans indicated that CAHPS was an important source of information and was a credible source for consumer experiences with their care and customer service. As shown in Table 2.2, 76 percent

of health plans interviewed found CAHPS credible in terms of its scientific credibility. This scientific credibility for CAHPS was reported to be due to its standardization (15 percent), consistent, trendable responses (7.4 percent), and its recognition and acceptance in the field (4 percent). For topic areas covered, CAHPS was credible to 64 percent of the interviewed plans and somewhat credible to another 16 percent.

Table 2.2
Health Plans' Views Regarding the Credibility of CAHPS

	Percentage of Plans Reporting CAHPS Feature is Credible		
	Scientific Integrity	Topic Areas	Specificity
No, not credible	12%	20%	52%
Yes, credible	76	64	40
Somewhat credible	8	16	4
Don't know	4	0	8

The views of health plans differed on the credibility of CAHPS regarding the specificity of information generated from the survey, with 52 percent of the health plans reporting the specificity of CAHPS to not be credible, 40 percent reporting it to be credible, and 4 percent reporting it to be somewhat credible.

The health plans that felt the specificity of CAHPS was not credible identified the following issues with the survey:

- Too general and not specific enough (N=8)
- Cannot do medical group/provider level analysis (N=3)
- Not actionable because the scale is too broad, from 0 to 10 (N=1)
- More customizable questions are needed (N=1)

Some plans that indicated CAHPS was credible in terms of its specificity also raised several issues that qualified their assessment. They felt the specificity of CAHPS had the following limitations:

- Unclear about member's perception of timeliness of care (N=1)
- Does not have provider level analysis (N=1)
- Composites do not contain relevant aspects of issue (N=1)
- Recall is a problem over a 12 month period (N=1)

HEALTH PLANS' USE OF CAHPS

As health plans have many types of data that they can access for improvement initiatives and assessing their performance, it is important to understand the extent to which health plans use CAHPS data (and why). This section discusses the use of CAHPS by health plans, and it provides details concerning the surveys used by health plans in conjunction with CAHPS. Finally, it presents the health plans' opinions about the main functions of the CAHPS data.

5. A large majority of health plans use CAHPS consumer-reported data in conjunction with other surveys and data sources. Most often health plans use the adult CAHPS survey and analyze the data only at the plan-level.

Highlights:

- 78 percent of health plans interviewed indicated that use CAHPS in conjunction with other survey data
- All 4 of the health plans that were selected because they “currently did not use CAHPS” indicated that they primarily did not use CAHPS because the cost of accreditation was too high and CAHPS did not fulfill their specific needs

Of the 27 health plans interviewed, 4 health plans used only CAHPS, 2 health plans used only other survey instruments and not CAHPS, and 21 health plans used both CAHPS and other surveys to collect consumer experience with care data. Two of the health plans that were selected because they “did not use CAHPS” actually reported not using CAHPS for their commercial product, but currently did use CAHPS for Medicare. They were classified in this case as using CAHPS and other survey data. Thus, 93 percent of the health plans interviewed use CAHPS (by design) and 78 percent use CAHPS in conjunction with other survey data.

As stated, four health plans were selected because they currently did not use CAHPS, although all of them had used it in the past. These health plans reported that they did not currently use CAHPS primarily because they chose not to get NCQA accreditation because it was too costly, and the CAHPS data did not meet their specific needs. These four plans also gave other extenuating circumstances or reasons that led them to discontinue using CAHPS, however in every case the health plan mentioned the high cost of accreditation and the availability of other member surveys that could satisfy their needs, particularly the BCBSA member survey.

Moreover, two-thirds of all of the health plan representatives that were interviewed indicated that they were “very familiar” with the CAHPS survey and one-third indicated that they were “familiar” with the CAHPS survey (on a five point scale from not familiar to very familiar).

Of the 25 who reported using CAHPS, 21 health plans used only the adult survey and 4 of the plans currently used both the child and the adult surveys. A few of the health plan representatives indicated that they used to use the child survey, for one year, but did not give explicit reasons why they discontinued using it.

Of the health plans that use CAHPS, all of them indicated that they conducted plan-level analysis with CAHPS. However, 22 of the health plans (82 percent) conducted only plan-level analysis with CAHPS, while 2 health plans reported conducting plan-level, medical group-level and provider-level analyses. One plan indicated that they conduct plan level analysis and contract specific analyses. Another plan indicated that they conduct plan-level analyses and pool analyses across PPO plans.

Health plans collected other consumer surveys of various types, besides CAHPS. Of the health plans that use CAHPS (n=25), 78 percent reported that they also used at least one other survey besides CAHPS. These plans administered an average of 1.74 other consumer surveys, ranging from 0-5 other surveys. In addition, 10 of the plans that use CAHPS and other survey data indicated that they compare, synthesize, or otherwise use the survey data together.

The 25 interviews with health plans that field CAHPS, yielded data on 40 other surveys used in conjunction with CAHPS: 35 surveys that were administered to consumers and 5 surveys that were administered to other audiences. Moreover, the number of other consumer surveys used in conjunction with CAHPS did not vary by the health plan's CAHPS performance from 2000-2002, by region, or by model type. These surveys are described in detail in Table 2.3 in terms of their type, respondents, reference period, and frequency.

The interview process did not capture the specific reasons why the health plans use these other surveys. However it is important to highlight what the interview data suggests concerning the relative importance of CAHPS compared to other consumer surveys for QI. We found that a significant number of the other surveys that health plans are using, which are outlined in Table 2.3, are similar to CAHPS in terms of being administered to consumers as a member survey or customer service survey. The majority of these other consumer surveys and customer service surveys were visit-based or allowed from more levels of analysis than at the plan-level, allowing for more specific and different types of analysis than allowed by CAHPS. In general, health plans reported that because of the limitations of CAHPS in terms of specificity and plan-level analysis, they needed to use other surveys and data sources to drill down in their QI activities, specifically in terms of developing and monitoring interventions. More research needs to investigate specifically how health plans integrate and analyze CAHPS alongside other surveys and performance measures.

6. Health plans reported using CAHPS data in the areas of quality improvement, credentialing and marketing. Health Plans indicated that they use CAHPS in their quality improvement efforts because it allows for benchmarking, provides reliable and valid data, and provides consumer-reported data that is not available from another source.

Highlights:

- *84 percent of health plans indicated that CAHPS was useful for quality improvement activities, but many of these plans also indicated that CAHPS was not their sole source of data for QI.*
- *44 percent of health plans indicated that CAHPS data is not actionable, 30 percent indicated that it is actionable, and 26 percent indicated that its actionability depends on the topic area addressed in the survey.*
- *85 percent of the health plans reported the data specificity was the primary barrier that restricted CAHPS from playing a more integral role in quality improvement.*

Table 2.3
Surveys that Health Plans Reported using in Conjunction with CAHPS

Surveys Administered to Consumers, besides CAHPS (N=35 surveys)

Customer Service Survey (33 percent; 13/40 surveys)

- Eleven encounter-based surveys and two surveys did not have the reference period specified
- Five surveys are monthly, 1 bi-annually, five annual, and two not specified

Member Survey (38 percent; 15/40 surveys)

- Five surveys used 12-month reference, one used a 6-month reference, eight were visit-based, and one survey did not have the reference period specified
- Two surveys monthly, 11 annual, and two not specified

Disease Management Survey (5 percent; 2/40 surveys)

- One encounter-based survey, one survey with a 12-month reference period; both were annual

Provider Survey, answered by consumers (5 percent; 2/40 surveys)

- One survey with a 12-month reference period and one survey that did not have the reference period specified; both were annual

Hospital Survey (8 percent; 3/40 surveys)

- Two visit-based surveys and one survey that did not have the reference period specified; all three were annual

Surveys Administered to Other Audiences besides consumers (N=5 Surveys)

Employer Survey, answered by employers (3 percent; 1/40 surveys)

- One survey with a 12 month reference period; annual

Medical Group Survey, answered by medical groups (3 percent; 1/40 surveys)

- One survey with the reference period not specified; annual

Provider Survey, answered by providers (8 percent; 3/40 surveys)

- Two visit-based surveys and one survey with the reference period not specified; one was annual and two surveys did not have frequency specified.
-

When asked about specific functions of CAHPS, the majority of health plans indicated that CAHPS was useful for quality improvement activities (84 percent), credentialing (56 percent), and marketing (56 percent), as shown in Table 2.4. Fewer health plans indicated that CAHPS was useful for consumer choice of health plans (44 percent) and purchaser contracting (48 percent).

