UNIVERSITY OF DELAWARE

The Quality of Health Care in Delaware: What Delawareans Say About Their Healthcare Experience

2003 Delaware CAHPS Notes

prepared for the
Delaware Health Care Commission

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TABLE OF CONTENTS

LIST OF FIGURES AND TABLES

What Consumers Say About the Quality of Their Health Plans and Medical Care
2003 Delaware CAHPS Notes

Prepared for the Delaware Health Care Commission by Eric Jacobson, Erin Kennedy, and Charles Whitmore, Institute for Public Administration, and Edward C. Ratledge, Center for Applied Demography and Survey Research, College of Human Resources, Education & Public Policy, May 2005.

Executive Summary

With exponential increases in health care costs on the horizon for the foreseeable future, providing higher quality health care is seen as one way to stem these increases. Efforts to measure and track quality have assumed increasing significance of late. In the world of health policy, the pendulum is swinging toward issues of quality. As if to punctuate the emergence of quality measurement in health care, a prodigious compilation of data was assembled and synthesized to produce a report on the current state of health care quality in the United States. The National Healthcare Quality Report, developed by the Agency for Healthcare Research and Quality (ARHQ), uses 147 measures—several derived from the National Consumer Assessment of Health Plans (CAHPS) Benchmarking Database—to gauge quality in everything from the screening for cervical cancer to the immunization of respiratory diseases to the chronic care provided in nursing homes. Finding high-quality health care to be anything but universal, the report notes that 37 of 57 areas with trend data have either shown no improvement or have worsened. The report card is *the first* comprehensive, national effort to measure the quality of health care for the entire country.

The *2003 Delaware CAHPS Notes* represents one such effort at the state level. The purpose of this report is to illustrate how Delawareans rate various health care providers and report on their specific experiences with the health care system—presenting summary results from the 2003 Delaware CAHPS study. The CAHPS survey instrument is a useful guide to policymakers seeking to improve both Delaware's health plans and the health care providers deliver to patients. It is the intent of this report to supply the relevant stakeholders and policymakers with objective, experience-based information regarding the quality of health care provided in Delaware. Equipped with three years of survey data (2001-2003), we generate comparisons of Delaware to national data benchmarks. We also discuss overall ratings and experiences with care within Delaware, health plan enrollment characteristics, and differences across plan types and regions.

Overall, both Delawareans and CAHPS respondents nationwide rate their doctors, specialists, health plans, and healthcare experiences highly. On a ten-point rating scale, with "10" the best possible rating and "0" the worst, the vast majority of respondents give ratings of at least a "7." With just one exception, a clear majority of Delawareans and CAHPS respondents nationwide report the most positive responses for questions that target specific experiences. In Delaware, for example, 75.9% of respondents give the most positive response to questions about *getting needed care*.

A key theme of this year's report is that, compared to the national CAHPS benchmarking data (NCBD), Delaware is worse in all four ratings (Doctor, Specialist, Health Care and Health Plan). Comparatively, it is also worse in 7 of 17 composite questions, including all questions that relate to health plan customer service. Judged against the previous year's Delaware CAHPS data, the ratings for all four categories in 2003 have gotten worse, and consumer reports for all but three composite questions have become more negative. When looking at the NCBD data, it does not follow the same trend as Delaware's values. In contrast, NCBD shows only one decrease in ratings (doctor), which is very slight. Similarly, NCBD only decreased in four out of the 17 composite questions, and there was no change in six of the questions, including all questions related to doctor's communication. Another example of a major change in Delaware since 2002 is in the area of

getting needed care by region. There has been an increase from 13.6% to 24.1% in consumer reports of facing "big" and "small problems." This percent is the worst it has been in three years in all three counties. In summary Delaware is more volatile than NCBD and more likely to be headed in the wrong direction.

The Importance of Measuring Quality

The importance of quality measures in health care has become a hot topic in the U.S. over the past few years, and was a major issue in 2004 elections. Improving the quality of care and reducing medical errors is one of the top four healthcare concerns Americans believe should be a main priority for the President and Congress this year. The survey conducted by Kaiser Family Foundation and the Harvard School of Public Health in November 2004 found that the public's attitudes regarding the healthcare agenda are focused on quality much more than in past years[1].

