2008 Washington Medicaid Chronic Care Management Client Satisfaction Survey Project: Detailed Methodology and Disposition Report

Prepared by Qualis Health for:
Washington Department of Social and Health Services

Department of Social and Health Services Contacts:
Shirley Munkberg
Health and Recovery Services Administration
King County Care Partners Chronic Care Management Program
1 (360) 725-1648
munkbsa@dshs.wa.gov

Candace Goerhing
Aging and Disability Services Administration
Chronic Care Management Project
1 (360) 725-2562
goehrcs@dshs.wa.gov

Washington Medicaid Chronic Care Management Client Satisfaction Survey, 2008

In 2008, the Health and Recovery Services Administration (HRSA) and Aging & Disability Services Administration (ADSA) of the Washington State Department of Social and Health Services (DSHS) contracted with Qualis Health to conduct a modified Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey for their chronic care management programs. The following supplemental questions were included in the survey:

- The 8-element Client Satisfaction Questionnaire© (CSQ-8);
- The 13-element Patient Activation Measure© (PAM-13);
- The 5-element EQ-5D; and,
- Questions developed by the DSHS.

The goals of the project were to measure members' experiences and provide timely and useful information to program management. The HRSA and ADSA chronic care management program coordinators received feedback regarding member experiences through the annual stakeholder report, the "2008 Washington State Medicaid Chronic Care Management Program Client Satisfaction Survey Results." Qualis Health reported results for 3,873 complete and valid surveys in the three following program-specific reports:

- Aging and Disability Services Administration Chronic Care Management Project (ADSA);
- HRSA AmeriChoice Washington Chronic Care Management Project (AmeriChoice); and,
- HRSA King County Care Partners Chronic Care Management Project (King County).

Study Populations

Specific fee-for-service Medicaid populations were targeted for survey receipt of the 2008 client satisfaction survey. Ten (10) subpopulations related to the 3 chronic care management programs were of interest for this survey. The subpopulations represent cross-classification by (a) intervention type, (b) randomization status (treatment vs. abeyance), and (c) enrollment status.

- HRSA King County Care Partners Chronic Care Management Project
  - Randomized to treatment and enrolled
  - Randomized to treatment but not enrolled
  - Randomized to abeyance (control)
  - Medical Home (receives care from a Medical Home network provider)
- HRSA AmeriChoice Washington Chronic Care Management Project
  - Randomized to treatment and enrolled
  - Randomized to treatment but not enrolled
  - Randomized to abeyance (control)
- Aging and Disability Services Administration Chronic Care Management Project
  - Randomized to treatment and enrolled
  - Randomized to treatment but not enrolled
  - Randomized to abeyance (control)

Sample Frame

Sample selection for CAHPS surveys involved two steps: 1) selecting enrollment files based on eligibility criteria, and 2) selecting a random sample of clients from the eligible enrollment data. Simple random sampling was used for the 4 subpopulations where sampling was necessary. Table 1 below shows the population size and sample size for each of the 10 subpopulations.

Table 1 - Subpopulations and Sample Sizes

Subpopulation	Population Size	Sample Size
HRSA King County Care Partners Project		
Randomized to treatment and enrolled	234	234
Randomized to treatment and not enrolled	1,258	1,258
Randomized to abeyance	1,492	1,492
Medical Home	4,396	1,350
HRSA AmeriChoice Washington Project		
Randomized to treatment and enrolled	2,117	976
Randomized to treatment and not enrolled	5,881	976
Randomized to abeyance	8,007	1,952
Aging and Disability Services Project		
Randomized to treatment and enrolled	103	103
Randomized to treatment and not enrolled	165	165
Randomized to abeyance	944	944
Total	24,597	9,450

Survey Instrument

The main questionnaire was a modified version of the 2008 Adult Fee-for-Service CAHPS 4.0 instrument as published in the 2006 NCQA *HEDIS Volume 3, Specifications for Survey Measures*. The Spanish translation of the questionnaire provided by NCQA was used. Where questions were modified, DataStat provided the Spanish translations.