Table 2.4
Functions for which CAHPS is Useful to Health Plans

	Percentage of Plan Responses (sum across row)			
	Yes, Useful	No, Not Useful	Don't Know	Missing
Consumer Choice of health plans	44%	48%	4%	4%
Purchaser Contracting	48	48	4	0
Credentialing	56	32	12	0
Quality Improvement activities	84	12	0	4
Marketing or advertising	56	40	0	4

Note: A total of 25 health plans responded to this question.

Of the 21 health plans that indicated CAHPS was useful for quality improvement, 11 plans indicated that they currently use CAHPS in their QI activities because it allows for benchmarking, provides reliable and valid data, and provides consumer reported data that does not come from another source. However, when asked whether CAHPS data was actionable, 12 health plans (44 percent) indicated that it is not actionable, 8 health plans indicated that it is actionable (30 percent) and 7 health plans (26 percent) indicated that it depends on the topic area addressed in the survey.

Data specificity was the primary barrier that restricted CAHPS from playing a more integral role in quality improvement. As shown in Table 2.5, 85 percent of the interviewed health plans reported this barrier. Other barriers reported by the plans, which also are presented in Table 2.5, include data aggregation, timeliness of data, and content of measures.

Table 2.5
CAHPS Features That Are Barriers to Health Plans'
Use of CAHPS in Quality Improvement

CAHPS Feature	Percentage of Plans Reporting Feature is a Barrier
Data aggregation	48%
Data specificity	85
Timeliness of data	48
Content of measures	48
Administration issues	30
Frequency of fielding	15

Note: Responses were to separate yes/no questions that asked about each feature, so the percentages reported do not sum.

- In terms of quality improvement, CAHPS data is used most often in the area of customer service. After customer service, four areas were of similar priority – complaints and appeals, access to care, availability of providers and paperwork and claims.**

Highlights:

- 25 percent of priority measures reported by health plans were in the area of Customer Service.
- After Customer Service, several areas were of equal priority in the CAHPS data: Access to care, Availability of providers, and Paperwork and claims.

Health plan representatives identified, the consumer assessment measures that were priorities to their organization's quality improvement activities, for which they collected data from both CAHPS and the other consumer surveys that they administer. Each plan listed up to three measures and indicated whether the priority measure was in CAHPS or not. The 27 health plans reported a total of 71 priority measures. As reported in Table 2.6, 49 of the 71 measures (69 percent) were from the CAHPS survey and 19 measures (27 percent) were from other types of consumer surveys. For three of the measures, the health plan representative did not indicate whether it was from CAHPS or another consumer survey. The majority of the priority measures were in the area of customer service. After customer service, four areas were of similar priority: complaints and appeals, access to care, availability of providers, and paperwork and claims.

Table 2.6
Priority Quality Improvement Measures Reported by Health Plans, Grouped by Domain

Domain	Number of Measures Reported by Data Source			Total
	From CAHPS	From Other Survey	Source Not Specified	
Access to care	7	0	1	8
Availability of providers	7	1	0	8
Complaints and appeals	6	2	1	9
Provider communication	0	0	0	0
Coordination of care	0	2	0	2
Customer service	10	7	1	18
Information and materials	5	1	0	6
Paperwork and claims	7	1	0	8
Health plan authorization of care	0	0	0	0
Ancillary clinical services	0	1	0	1
Preventative care	0	0	0	0
Overall rating of health plan	5	0	0	5

Note: A total of 71 different measures were identified by health plans as priority areas for their quality improvement activities.

In this section, we have reviewed why consumer-reported measures about their health care experience is important to health plans and the extent to which health plans use the CAHPS data and other consumer surveys for QI and other functions. Through this review, we have learned that CAHPS is a credible source for consumer assessment information about their care and customer service and that health plans use CAHPS primarily for benchmarking, trending,

and quality improvement. However, several issues were raised concerning the inadequate specificity of CAHPS data that prevents CAHPS from being a more useful information source for quality improvement activities. This may be one of the main reasons why health plans also are investing money and time in collecting other consumer reported performance measures. These issues and others will be discussed in greater detail in the next chapter, which lays out the health plans' opinions of the strengths and weaknesses of CAHPS.

3. FEEDBACK ON CAHPS' STRENGTHS AND WEAKNESSES

According to the health plans interviewed, CAHPS has strengths that they value as well as several weaknesses that limit its ability to assist plans in quality improvement activities. Overall, CAHPS is a good, general tool that assists health plans in comparing themselves to other health plans, and for trending and benchmarking. Its utility stems primarily from its scientific credibility and the array of appropriate topics covered in the CAHPS survey. Plans did not appear to want to change the existing content areas of the survey, but they were interested in refining items and adding items.

The following themes provide useful information for our work on strengthening CAHPS for use in quality improvement initiatives by health plans. They also offer a useful context for understanding the health plans' input on specific design changes being considered for the CAHPS survey, which are presented in Section 4. The themes identified here did not vary by plan groups as defined by the sample selection criteria (not fielding CAHPS; not publicly reporting CAHPS; or publicly reporting plans grouped based on CAHPS performance from 2000 to 2002).

STRENGTHS AND WEAKNESSES OF CAHPS IDENTIFIED

We begin with identification of the most and least useful topic areas in CAHPS as reported by the health plans. Then we present suggestions made by the health plans for additions to CAHPS, followed by reports of the type of other surveys health plans use in conjunction with the CAHPS data in QI activities

- 8. CAHPS is used primarily for trending, benchmarking, making comparisons to other health plans, and identification of quality improvement issue areas. Moreover, health plans rated CAHPS' standardization, capability for trending, and its appropriate unit of analysis as its best features.**

Highlights:

- *85 percent felt the main strength of CAHPS was trending and benchmarking for comparisons with other health plans*
- *78 percent used CAHPS to identify quality improvement issues*
- *44 percent used CAHPS because it is required for NCQA accreditation*
- *CAHPS standardization was rated by the health plans as an 8 on a 0 to 10 scale*
- *CAHPS trending and unit of analysis were rated by the health plans as a 7 on a 0 to 10 scale*

Of the of 27 health plan interviews conducted, 85 percent indicated that the main strength and use of CAHPS was trending, benchmarking and making comparisons to other health plans. Additionally, 78 percent of the plans indicated that they used CAHPS primarily to identify quality improvement issues and areas. When asked to rate several characteristics of the CAHPS

survey on a scale from 0 to 10, with 0 being the worst and 10 being the best possible, the health plans responded by rating CAHPS' standardization, trending, and unit of analysis as its best features. Their responses are summarized in Table 3.1.