The quality of health care in this country is not at the level it should be; quality varies widely across health plans and providers. Many procedures, therapies, and prescription drugs are used too often while others are not used often enough. Although most of the information collected comes from managed care organizations, it is easy to see that quality is uneven throughout the industry. It is not only uneven in health plans, but also in physicians' offices, nursing homes, hospitals, and home healthcare agencies. By reporting on the quality of health care, consumers can make educated decisions, and competition between healthcare providers will spark increased performance and quality.

Quality measurement is fast becoming *the* critical issue in health policy. Why? First, quality measurement improves patient outcomes and decreases morbidity. As a recent study in *The New England Journal of Medicine* highlights, Americans typically receive only half of the care recommended by the current medical best practices.[2] The quality "gap" between care that is proven to work and the care that is actually delivered is an astonishingly wide, gaping chasm. Quality measurement will be an indispensable tool in exposing, and narrowing, this gap. Second, quality measurement saves money. George Halvorson and George Isham, in their new book *Epidemic of Care*, hit this theme often. After all, the authors note, "It costs a lot more to do [health] care wrong. It saves a lot of money to do it right."[3] Measuring quality identifies wrong care and right care.

Consider these two themes—improved patient outcomes and cost savings—then consider the devastating toll of "quality gaps" in the healthcare system. According to a recent National Committee for Quality Assurance (NCQA) report, this is the annual tally for failure to deliver appropriate, quality health care: up to 79,000 avoidable deaths, 41 million sick days, over $9 billion in lost productivity, and billions in hospital costs. These massive costs could be avoided, NCQA writes, "if well known 'best practices' were more widely adopted." The "quality gap" between what we know and what we do is expensive, and it is crippling.

In its seminal report, *To Err Is Human: Building a Safer Health System*, the Institute of Medicine (IOM) exposes the appallingly high number of medical errors that cripple the nation's healthcare system. IOM finds that "At least 44,000 people, and perhaps as many as 98,000 people, die in hospitals each year as a result of medical errors that could have been prevented." All too often, doctors operate on the wrong side of the brain, remove the wrong kidney, and fail to prescribe beta blockers to heart attack victims. And while many thousands of people die from medical errors, many thousands more die because known health conditions are not adequately monitored and controlled. Put another way, more than 1,000 Americans die

[1] Harvard School of Public Health and the Kaiser Family Foundation. "National Survey on Consumers' Experiences With Patient Safety and Quality Information." http://www.kff.org/kaiserpolls/pomr111704nr.cfm November 17, 2004.
[2] Elizabeth A. McGlynn, et al. "The Quality of Health Care Delivered to Adults in the United States." *The New England Journal of Medicine.* 2003. Vol. 348, No. 26.
[3] George C. Halvorson and George J. Isham, M.D. *Epidemic of Care*. Jossey-Bass. 2003. p.18.

each week, because the care they get is not consistent with the care that medical science says they should get. The healthcare infrastructure to drastically curtail these incidences of medical neglect, to prevent life-threatening mistakes from recurring, is not yet in place.

Quality measurement is the first step in building such an infrastructure. The IOM's *Crossing the Quality Chasm* report, released in March 2001, is in many ways the prism through which quality measurement is viewed. Taking a macro view of healthcare system, the purpose of the report is to "improve the health and functioning of the people of the United States." IOM articulates six principles to guide quality improvement: safety, effectiveness, *patient-centeredness*, *timeliness*, efficiency, and equity.

IOM's influence in quality circles is unmistakable. A recent Medicare Payment Advisory Commission (MedPAC) report to Congress, emphasized that the overall goals for quality of care in the Medicare program shall be consistent with those recommended by the IOM, namely, "that care be safe, effective, *patient-centered*, and *timely*." Indeed, IOM helped to shape the framework for the National Healthcare Quality Report. Donald M. Berwick, Harvard professor, CEO, and President of the Institute for Healthcare Improvement, in a recent *Health Affairs* article, calls for "more sophisticated, extensive, and informative measurement of performance and outcomes, especially with respect to the six [IOM] aims for improvement." Berwick's contribution expands on IOM aims (and confers legitimacy to CAHPS-based measures), particularly with respect to *patient-centeredness*, concluding that "patient's experiences should be the fundamental source of the definition of 'quality'."