The core CAHPS questions covered the following topics:

- Getting care that is needed
- Getting care without long waits
- How well doctors communicate
- How people rated their health care
- How people rated their personal doctor or nurse
- How people rated the specialist they saw most often

Additionally, the questionnaire included questions about utilization of services, health status, and demographics in order to describe the survey respondents

Several sets of supplemental questions were utilized in this survey. These included the CSQ-8©, PAM 13©, EQ-5D, and DSHS derived questions. The 8-item version of the CSQ-8©, developed by researchers at the University of California at San Francisco (UCSF), was used to assess consumer satisfaction with health and social services. Use of this instrument was copyrighted; English and Spanish versions of the questionnaire were obtained from UCSF by Qualis Health and provided to DataStat, the survey implementation subcontractor, for insertion in the mail questionnaire packets as a stand-alone questionnaire. For the phone follow-up, the CSQ-8© questions were added after the CAHPS questions.

The 13-item PAM tool, developed by researchers at the University of Oregon at Eugene, was integrated into the CAHPS survey tool and used to assess patient activation in their own care. Use of this instrument was copyrighted; English and Spanish versions were provided by Insignia Health, licensing agent for the PAM 13. The 5 EQ-5D questions were also added. The EQ-5D is used to describe generic health status in terms of 5 dimensions:

- Mobility

- Self-care
- Usual activities
- Pain/discomfort
- Anxiety/depression

Each dimension comprises 3 levels, indicating no problems, some or moderate problems, and extreme problems. In addition, DSHS developed 7 questions that were integrated into the survey tool.

Copies of the final 2008 questionnaires and the CSQ-8 instruments are in Attachment A. Please see Attachment B for the CATI scripts.

Letters and Postcards

Modified versions of the standard CAHPS© letters and reminder postcards were used. Cover letters were customized and printed in English, with a non-customized Spanish version of the letter text on the backside. A text box containing a toll-free phone number appeared in Spanish at the bottom of the Spanish side of the cover letter, directing respondents to call the 800 number to request a Spanish questionnaire or interview, if needed.

Copies of the letters and the postcard texts can be found in Attachment C.

Data Collection (Field Activities)

The survey was administered over a 9-week period in the late winter and spring of 2008, using a mixed-mode (i.e., mail and phone) 4-wave protocol (Table 2). The protocol consisted of a first survey mailing, a first reminder postcard to all respondents, and a second survey mailing to non-respondents. A phone follow-up was conducted for all enrollees who had not responded to mailings. A minimum of 3 callback attempts to each sampled case was conducted.

Table 2 - Data Collection Calendar

EVENT	DATE
1st mailing of survey packets	February 6, 2008
1st reminder postcard	February 15, 2008
2nd mailing of survey packets	March 12, 2008
Phone follow-up start	March 26, 2008
Mail and phone data collection closed	April 23, 2008

First mail packets and first reminder postcards were sent to 9,442 enrollees in the survey sample frame. A total of 3,202 usable mail questionnaires were returned, based on CAHPS 4.0 definition of completeness as a questionnaire with at least 1 completed survey question. Of those, 3 Spanish language mailings were returned. DataStat successfully completed phone interviews for a total of 671 respondents (29 in Spanish). A few people completed both a phone and mail questionnaire, meaning that the number of mail and phone interviews is not mutually exclusive.

Field Data Cleaning and Preparation

Key steps in the data cleaning and preparation for analysis that was conducted by DataStat prior to sending to Qualis Health included the following:

- *Recodes for missing data, skips*. Based on responses to screener questions, respondents may be instructed to skip some questions. DataStat coded appropriately skipped items as missing and used ‘9’ to indicate missing data.
- *Reconciliation between mail and phone phases.* Due to the overlap of mail and phone phases, a small number of respondents may have completed 2 interviews. In such cases, the interview retained for analysis was the more complete of the 2. If both interviews were at equal levels of completion, responses provided in the mail questionnaire were retained.