Table 3.1
Health Plan Ratings of the CAHPS Survey Strength on Various Characteristics

	Rating Scores Reported by Health Plans (scale of 0 to 10)				
	Mean	Count	Maximum	Minimum	SD
Standardized	8.4	27	10.0	5.0	1.5
Appropriate unit of analysis	7.1	26	10.0	1.0	2.4
Affordable/cost effective	5.3	26	9.0	1.0	1.8
Timeliness for QI use	5.2	26	10.0	0.0	2.6
Capable of trending	7.4	27	10.0	0.0	2.3

NOTE: The scale is from 0 to 10, with 0 being the worst and 10 being the best.

When a health plan rated any one of the characteristics lower than a 7, we asked for their reasoning during the interview process since this data was collected from the pre-interview survey. The health plans that rated CAHPS low on its unit of analysis (N=6) indicated that CAHPS was not actionable and needed to be more customized or specific in terms of unit of analysis and question drill downs. Of those that did not report CAHPS as affordable or cost effective, three health plans stated that CAHPS was too expensive, while 6 indicated that its utility was low for their purposes. Eight health plans indicated that they receive the CAHPS data too late for it to be effective in QI, and 3 health plans indicated that the frequent changes in CAHPS items makes it difficult to trend. There have been 3 versions in 7 years.

As stated in one interview, "CAHPS is great for standardization. No other survey does this." Another health plan commented, "CAHPS has done a good job of getting a common background across all the health plans. This means plans are talking a common language and on a similar platform. There is a common method and common vendors. There is some equivalency there. CAHPS has provided us standardization."

Many plans remarked on CAHPS ability to benchmark and make comparisons. For example, one plan said, "CAHPS allows us to benchmark our plan against other plans. It gives us anecdotal information, but not information that can be used to manage the plan. We look at the results and compare them over time and against other plans, that is i.e. competitors".

One health plan representative indicated, "The one thing that I really like about CAHPS is that it is audited data and it allows us to compare our plan nationally against other plans. It gives us a jumping off point. It does not give us some of the detail that we want when we want to go out and obtain physician specific data to determine what or who is driving the problem. But I like having this sort of data and we do not have this type of data from any other surveys. Benchmarking and comparing is its highest value."

A few plans commented that one problem with trending was changes made to CAHPS over time. "From the standpoint of the entire team of people at our health plan, including the market

strategy people, the changes in the CAHPS surveys that have happened each year have been a particular problem for trending. And trending is what is most useful with CAHPS”.

The health plans also commented on the usefulness of CAHPS in identifying issue areas. As one plan said, “CAHPS validates findings or shifts focus, but does not identify new issues. It is a tool to gauge what members are experiencing and feeling. The measures that we use to measure ourselves are complaint resolution, access, customer service and pharmacy benefits.”

Another health plan reported it this way: “We have used CAHPS for accessibility, complaint resolution, and claims processing QI projects, specifically, in terms of improving customer service, which we have been doing for 3 years. We use benchmarks of specific customer service questions (e.g. calling for help, accessibility). CAHPS and the benchmarks are part of our goals in measuring customer service. We knew that there were problems in this customer service area and that the members knew that there were problems in this area as well. So the CAHPS data identified this as a problem.”

Many plans made the distinction about the usefulness of CAHPS as it relates to issues under the plan’s control or under the provider’s control. “CAHPS is useful because it clearly delineates the member satisfaction with what is going on with the clinician and what is going on in the health plan. ... The services operation areas make a lot of adjustments based on the CAHPS data and use it in determining how the changes have affected service improvement. On the clinician side, it is hard to get our arms around the issues, and it is sometimes hard to determine what the member is specifically unhappy about regarding their experience with the practitioner. But it is still good information and we use it to go deeper into other data sources. We see patterns over time in the CAHPS data and how it relates to our other data.”

There was a prevailing view that the health plans used CAHPS because it is required by NCQA and accreditation. Many of the health plans (44 percent) explicitly stated that they used CAHPS because it was required for NCQA accreditation. It was also evident from the interviews that CAHPS was perceived as useful because of the scientific integrity of the survey, its standardization, and the array of topics that are covered in the CAHPS survey. An example of how its usefulness was characterized was one health plan that stipulated “CAHPS is also a direct line to the customer to gain feedback from consumers and where they stand with us.” Further investigation of this juxtaposition felt by plans of on one hand fielding CAHPS primarily because of accreditation and on the other hand, the depth of the overall utility of CAHPS for QI is needed.

9. The content topic areas covered in the CAHPS survey are relevant to health plans, but within a few of the topic areas, health plans want to add more items and make some specific changes to existing items.

Highlights:

- 63 percent of the health plans felt the topics covered by CAHPS were appropriate
- Topic areas on CAHPS that were most useful:
 - Customer service (89 percent)

- *Access to care (59 percent)*
- *Claims and paper work (59 percent)*
- *Topic area on CAHPS that was least useful – provider communication (67 percent)*
- *30 percent wanted more questions on health plan customer service issues*
- *19 percent disliked the negative frame of the “How much of a problem is.” CAHPS question stem*
- *22 percent felt the specialist referral questions were too focused on HMOs*
- *Health plans rated the CAHPS composites as stable, but not very actionable.*
- *CAHPS composite dealing with ‘plan customer service’ was rated the highest across several various characteristics, followed closely by ‘getting needed care’ and ‘getting care when needed’.*

The majority of the health plans (63 percent) indicated that the content of the topics covered in the CAHPS survey was fine. As reported by one health plan, “The content of the survey measures a lot of things that the health plans are unable to measure themselves. The content is great”. The remaining ten health plans (36 percent) provided suggestions to improve the CAHPS content. Eight of the ten plans indicated that more questions should be added for customer service, health plan services, and operations; while five plans indicated that the content areas were too general. Moreover, in the ensuing discussion concerning the most and least useful topic areas covered by CAHPS, the health plans elaborated further on the content of the CAHPS survey. Table 3.2 reports the topic areas in CAHPS that the respondents reported as most and least useful. The percents shown are mutually exclusive counts of health plans.

Table 3.2
CAHPS Topic Areas that Health Plans Reported as Most Useful and Least Useful

CAHPS Domain	Percentage of Health Plans that Identified the Topic:	
	Most Useful	Least Useful
Overall Ratings	37%	7%
Access to Care	59	11
Availability of Providers	37	11
Provider Communication	0	67
Complaints and Appeals	19	4
Health Plan Services:		
Customer Service	89	4
Claims and Paperwork	59	4
Information and Materials	37	15

Note: A total of 27 health plans responded to this question.

Health plans indicated that the most useful topics were on customer service (89 percent), claims and paperwork (59 percent), access (59 percent), availability (37 percent), and the overall ratings (37 percent). More questions on customer service and health plan service issues were requested by 30 percent of the plans. The CAHPS questions the plans judged to be least useful

were those on provider communication (67 percent). All of the plans that indicated these questions were “least useful” stated that provider-specific data was needed to make the questions more useful.

A few plans felt that the least useful questions were those on information and materials (15 percent) and getting care when needed (11 percent). The health plans that indicated the questions on written information and materials were “least useful” stated that the questions “were too general”, “needed to be better defined”, or “were not specific enough to act on”. The plans that rated the questions regarding care when needed as “least useful” said they did so because they could not control providers’ actions.

Health plans also reported that the most useful questions were those that provided data on issues over which the health plans had control. One plan summed it up nicely: “In general, the more useful questions are the ones concerning what the health plan controls and the least useful are those questions about issues not in the health plans control”.