Reporting quality information is a critical second step. The reason, pointed out in *Epidemic*, is that "care improves when quality is reported publicly."[4] As a private, nonprofit organization that assesses and reports on the quality of the nation's managed care plans, NCQA collects information regarding quality of care, access to care, and satisfaction with health plans and doctors, then generates report cards, making them publicly available so that consumers can compare provider performance before they purchase a plan. Taking quality information public improves quality of care, because consumers—armed with quality data—will demand the best while providers become incentivized to meet that demand. Doctors, for example, have a strong incentive to improve their management of diabetic patients when they know that their performance will be monitored publicly.

If consumers receive better care when quality is measured and reported, they also receive *less-expensive* care. Poor-quality, inappropriate care is expensive care. The Kaiser Family Foundation (KFF), like NCQA, estimates that "Not providing the best treatments costs the United States more than $1 billion per year in avoidable health care bills" (KFF Daily Report, 9/22/03). Some estimates are even higher. Unnecessary and avoidable episodes of congestive heart failure and preterm births create many billions of dollars in unnecessary and avoidable expenditures.

Some analyses estimate that closing the "quality gap" could generate cost savings ranging from 15% to 30% of the country's $1.4 trillion annual healthcare tab (Wall Street Journal, 12/23/03). But closing this gap begins with quality measurement. Measuring quality further enables payers and providers to level the tremendous quality variations that exist nationwide. "There are 'enormous variations' in health plans' rates of delivering the most-effective treatments or services" (KFF Daily Report 9/22/03)—and this variation in quality is quite expensive. Dr. John Wennberg, known for his research in healthcare variation, predicts that, "Medicare could trim 30% of its $285 billion budget by bringing the highest-spending regions of the U.S. in line with the rest." (WSJ, 12/23/03)

[4] Ibid. p. 29.

Recent initiatives, like ones taken by CMS, Leapfrog Group, and NCQA, aim to narrow the "quality gap," improve health care, and save money for all Americans. *In Delaware, rigorous quality measurement and quality-improvement efforts are essential if Delawareans are to receive a better value for the more than $3 billion spent annually on health care*. Based on national trends, more Delawareans are more concerned with the quality of their health care than ever before, but they have precious little information at their disposal. This report aims to address that concern.

Growth of CAHPS

Initially, CAHPS was designed to measure and report consumer's experience with their health plans and care provided. The wide use of the CAHPS program has made it an industry standard; this has allowed individuals the opportunity to comment on the quality of their health plan. However in the past few years the CAHPS program has grown in order to accommodate increasing standards for the quality of health care. One of the biggest improvements that CAHPS has brought to its users is the ability to customize their survey instruments. This allows users to better meet organizational, community, and market needs. Along with improving the existing system, CAHPS has created a survey to assess patients' experience across the spectrum of ambulatory care.

This new initiative, called Ambulatory CAHPS, establishes a set of goals for new instruments in assessing quality ambulatory care. This allows for users to assess the quality of care on a variety of levels within the ambulatory-care system by looking at health plans, medical groups, and individual physicians. It will also provide users with valuable information on their organizations and other similar organizations within the same market. The Ambulatory CAHPS program will retain the standardization of survey instruments and reporting measures that allow users to compare their results to those of other survey sponsors and to local and national benchmarks. Additionally, it will also facilitate quality-improvement efforts by offering users survey items that generate the specific and detailed data required for internal reporting and analysis. It is hoped that the initiative will establish a national standard for ambulatory care, as well as improve the quality of that care (www.cahps-sun.org/Home).