Response Rate and Survey Disposition

The response rate for the overall survey project was 43.3%. Tables 3 and 4 report the survey dispositions for each subpopulation in summary and detailed format.

Table 3 - Survey Disposition Summary

Subpopulation	Total Survey Response Rate[1]
King County, Randomized to Treatment, Enrolled in Intervention	48.87%
King County, Randomized to Treatment, Not Enrolled in Intervention	34.86%
King County, Randomized to Abeyance	40.71%
CCMP Medical Home	35.46%
AmeriChoice, Randomized to Treatment, Enrolled in Intervention	57.57%
AmeriChoice, Randomized to Treatment, not Enrolled in Intervention	39.49%
AmeriChoice, Randomized to Abeyance	44.68%
ADSA, Randomized to Treatment, Enrolled in Intervention	61.22%
ADSA, Randomized to Treatment, Not Enrolled in Intervention	52.38%
ADSA, Randomized to Abeyance	51.56%
TOTAL	43.30%

---

[1] Total Usable Surveys/ (Initial Sample – Ineligibles*)
*Ineligibles include deceased, bad address and bad phone, language barrier, mentally or physically incapacitated, and does not meet program criteria.

Table 4 Survey Disposition Details

Subpopulation	Total Number of Usable Surveys[2]	Mail Response Rate[3]	Telephone Response Rate[4]	Raw Response Rate[5]	Total Survey Response Rate[6]
King County, Randomized to Treatment, Enrolled in Intervention	108	36.75%	9.40%	46.15%	48.87%
King County, Randomized to Treatment, Not Enrolled in Intervention	419	27.92%	5.41%	33.33%	34.86%
King County, Randomized to Abeyance	583	34.27%	4.83%	39.10%	40.71%
CCMP Medical Home	445	28.64%	4.38%	33.01%	35.46%
AmeriChoice, Randomized to Treatment, Enrolled in Intervention	544	42.73%	13.01%	55.74%	57.57%
AmeriChoice, Randomized to Treatment, not Enrolled in Intervention	370	30.05%	7.90%	37.95%	39.49%
AmeriChoice, Randomized to Abeyance	836	34.56%	8.31%	42.87%	44.68%
ADSA, Randomized to Treatment, Enrolled in Intervention	60	49.51%	8.74%	58.25%	61.22%
ADSA, Randomized to Treatment, Not Enrolled in Intervention	77	40.61%	6.06%	46.67%	52.38%
ADSA, Randomized to Abeyance	431	38.81%	6.89%	45.71%	51.56%
TOTAL	3,873	33.91%	7.11%	41.02%	43.30%

Data Analysis and Presentation

Overview

Results of data analyses contained in the stakeholder report were calculated using SAS version 9.1 and SUDAAN version 9.0.1. Statistical testing was completed using SUDAAN to properly account for

---

[2] Mail Usable Surveys+ Telephone Usable Surveys
[3] Mail Usable Surveys / Initial Sample
[4] Telephone Usable Surveys / Initial Sample
[5] Total Usable Surveys/ Initial Sample
[6] Total Usable Surveys/ (Initial Sample – Ineligibles*)
*Ineligibles include deceased, bad address and bad phone, language barrier, mentally or physically incapacitated, and does not meet program criteria.

weighting, stratification and differential sampling rates across subgroups. Survey responses were weighted to reflect the study population. Respondents were classified in either the treatment or control group based on their initial randomization, regardless of their enrollment status.

Completeness
Qualis Health analyzed a total of 3,873 complete surveys based on CAHPS 4.0 definition of completeness as a questionnaire with at least 1 completed survey question.

Other Data Validation and Cleaning
Qualis Health checked for out-of-range responses and found none.