A few plans (19 percent) complained about the negative frame to questions that asked, “How much of a problem is.” One health plan that currently does not field CAHPS indicated, “The issue is not the overall content of the questions. The issue is that the questions should be asked more objectively. For example, the questions ask, “How much of a problem is.” This type of lead makes these questions inherently biased. The survey is implying that it is a problem by the way that it is asked, even with the option of “It is not a problem”. The survey is putting words in the customer’s mouth. The phrasing seems biased and badly phrased.”

A few plans (22 percent) suggested that the approach of questions on referrals to a specialist should be changed. As one health plan indicated, “Currently all questions on specialists are focused on the health plan. We need a question about access to specialists. In this environment with open access HMO and PPOs we need questions on direct access to specialists. Their needs to be questions about customer satisfaction with their ability to access a specialist from a health plan that do not require a referral. Also how satisfied customers are with the number of specialists in the network.”

In addition to commenting on the usefulness of the questions, many of the health plans wanted to add questions, primarily in the area of customer service, to gain more specificity. Table 3.3 lists the suggestions by the health plans for additional questions by topic area. One plan suggested the following: “We are interested in questions such as, was the phone answered in how many minutes. On operation issues, was the representative polite? Did she give you her name? We want data based on behaviors and not on subjective opinion. For example, we would think that being polite and caring in tone would be important. But the first thing is whether the rep is knowledgeable and then whether the rep did what was promised. CAHPS does not ask about resolution. The point is, did you get what is promised to you during the encounter.” Another health plan suggested the following: “The customer service questions on CAHPS are something like: Was your call handled the way you wanted it to be? Was it handled to your satisfaction? What we added and what we wanted to know was whether the customer service representative sounded like they cared and that they did what they said they would do in a timely fashion.”

Table 3.3
Additional Questions the Health Plans Suggested to Add to CAHPS by Topic Area

<p>Access to Care</p> <ul style="list-style-type: none"> • Questions on the time it takes to get into an office routine visit, preventative health care visit, and urgent visit • Question about appointment availability for after hour care that would complete all the standards for QI 5 • Questions concerning wait time on the phone and calling during off hours • Questions whether their waiting times were reasonable (emergent or urgent)
<p>Availability of Providers</p> <ul style="list-style-type: none"> • No suggestions for additional questions in this topic area
<p>Provider Communication</p> <ul style="list-style-type: none"> • Questions on whether the patient believes they have received thorough care and was approached by their physician in a caring and polite manner
<p>Complaints and Appeals</p> <ul style="list-style-type: none"> • No suggestions for additional questions in this topic area
<p>Customer Service</p> <ul style="list-style-type: none"> • Questions about why they called, what happened on their last call, how was the issue resolved, were their questions answered right the first time • Questions about the representative’s politeness and did she give his/her name. • Questions about representative’s communication in terms of being polite and caring in tone, being knowledgeable, whether the rep did what was promised, and did the consumer get what was promised to them during the encounter
<p>Claims and Paperwork</p> <ul style="list-style-type: none"> • Questions to better understand consumer expectations with their problems and complaints and their claims. For example, on-line customer service expectations are different than on the phone. On-line they want more immediate gratification. This new medium is changing the models. • Question on claims processes that include more questions about timeliness and accuracy of the process
<p>Information and Materials</p> <ul style="list-style-type: none"> • How they feel about the health plan generally, health plan communications, what is their understanding of the plan, who provides them the information on the plan -- is it from the company, or the health plan representative, or how did they get their information and data • Question on whether consumer got their membership ID card on time • Questions on cost of their premiums, percentage of premiums are paid by employer, if in fact their employer pays for it, out of pocket costs, prescription costs, co-payments, etc.

- Questions with specific feedback on how much consumers use on-line services, how helpful it is, satisfaction with website, gained/got what needed from the website
- Questions about whether consumers are accessing information about cost and quality on-line to make their decision about a plan and or primary care physician

Other Suggestions and Additions

- Questions on the health care delivery system
- Questions that evaluate the “Why” behind the ratings and other questions
- Questions related to the new services added by health plans, such as wellness programs, alternative therapy discount services, etc.
- Questions on pharmaceutical issues such as questions regarding satisfaction with benefits, the preference or use of generic vs. brand drugs
- Questions on patient safety and on disparities in health care

When asked to rate the specific CAHPS composites from 0 to 10, with 0 being the worst and 10 being the best possible, health plans indicated that the composite scores were stable overtime, but not very actionable. As shown in Table 3.4, the CAHPS composite dealing with plan customer service was rated the highest across the various characteristics, followed closely by getting needed care and care when needed.

**Table 3.4
Health Plan Ratings of the Characteristics of CAHPS Composites**

Composite Characteristic	Mean Ratings by Plans (scale of 0 to 10)				
	Getting Needed Care	Care When Needed	Provider Listen	Courtesy and Respect	Plan Customer Service
Actionable	5	5	3	4	6
Stable	8	8	8	8	8
Relevant	7	7	6	6	7
Credible	7	7	7	7	7

NOTE: The scale is from 0 to 10, with 0 being the worst and 10 being the best.

10. The main drawbacks of CAHPS for quality improvement activities are its lack of specificity, the timeliness of receiving the data, and aggregation of the questions concerning providers at the plan level. All of these issues limit CAHPS ability to provide actionable information for quality improvement and may explain why plans are fielding similar surveys with members.

Highlights:

- 74 percent identified the limited specificity of the survey as a drawback, including scope of survey items, unit of analysis (plan, group, provider), and type of health plan

- 41 percent identified poor timeliness of the survey as a drawback
- 70 percent wanted provider data aggregated at the group or individual clinician level

Specificity

Three-quarters (74 percent) of the plans indicated that specificity was a limitation for CAHPS. There are three main ways in which lack of specificity hinders its usefulness:

- The scope of the survey items (general versus specifically focused on actionable information)
- The unit of analysis (health plan, group, individual clinician)
- The fit of CAHPS items to the different type of health plans (HMO versus PPO or other fee-for-service models or other HMO model types)

Several plans commented on the lack of specificity in the scope of the questions. As stated by one plan, “We have some real concerns. Basically we think that there are lots and lots of drivers that could be influencing these questions. And because we don’t know what these drivers are, we can’t drill down. It’s also hard to know exactly what impact a particular score is measuring.” Another health plan reported, “The questions are too general to determine what the member meant. Interpreting the results is hard and needs other data to decipher what it means and to determine where the specific trouble occurred.” Another plan gave a good example, “Our concern is that many of the questions are not written in a way to really understand what the consumer feels and what the member’s perception really is. The questions on written materials provide a good example. It is difficult to know what particular piece of written material exactly the member is not satisfied with. The questions are sometimes not detailed enough. Therefore, it is hard in the analysis phase and also in building an initiative for improvement. Many times we feel like we are making a stab in the dark about what needs to be improved instead of being able to drill down to understand and breakdown the issues”.

Other health plans brought up another specificity issue with respect to the level of analysis (plan versus provider): “The CAHPS survey is broad. It is hard to know how to address the courteousness of staff or the doctor communication issues. These are not in control of the health plan. The data needs to be at the provider-level to address this issue.”

Several other plans spoke out about the CAHPS survey taking a managed care perspective. One plan said, “CAHPS is written from a managed care perspective. The referral questions are not appropriate. Patients in a PPO do not know how to answer the questions as they are currently written.” Morales, L., Elliott, M., Brown, J., Rahn, C., & Hays, R. D. (in press) also found this similar issue. Another plan stated, “In an IPA format, most of the data from CAHPS is directed toward the primary care physician, but not to a direct individual primary care physician. For this reason, we cannot get a lot out of the CAHPS data. It is so generalized that it does not have teeth to it for change.”