Comparison of Delaware to National CAHPS Benchmarking Database (NCBD)

Presented below are two sets of comparisons: (1) consumer ratings (e.g., on a scale of 1 to 10, how would you rate your health plan?) and (2) consumer reports of specific experiences with care (e.g., how often did you get care as soon as you wanted?).

Consumer Ratings

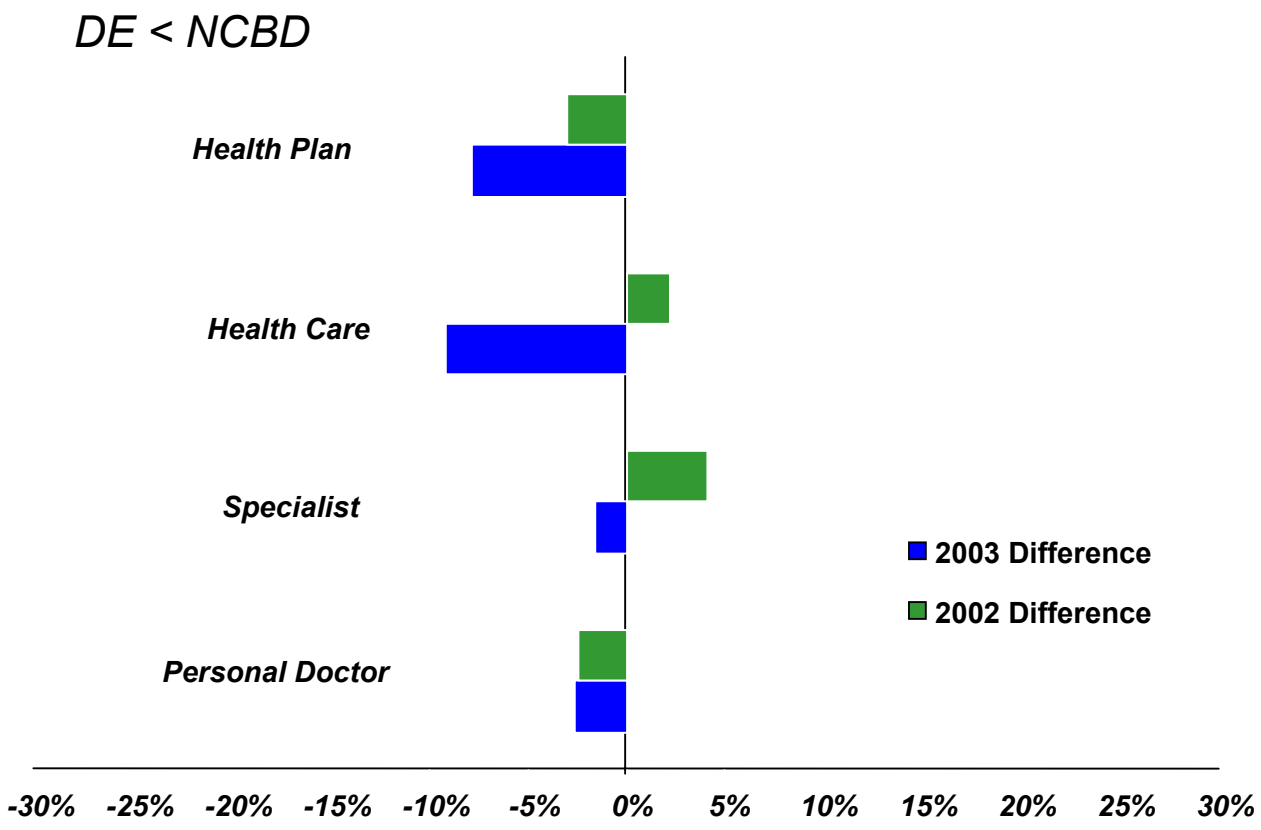
- Overall, both Delawareans and CAHPS respondents nationwide rate their health plan and health care experiences highly. For example, on a ten-point rating scale, with "10" the best possible rating and "0" the worst, the vast majority of Delaware's respondents give ratings of at least a "7" on questions asking about their overall health care and health plan (85.8% and 77.5%, respectively). Similarly, the NCBD reports that 88% and 80% of respondents rate their health care and their health plans "7" or higher. However, the Delaware ratings are down about 5%, and the NCBD ratings are up 1%. The consumer assessment data, therefore, show that Delaware is not keeping up with the national trend of improving health plan and healthcare quality ratings.