Displaying Data
Most of the bar charts in the stakeholder report represent a range of responses. For charts reporting questions with *never/sometimes/usually/always* responses, “sometimes” and “never” were grouped together, while “usually” and “always” were presented separately.

The “never” and “sometimes” responses in the stacked, 3-category bar chart were combined to simplify the presentation of data. Results from repeated demonstrations of the CAHPS survey instruments indicate that the “never” response option is seldom selected by respondents. Typically less than 5% of the respondents select the “never” response to questions such as, “How often did doctors or other health providers listen carefully to you?”

Combining the “always” and the “usually” responses would result in severe loss of information. In CAHPS demonstration projects, about 50% of respondents stated that their health care providers “always” listen, explain, and respect their comments. Another 20% stated that their providers “usually” listen, explain, and respect their comments. Combining these categories would reduce the ability to discriminate performance on these items in the CAHPS survey. In other words, important information about health plans that consumers can use to examine plan performance is contained in the top 2 responses (“always” and “usually”) to the *never/sometimes/usually/always* questions.

Case-Mix Adjustment
People in worse health tend to report lower satisfaction and more problems with care than do people in better health. Older patients tend to report more satisfaction and fewer problems than do younger patients. There is some evidence that education level may affect scores as well, although the effects of age and education are not as strong as health status. Since case-mix may result in differences in ratings between subpopulations that are due to sampling error and not to differences in quality or satisfaction, the case-mix of each program client’s treatment and control groups were compared on general health status (question 45), age (question 60), and education (question 62). Standard overall chi-square tests were performed. The HRSA Americhoice Statewide Chronic Care Management program groups only differed significantly on the age measure. The King County Care Partners Chronic Care Management Program treatment and control groups differed significantly on self-reported health status measures, and the Aging and Disability Services Administration Intensive Chronic Care Management programs weighted treatment and control groups differed significantly on the education level measure.

Statistical Significance and Star Ratings
Overall chi-square tests were done to determine the significance of unadjusted differences between the treatment and control groups. When overall differences were significant, pair-wise comparisons were done. Subsequently regression analysis controlling for client age, gender, health status, and education level were done. P-values less than or equal to 0.05 were considered significant. No correction to the significance level was made for multiple comparisons. Significant findings were noted with stars on the stakeholder reports. Non-significant findings were not annotated.

Limitations and Cautions

The findings in the stakeholder report are subject to some limitations in the survey design, analysis, and interpretation. These limitations should be considered carefully when interpreting or generalizing the findings presented. These limitations include:

Case-mix
While there were some differences in self-reported general health status, age, and education between the treatment and control groups, it was not possible to test for possible other differences in enrollee characteristics that were not measured. These characteristics include income, employment, or others that may not be under the program's control for delivery of health services.

Single Point in Time
The results of this survey provide a snapshot comparison of subpopulations at a single point in time. These comparisons may not reflect stable patterns of consumer ratings over time.

Causal Inferences
Although the report examines whether enrollees of various subpopulations report differential satisfaction with various aspects of their health care experiences, these differences may not be attributed totally to the program. This analysis identifies whether enrollees in various subpopulations within a Chronic Care Management program give different ratings of satisfaction with their health care experience. The survey was not designed to examine why the differences exist.

Response Bias
Additionally, there is potential response bias in the survey results. The accuracy of these findings depends on how well respondents represent the overall population under study. If the 43.3% of clients that responded to the survey are systematically different than the study population, then conclusions drawn here may be incorrect

Intent-to-treat analysis
Finally, due to the study design, in which clients were randomized to the treatment and control groups prior to enrollment in the program, an intent-to-treat analysis was performed. This means a large percentage of those clients randomized to the treatment group (and analyzed as such) chose not to enroll in the program and therefore did not actually receive program services. If in fact the program was effective in improving clients' health care experiences and satisfaction, this would dilute the program effect and diminish the ability of this survey to detect statistically significant differences.