Several of the health plans (26 percent) reported they use a strategy that one health plan characterized as follows: “CAHPS is not diagnostic enough to create actionable initiatives. To compensate for this, we have used the additional 15 questions that NCQA allows to be added to

the CAHPS survey to help us drill down”. Other health plans (22 percent) also specifically mentioned using their own data sources to supplement the CAHPS data and to drill down. They also indicated that they verify the trends and patterns found in the CAHPS data against their other survey data and secondary sources in an effort to triangulate.

Timing and timeliness of receiving CAHPS data

Many of the health plans (41 percent) explicitly mentioned the issue of timing and timeliness of the CAHPS data. As one health plan indicated: “We use the CAHPS metrics for QI, but we’re finding that it is quite retrospective and not timely enough to pick up the opportunities for improvement, both in terms of reference period and timing of receiving the actual data.” One plan articulated the issue in the following words:

“Sometimes I look at the global CAHPS and say, ‘Oh there’s an issue – let’s look at the {Internal Survey} and see if there is more specific data that can be looked at. But in general, I’m not sure that can happen a lot. This is partly because CAHPS comes out in July and our {Internal Survey} comes out sooner in the year. So, it’s a timing issue.

If July is the baseline and we have 5 months left in the year to put an intervention in place, then we are already 6-7 months into the year for HEDIS, since it is based on the calendar year. The problem is once we’ve found an issue; we’ve already wasted almost a year. Interventions take time to put into place”.

Other health plans provided further perspective on the timing issue. As stated by one plan, “The primary problem is that the data is very old, by anybody’s standards, when it is received by the plan. When we finally receive the CAHPS results, the problem issue either went away because we have fixed it, it fixed itself, or the members went away because they were dissatisfied with the service. The same problem exists with HEDIS because we receive it at 18 months old.” Another plan recognized the dilemma inherent in this timing issue: “Even if we could move the survey back six months we would still run into the same issue of timing, because of the timing of administering the survey itself.”

Aggregated at the plan level

More than two-thirds of the health plans (70 percent) indicated that they would like to have provider-level CAHPS data. As one plan indicated, “We analyze the CAHPS data every year, trend it, etc. It is hard to isolate or to identify barriers or real targeted opportunities because we didn’t have clinician/group level information. The data was at the plan-level and we could not identify the specific primary care physician or the group level.”

Another plan also pointed out this mismatch between the content of the question and the data aggregation: “A lot of the CAHPS survey is based on the consumers’ experience with his/her doctor. One third of the survey is on these types of questions. We recognize the need, but CAHPS is weak on the health plan-oriented questions, although the data is aggregated at the health-plan level. It is the internal stuff going on behind the scene of the consumer that is the health plan’s responsibility, such as the health plan paying a claim.”

The health plans also believe that provider-level data would increase the actionability of CAHPS. This is reflected in a health plan's comment, "Doctor questions are not in the control of the health plan. If we could use these questions to give feedback to a doctor then the data would be actionable, but I am not sure about the sample size and the cost."

SUMMARY

Overall, the health plans that were interviewed indicated that CAHPS has various specific strengths and weaknesses that limit its ability to assist in quality improvement activities. It is a good, general tool that assists health plans to compare themselves to other health plans and to do trending and benchmarking. This usefulness stems primarily from its scientific credibility and the array of topics that are covered in the CAHPS survey. Plans do not appear to want to change the existing content areas of the survey, but they are interested in refining items and adding items.

Health plans further reported that CAHPS is limited in its ability to establish specific actions and interventions in improving their health plan's quality and performance. Reasons cited are that the CAHPS data are reported at the plan level and are anonymous rather than at the specific provider level, the contents of questions are too general, and results are not reported quickly enough back to health plans to allow for improvements and monitoring of interventions.

Given these limitations, the health plans reported they tend to supplement CAHPS with other, more real-time data (i.e. claims data or operations data such as average response time and average wait time) that are specific to their markets and to the content areas they have been identified as having problems. In addition, by supplementing the CAHPS data with other survey data, the health plans can pinpoint more specific issues on which they need to improve, to set and establish goals, and to monitor these interventions. In this on-going process of quality improvement, health plans report that CAHPS assists primarily in identifying the general area(s) that need improving, but is not diagnostic enough to identify needed improvements solely on its own.

4. FEEDBACK ON POSSIBLE CAHPS DESIGN CHANGES

In addition to identifying overarching themes, we conducted an item-by-item analysis of the health plans' responses to the design changes being considered for the CAHPS survey. The health plan representatives were asked the following introductory question, followed by a list of possible changes to the CAHPS survey:

- Q23. I'm going to read a list of changes that are being considered by the CAHPS II developers. Please tell me how important you think each change is to your future plans for consumer surveys.

The responses to these questions (Q23A through Q23G) were read and the reasons for their responses were coded. We first tabulated health plan responses regarding whether they were in favor of a particular change (responses of yes, no, or maybe). Then we coded the reasons reported by the health plan for why they were or were not in favor of each change.

ITEM BY ITEM ANALYSIS

Overall, we found that the health plans had favorable responses to several major design changes, as shown in Table 4.1, especially for the following changes:

- Collecting data at the plan, group and clinician level (70 percent),
- Reducing administration costs (67 percent), and
- Including items for common quality improvement efforts (63 percent).

Table 4.1
Percent in Favor and Not in Favor of Suggested Design Changes to the CAHPS Survey

Design Feedback (N=27)	Percentage		
	Yes	No	Maybe
Survey at plan, group, and clinician-level (Q23A)	70	15	15
More frequent data collection and reporting (Q23C)	48	44	8
Reduce survey administration costs (Q23D)	67	7	26
Include items for common QI efforts (Q23E)	63	15	22
Survey with non-physician providers (Q23F)	19	78	4
Change reference period (Q23G)	22	78	0

The majority of the health plans did not think that CAHPS should include questions about non-physician providers (78 percent) or change the reference period of the current survey (78 percent). There was no consensus about CAHPS providing a protocol for more frequent data collection and report feedback.

In the paragraphs that follow, we provide information on the reasons why health plans were or were not in favor of a design change. Because health plans had more than one reason for their opinions, these counts are not mutually exclusive.

Collecting CAHPS Data at the Plan, Group, and Clinician-Level

The health plan representatives interviewed had favorable responses to a CAHPS survey that collected data at the plan, group, and clinician level because they felt it could increase the specificity of the data and its usefulness in identifying problem areas and pinpoint interventions. The 17 health plans that were in favor of this change felt that it would “create more relevant data” (N=11) or “pinpoint direct interventions” (N=5). One plan agreed with the change, but worried about it “raising the cost of the surveys”. One plan did not comment.

The plans (N=8) that were *not* in favor of collecting plan-, group- and provider-level data (15 percent) gave the following reasons for their views:

- It would be “too costly” (four plans).
- It is both “costly and has sample size issues.” (two plans)
- This detailed level of analysis and surveying “should be done by the plans themselves.” (two plans)

Three health plans were undecided about collecting data at the plan, group and clinician level. Two plans indicated that it “depends on the specificity and focus of the questions” and one plan said that it “depends on the ability to trend the data”.

Developing a Visit-Specific Provider-Level Survey

Health plans were also asked about designing CAHPS as a provider-level survey. They were further asked whether it would be better to have the questions in a provider level survey, asked as visit-based or using a common reference period. As shown in Table 4.2, 33 percent of the plans indicated that the survey should be visit-based and 22 percent indicated that it should use a reference period common across all questions in the survey. The remaining 45 percent of the health plans (N=12) did not specify that either approach would be preferable; rather they indicated that the method would “depend on the content” of the provider level items or survey.