- Higher ratings are also the rule for personal doctors and specialists. Most Delaware respondents give ratings of at least a "7" to their doctors and specialists (87.6% and 87.3%, respectively), while the NCBD reports that 89% and 87% of respondents rate their doctors and specialists "7" or higher. However, Delaware's ratings have decreased this past year by 2%, whereas the NCBD

ratings have increased by 1% or stayed the same. Ratings for doctors and specialists also follow the same trend, where the national averages are on the rise and Delaware's ratings declining. If it were not for the repeated cases of Delaware's ratings heading in the opposite direction of the national ratings – albeit by small margins, the small changes noted easily could be considered statistical anomalies. Clearly these trends warrant further study.

- **Figure 1A** reveals the percentage of respondents who gave only the highest ratings ("9-10") for their health plans, health care, doctors, and specialists, comparing the percentage differences between Delaware and NCBD data. The figure presents two years of data (2002, 2003) and highlights the similarities between Delaware's findings and the NCBD data. This graph also shows that Delaware is worse off in all four ratings.

Figure 1A.
Comparison of Consumer Ratings: Delaware vs. NCBD



- For any one consumer-ratings comparison, Delaware and the NCBD do not differ by more than 10%. The margins, however, are increasing. Without exception, the absolute value of every 2003 difference is greater than 2002. Delaware tends to rate their health plan, health care, specialist, and doctors worse than the national benchmark. In 2003, Delawareans rated their

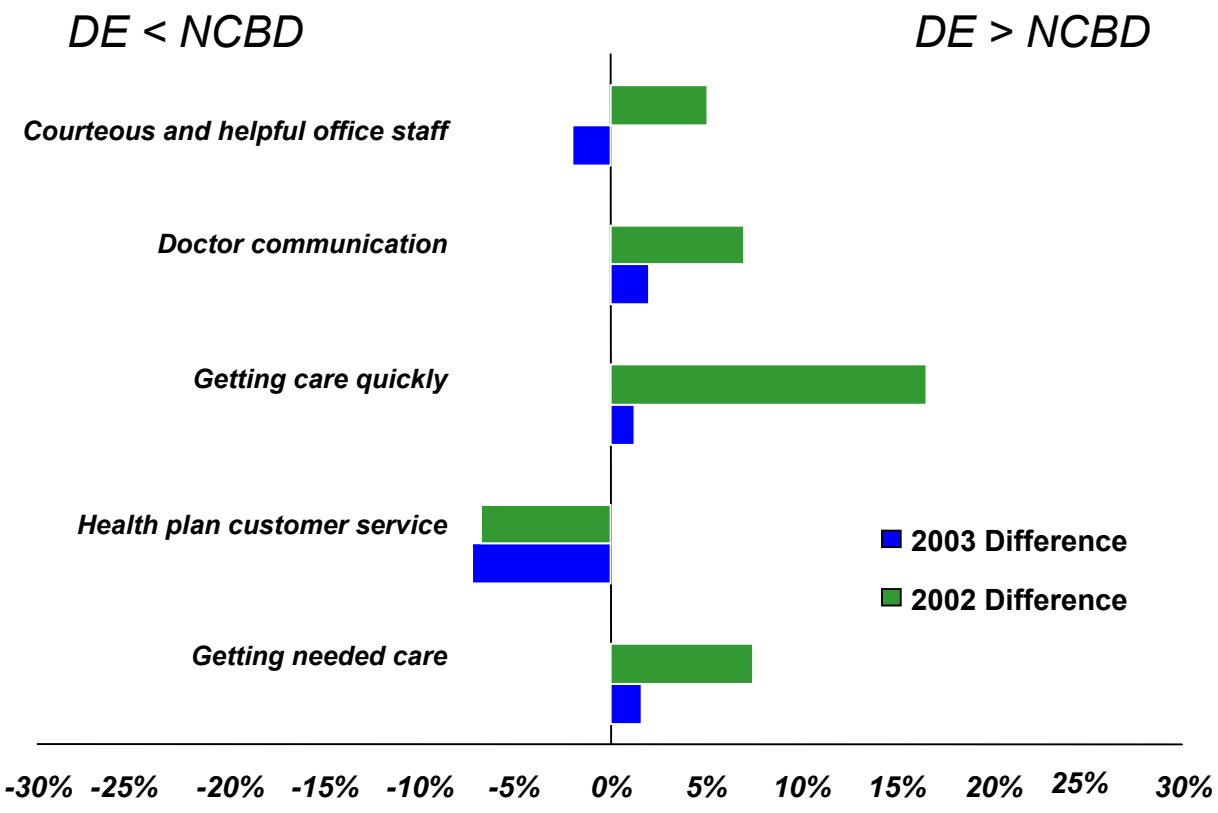
personal doctors lower than the national benchmark; however, doctors' communication ratings were higher than the national benchmark in all composite questions.