Table 4.2
Views of Health Plans on Visit-Based Questions for a Provider-Level Survey

	Percentage Responses
For the provider-level survey, is it better to have questions that are visit-based or with a common reference period (Q23H)	
Visit Based	33%
Common Reference period	22
Depends on Questions and Content	45

In addition, as shown in Table 4.3, 63 percent of the health plans reported it was feasible for them to collect visit-specific samples (i.e. they were capable of identifying when a visit occurred and who the provider was). Of those that indicated it was not feasible to collect this information, it was primarily because the health plan could not accurately link a visit with a

specific clinician. The link they had available to them was the link from a patient to a medical group. Overall, 44 percent of the health plans interviewed had visit-specific surveys. All 9 of the health plans that supported development of a visit-specific CAHPS survey currently administered visit-specific provider level survey. Three of the health plans that did not support a CAHPS visit-specific survey currently had visit-specific surveys. Two of these plans indicated they did not support a CAHPS visit-specific survey because they would rather continue to use their own visit-specific survey, which they had been using for a number of years. One plan indicated its use of a visit-specific CAHPS survey would depend on the content of the survey.

Table 4.3
Reports by Health Plans on the Feasibility of Visit-Based Surveys and Samples

	Responses on Survey Basis		
	Percent Yes	Percent No	Don't Know
Percentage of plans that currently use visit-specific samples (Q23J)	44%	56%	0%
Percentage of plans for which it is feasible to collect visit-specific samples (Q23J)	63	11	26

There were various comments concerning the development of a visit-specific provider-level survey. The 9 health plans that supported it offered a variety of comments. Health plans said that a visit-based survey at the plan level or at the provider level would:

- “Better pinpoint interventions” (N=3),
- “Replace what we are doing” (N=3),
- “Would need a larger sample size” (N=3).
- “Shorten the lag time of getting the data and results” (N=3),
- “Depends on the cost efficiency” (N=3)
- “Should include in the question the provider name and the reason for the visit” (N=2)
- Five of the supportive health plans did not comment on their reason for support.

The health plans that did not support the development of a visit-based survey gave various reasons for their opinions. They indicated that such a survey method:

- “Raised HIPAA issues” (N=2),
- “Is more beneficial to the providers and not to the health plans” (N=2),
- “A plan-level survey (i.e. CAHPS) that assessed overall care was fine and what was needed, not a visit-based survey” (N=2),
- “Could not accurately identify a primary care physician because of the medical group structure” (N=3)
- “Patients’ recall concerning a visit differed”(N=2),
- “Was too specific because a patient sees many doctors pertaining to a visit” (N=1)

- “The cost was too high given the sample sizes needed for this type of survey” (N=1).

Providing a Protocol for More Frequent Data Collection and Reporting

Health plans had mixed opinions regarding a protocol that provided more frequent data collection and reporting. A similar percentage of health plans were in favor (48 percent) and not in favor (44 percent) of providing more frequent data collection and reporting (Table 3.1). Of those who agreed with this change, four health plans indicated that this would “make data collection closer to the consumer’s incident and intervention”. Several health plans agreed with this change, but also voiced the following concerns:

- “Yes, but how would it be paid for” (N=5)
- “Yes, but maintain the quality of the data” (N=1)
- “Yes, have more frequent data collection, but still report it annually” (N=2)

Most of the plans that disagreed with this change did not comment on their reasons. However three health plans indicated that “it would be cost prohibitive”, two plans said they “want data collection that is more timely, not more frequent”, and two plans said they “have other data sources and do not need this”.

Reducing Survey Administration Costs

The majority of the health plans (67 percent) indicated that they would like to reduce the administration costs, but their views varied on how to do this (Table 4.1). Almost half of the plans (44 percent) wanted to shorten the survey to cut costs, and some of these plans offered the following comments:

- “Shortening the survey would “lower respondent/ consumer burden and make the survey clearer.” (N=3)
- “Shortening the survey would be a good idea because it would lower the cost of the survey overall.” (N=5)

Two health plans disagreed with the premise that shortening the survey would decrease the cost. One plan argued, “Shortening the survey will not impact the cost that much. The cost is really from the fixed cost to set up the sampling, the programming cost, and the internal analysis. The only reason to shorten the survey would be to impact response rates, not cost.”

A few health plans (15 percent) felt that using Internet survey administration would help reduce costs. On the other hand, 30 percent of the plans indicated that they would *not* suggest using the Internet. Reasons for this lack of support included concern that an Internet survey would “have a low response rate,” and that data from an Internet survey would have “response bias.”

Including Specific Items that can be Easily used for Common QI Efforts

Health plans supported including specific items to be used in common quality improvement efforts. The majority of plans (67 percent) indicated that they thought including additional items for common quality improvement efforts was a good idea (Table 4.1). Yet they

saw difficulties in this change, and they expressed some advice, concerns, or issues to be addressed in implementing such a change, as follows:

- “Needs to facilitate drilling down to the respondent level and the individual clinician-level” (N=3)
- “Focus on the experience with the health plan, instead of the doctor”(N=1)
- “Needs to be accompanied by addressing the issues of timeliness of receiving data and timing of data collection”(N=3)
- “Should be done with a modular, flexible approach” (N=2)
- “Should be done in a specific area for specific questions, not all questions” (N=3)

The health plans that did not agree or were unsure about adding QI items to the CAHPS survey raised the following issues in their comments:

- “No, would add burden and length” (N=1)
- “No, finding questions that fit all plans needs is hard” (N=1)
- “No, this survey is not the right method for this type of QI task” (N=1)
- “Maybe, it would depend on which specific measures and items were selected”(N=1)
- “Maybe, however certain QI items or tasks are selected based on NCQA Quality Improvement requirements” (N=2)
- “Maybe, if the issues or items were identified through focus groups with health plans” (N=1)

Developing a Survey or Module on Non-physician Providers

There was little support among the health plans for a non-physician provider module of CAHPS. The majority of the health plans (78 percent) indicated that they did not want a survey or module that collects information on care provided by non-physician providers (Table 4.1). Some of these plans offered the following reasons for their opinions:

- Non-physician practitioners are “too few in number to survey.” (N=6)
- Non-physician practitioners are “not an important group.” (N=3)

Only one of the five plans that agreed with having a non-physician practitioner survey module commented on its reasons. This plan indicated that they supported such a survey module for non-physician providers but worried about the complexities of designing such a module given that there are many different types of non-physician providers.

Changing the Reference Period

Health plans did not support changing the current reference periods on the CAHPS survey: 6 months for Medicare/Medicaid and 12 months for commercial. Overall, more than three-quarters of the health plans (78 percent) did not want to change the current reference period(s) of the survey (Table 4.1). Of the remaining plans that favored a change in the current reference period, two health plans suggested 3 months, 3 health plans preferred 6 months, and one health plan preferred 12 months.

SUMMARY

The health plans supported several major design changes. They supported collecting data at the plan, group and clinician level because they believed that this type of change would increase the specificity of the data and therefore increase its usefulness in QI activities, particularly in terms of identifying problem areas and pinpointing interventions. Those health plans that did not support this change were concerned mainly about cost and sample size issues.

Only one-third of the health plans responded favorably to the concept of creating a visit-based CAHPS survey for a provider-level survey. A substantial percentage of the plans already had their own visit-specific survey. Those in favor of a visit-based survey believed this change would assist them in targeting their QI interventions, potentially replacing their own visit-based member surveys, and would shorten the lag time of getting the data and results. Those that were undecided about the visit-based survey indicated that the appropriateness of a visit-based survey depended upon the specific content and items on such a survey. Those plans that did not support a visit-based CAHPS survey were concerned about HIPAA issues and differences in patients' recall concerning a visit-based versus a reference-period survey. However, these plans were in favor of a provider level survey that was not visit-specific.

Health plans also were in favor of reducing administration costs, but they were unclear on the best method. Almost half wanted to shorten the survey to cut costs, and a few plans supported using Internet administration to cut costs. Several plans disagreed that either of these strategies would cut costs and maintain a high quality sample.

Health plans supported including items on CAHPS for common quality improvement efforts, which would assist in drilling down to specific actionable issues and would help document improvements in those areas. However many concerns were voiced about how the common QI issues would be determined. The plans that did not support this design change echoed these concerns about how to effectively define the common QI issues for the survey, and they also were worried about adding respondent burden.

Changes to CAHPS that were not supported by the health plans were a module on non-physician providers, changing the existing reference periods of the CAHPS survey, and providing more frequent data collection and reporting.

Overall, health plans supported improving the CAHPS survey to make it more useful for QI efforts. They supported changes that would enable CAHPS to assist the health plans in drilling down deeper into issues that the health plans and providers face as well as better target interventions. They expressed concerns over making these changes and not increasing costs or survey length or losing the credibility, standardization, and comparability that is now present with the CAHPS data.

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**APPENDIX A.
PRE-INTERVIEW SURVEY AND INTERVIEW PROTOCOL**

All health plan representatives were asked to fill out and return the Pre-Interview Survey before the day of the interview. During the interview the interview protocol was followed.

CAHPS QUALITY IMPROVEMENT INTERVIEWS PRE-SURVEY

Pre-Interview Questions

How familiar you are with the CAHPS project?

Not Familiar	A little Familiar	Somewhat Familiar	Familiar	Very Familiar
0	1	2	3	4

With CAHPS Surveys?

Not Familiar	A little Familiar	Somewhat Familiar	Familiar	Very Familiar
0	1	2	3	4

With CAHPS Reports?

Not Familiar	A little Familiar	Somewhat Familiar	Familiar	Very Familiar
0	1	2	3	4

1. Which consumer assessment (customer service) measures are priorities for your organization’s quality improvement activities? (IDENTIFY UP TO 3; IF NONE, LEAVE TABLE EMPTY)

2. Which, if any, of these priority measures are obtained from CAHPS survey data? What other data sources are used for these measures?

Measure	CAHPS?	Other Data Sources
	Y N	
	Y N	
	Y N	

PLEASE COMPLETE THE FOLLOWING IF YOUR ORGANIZATION USES CAHPS.

3. Rate the following characteristics for the overall CAHPS survey on a scale of 0 to 10, with 0 being the worst and 10 being the best.

- Standardized
Comment? _____
- Appropriate unit of analysis
Comment? _____
- Affordable/cost effective
Comment? _____
- Timely for quality improvement
Comment? _____
- Capable of trending
Comment? _____

4. For each of the following characteristics of a useful performance measure (i.e. stable), rate the CAHPS composite measures on a scale of 0 to 10 with 0 being the worst and 10 being the best.

	CAHPS Composite: Needed Care	CAHPS Composite: Care When Needed	CAHPS Composite: Provider Listen	CAHPS Composite: Courtesy and Respect	CAHPS Composite: Plan Customer Service
Actionable					
Stable					
Relevant					
Credible					

**INTERVIEW PROTOCOL
CAHPS HEALTH PLAN QUALITY IMPROVEMENT INTERVIEWS**

INTERVIEW QUESTIONS

A. If you don't mind, why don't we start with some specific questions regarding your job responsibilities at _____ health plan?

1. We have your official job title listed as _____. Is that correct?
2. Can you describe your chief responsibilities?
3. How long have you been in your current position?
4. Who do you report to within the organization?
5. What model type is your health plan (e.g. IPA, group, staff, network, mixed)?
6. What is the plan's total enrollment?

**B.1. PERCEPTIONS OF INFORMATION FROM CONSUMER EXPERIENCES
WITH CARE SURVEYS**

Let me start with some questions about your opinions/your organization's view of consumer experience surveys in general.

1. How important do you think consumer reports on their experiences with care and customer service are relative to other performance issues, such as clinical quality measures like HEDIS, or cost information?
2. We're interested in the priority that your organization gives to measuring and improving performance based on consumer reported measures. Think about how this is reflected in the time, money, and/or visibility given to these kinds of measurement and improvement projects. Would you say, high, medium or low priority is placed on consumer reported performance measures? (B.2)

PROBE: What is the main factor(s) in your rating? % of budget, FTEs, number of projects
(Main issue: how important consumer measures are vs. other measures)

3. What is your organization most interested in knowing from consumers or patients about their experiences with their health care and customer service? Why? What drives them? (B.3)

4. Are there reports with quality data available for consumers in your state? CAHPS? Others?

**B.2. PERCEPTIONS OF THE CAHPS PRODUCTS OR CONSUMER SURVEYS
USED BY THEIR ORGANIZATION**

Next I have some questions about your experience with CAHPS or other Consumer Surveys.

1. What surveys do you use to collect consumer experience with care?

CAHPS - Yes/No:

Other- Yes/No:

Both-Yes/No:

IF CAHPS (C.1&D.1)

In CAHPS, which survey have you used?

-Adult / Child

What level of analysis?

- Plan / System / Group / Practitioner/ Other

Did you use a report? If so, which one?

IF OTHER SURVEY:

Can you tell me a little about the survey that you use?

Audience

Reference period

Frequency of administration

Unit of analysis

Could we get copies of these surveys sent to us?

What is the main reason that you choose to use this survey?

IF USE BOTH CAHPS & OTHER SURVEY:

Are the data compared, synthesized, or otherwise used together? (D.21)

2. Based on your experience, what are the main uses of CAHPS or the other surveys?

3. {CAHPS/your current survey/both surveys} useful for the following functions (B2.1)

CAHPS	OTHER SURVEY	BOTH
Yes / No	Yes / NO	Yes / NO

IF YES: In what ways? *IF NO:* Why hasn't it been useful?

- a. Consumer choice of health plans or providers
- b. Purchaser contracting with health plans or providers
- c. Credentialing of health plans or providers
- d. Quality improvement activities of health plans or providers
- e. Marketing, advertising to the public (D.29)
- f. Other uses

4. Now thinking about the content of the surveys, what do you find *most useful* about the content of the surveys you use? *Least Useful?* (D.4 & D.5)

5. To people important to you and your organization, is {CAHPS/your current survey} **credible** with respect to: (B2.3) Y/N, Why?

- a. Scientific integrity of the survey instrument

- b. Topic areas addressed by the survey
 - c. Specificity of the information generated from the survey
6. Does the {CAHPS/your survey/both} measure processes of care or service issues that you think are important? (D.7)
- IF YES*, which ones?
- IF NO*, why not? What could be improved or added?
7. Does the {CAHPS/your survey/both} provide you with actionable data? (D.8)
- IF YES*, in what areas? How most commonly used?
- IF NO*, what would you like to see produced from CAHPS that would make it actionable? (Probe: specific changes or different measures)

Health Plan/Group/Clinician Use of CAHPS

IF THE PLAN/GROUP USES CAHPS, ASK ABOUT CAHPS HERE. OTHERWISE ASK ABOUT THE SURVEY THEY USE. IF NO SURVEY, SKIP THE SECTION.

Administrative issues

1. What department or office is responsible for coordinating the collection of {CAHPS /your survey/both} in your organization? Does this involve a vendor? (D.32)
2. Who pays for your patient surveys? How much do you pay for your survey data? What are your sources of funding? Is it worth it? (D.33)

D. REPORTING CONSUMER ASSESSMENT SURVEY RESULTS

Next, I would like to talk about reporting issues.

1. Who in your organization receives the results of {CAHPS/your survey/both}? (D.19)
 2. Where is the demand coming from within your organization for the consumer assessment information (i.e., which offices/ departments/providers are actually using it)? (D.20)
 3. What do you think is important in a report? (D.24)
- PROBE:

--Benchmarks, type of scoring, trend analysis, unit of analysis, incorporation of additional types of performance data?

--Reporting to various audiences?

4. What data is most useful to your organization for benchmarking or for making comparisons?

PROBE: Local? Regional? National? Other, e.g. by Specialty? Group size? Urban? Rural? 330 funded?)? (D.26)

5. Are data from the consumer assessment surveys compared to benchmarks such as NCBD or the NCQA Quality Compass data?)? (D.27)

6. Do you publicly report the data to consumers? Do you report the data to purchasers? Any other audiences?)? (D.30)

a. *IF YES*, did you use the CAHPS template for reporting or design your own?

7. In which ways would your organization like to change the {CAHPS/Other} survey process? Are there barriers to being able to make these changes?

E. Quality Improvement Use

Use of Consumer Assessment Data in Quality Improvement

1. Where is your organization's quality improvement (QI) program placed in the organization? Who leads the program and how does it interact with other departments?)? (E.1)
2. How are QI information and data reported into the organization management and governance? How involved are the board and management in creating accountability for QI performance? (E.4)
3. What factors have contributed to defining the approach the organization takes for QI? (E.5)

Accountability and Incentives for Performance on Consumer Surveys

4. If you score well on your survey, who gets credit? If you do not score well, who is responsible for taking corrective actions/implementing improvements?)? (E.8)

5. Does your organization use incentives or penalties for providers for improvements or degradation on consumer assessment (customer service) measures? If so, what types of incentives are used (e.g., financial, recognition award, etc.) (E.10)
6. What aspects of the CAHPS survey or methods are useful for QI? (E.15)
7. How do you use CAHPS for QI? For example: benchmark, to identify problem areas, to establish improvement goals, to develop specific interventions, to monitor intervention effectiveness. (E.18)

CONSUMER ASSESSMENT PERFORMANCE MEASURES

In the pre-survey, you identified priority measures for your organization's quality improvement activities. *READ THROUGH THE LIST THEY GAVE. IF THEY DID NOT PROVIDE THIS INFORMATION, ASK THE QUESTIONS HERE.*

8. How are Quality Improvement issues prioritized? What factors lead to actionable changes from QI initiatives?
9. Taking one of these measures as an example, I would like to ask you questions about how a specific measure was used in QI activities. (E.11)

Measure: _____

- a. How was the area identified as needing attention?
- b. What measures were used for identification?
- c. What were the strengths/weaknesses of the measures and surveys?
- d. How were improvement goals established?
- e. Was benchmarking used in the process?
- f. Were specific interventions developed/acquired?
- g. Was the intervention monitored for effectiveness? Explain.

Use of CAHPS for Quality Improvement

8. Earlier you indicated that your organization {uses/doesn't use} CAHPS specifically for QI activities? Why or why not? (E.13)
9. If CAHPS is used, and no CAHPS measures are included in the list of important measures we discussed earlier, why is it not given high priority? (E.14)

10. What aspects of CAHPS restrict it from playing an integral role in QI? (Part of E.23)
 - a. data aggregation
 - b. data specificity
 - c. timeliness of CAHPS data to receive/generate report feedback
 - d. content of CAHPS measures
 - e. administration issues
 - f. frequency of fielding the instrument
 - g. open-ended questions with verbatim responses
 - h. specific elements of report such as benchmarks, type of scoring, trend analysis, unit of analysis
 - i. dissemination of reports (to all necessary parties in different modes)
 - j. Web-based report (including the ability to actively select data/comparisons to view, etc. vs. canned or less flexible reports on the web)

11. *[If not already in answering above and appropriate]* Can you tell us about a specific member satisfaction/customer service improvement project in which CAHPS data was used? (E.19)
 - a. How was the area identified as needing attention?
 - b. What measures were used for identification?
 - c. What were the strengths/weaknesses of the measures and surveys?
 - d. How were improvement goals established?
 - e. Was benchmarking used in the process?
 - f. Were specific interventions developed/acquired?
 - g. Was the intervention monitored for effectiveness? Explain.

Usefulness of CAHPS Measures for Quality Improvement

On the pre-survey, you rated several characteristics of the overall CAHPS survey on a scale of 0 to 10. *REVIEW THEM, OR ASK FOR RATINGS IF NOT GIVEN IN PRE-SURVEY*

12. What issues were you considering when you gave those ratings? (E.20)

(NOTE for Q14 and Q15: do not need to go over every individual rating. If there are ratings that are low i.e. 6s and below, then ask specifically what the factor is for that rating. If the ratings are all high do not probe for each dimension)

On the pre-survey, you rated several characteristics of the five CAHPS composites on a scale of 0 to 10. *REVIEW THEM, OR ASK FOR RATINGS IF NOT GIVEN IN PRE-SURVEY*

13. What issues were you considering when you gave those ratings? (E.21)

14. What do you think are the key barriers for using CAHPS data for quality improvement? (E.22)

20. What additional **tools or approaches** would be useful to you to develop information on why your organization achieved survey scores? (e.g., focus groups with staff, consumers, etc. to better determine the underlying source of the poor scores)? (E.28)

USE OF TRAINING

21. Is there training provided for employees or providers in your organization on patient experiences of care/customer service issues to improve performance on consumer surveys? (E.6)

22. What are the sources of ideas or expertise that you use for training on approaches to improve consumer assessment scores? (E.7)

DESIGN FEEDBACK

23. I'm going to read a list of changes that are being considered by the CAHPS II developers. Please tell me how important you think each change is to your future plans for consumer surveys.
 - a. Develop a group of surveys that provide data at the plan, group/clinic and clinician-level
This would allow for the surveys to be administered separately or together with a sampling and analysis plan that permits for a cost effective way to make estimates at more than one level (B2.2c)
 - b. Develop a visit-specific CAHPS survey (B2.2d)
 - c. Provide a protocol for more frequent data collection and report feedback (B2.2e)
 - d. Reduce survey administration costs by making the survey shorter, changing sampling strategies, or using alternative modes of administration such as internet based surveying, or interactive voice response. (B2.2f)
 - e. Include specific items that can be easily used for common QI efforts
 - f. Developing a survey or module that collects information on care provided by non-physician providers such as nurse-practitioners or physician assistants? Would this need to be different for

non-physician providers who work as part of a team with a sampled provider and those who practice independently? (D.6)

- g. Changing the reference period of the survey. What is the reference period for your current {CAHPS/your survey}? What is the ideal reference period? *IF OFFERS ONE*, why is it ideal? (D.10)
- h. For provider-level items, is it better to have questions that are visit-based or questions that use a common reference period (6 months Medicaid, 12 months Commercial and Medicare)? (D.11)
- i. We are thinking about developing visit-specific samples for CAHPS? Currently do you construct sampling frames? If so, what data systems and elements do you use? How accurate are they? (D.12)
- j. Does your data system allow for you to identify when a visit occurred and who the provider was? Would it be easy to collect visit-specific samples? (D.13)

PROBE: How feasible would it be to draw a sample of patients who have visits within a specified time period? Or to accurately identify an individual provider visited by a given patient?

G. CONCLUDING COMMENTS AND SUGGESTIONS

We have covered a lot of informative topics in this discussion, and we thank you for your participation.

What other topics or issues do you think are important that we have not already covered?

As we close, we'd like to know what is the most important lesson or message that you would like us to take away with us?