Consumer Reports of Specific Experiences with Care

- Delaware and the NCBD data show that respondents report encountering a *courteous and helpful office staff* 62.1% and 64.0% of the time, respectively. Compared to 2002, Delaware has decreased in service from office staff and is now less favorable than the NCBD benchmark.

- **Figure 1B** is constructed in the same manner as **1A** but evidences the percentage of respondents who gave only the most positive responses to questions related to specific experiences with some aspect of care or service. Like 1A, 1B compares the percentage differences between Delaware and NCBD data for 2002 and 2003. What **Figure 1B** also shows is that the discrepancies between Delaware and the NCBD data are about the same for consumer reports on specific experiences with care and the satisfactory ratings, with the exception of a few questions on *getting care quickly and health plan consumer service*.

Figure 1B.
Comparison of Consumer Reports on Experiences: DE vs. NCBD



- With the exception of one category—*health plan customer service*—a higher percentage of Delaware respondents gave the most favorable responses to questions tied to specific experiences with care. See **Appendix B** for a definition of the questions that comprise the *health plan customer service* composite.

- Delaware most noticeably exceeds national benchmarks with respect to *getting care quickly*—by 16.6%—for a specific composite question, which is about a 5.3% increase from 2002. Delaware also surpasses NCBD rates for *doctor's communication* and *getting needed care* for certain composite questions.

- Helping in part to explain the large differential in positive ratings for *getting care quickly* are responses to two questions in particular, namely, "When you needed care right away for an illness or injury, how often did you get care as soon as you wanted?" and "How often did you wait in the doctor's office or clinic more than 15 minutes past your appointment time?" For example, 75.9% of Delawareans report that they "always" got care for an illness or injury as soon as they had wanted it, compared to 70.0% of respondents from the NCBD sample. A more complete comparison of experience reports for each of the 17 individual questions that comprise the five separate composites is presented in **Appendix A, Figure A-14**. Though these figures show a positive rating for Delaware, there has been an overall increase in *getting needed care,* with both big and small problems. The percent of big and small problems has increased from 13.6% to 24.1% in the past year, which is the worst rating in three years.

- Running counter to the overall comparison, fewer Delaware respondents than the national benchmarks give the most positive reports for *health plan customer service* (national 58% vs. Del. 55.6%). All areas *of health plan consumer service* were less favorable in Delaware compared to the national benchmark. Compared to the national results, fewer Delawareans report the most positive response—by a difference of 0.6 and 6 percentage points, respectively—to the following questions: "How much of a problem was it to get help when you called customer service?" and "How much of a problem did you have with paperwork for your health plan?" Delawareans, it would appear, report more problems with customer service and health plan paperwork (see **Figure A-14**).

- Moreover, reports on *health plan customer service and getting care quickly* have not improved between 2002 and 2003, widening the discrepancy between Delaware and NCBD data. *These findings suggest that **health plan customer service and getting care quickly** continues to be a problem area for Delaware's health plans.*

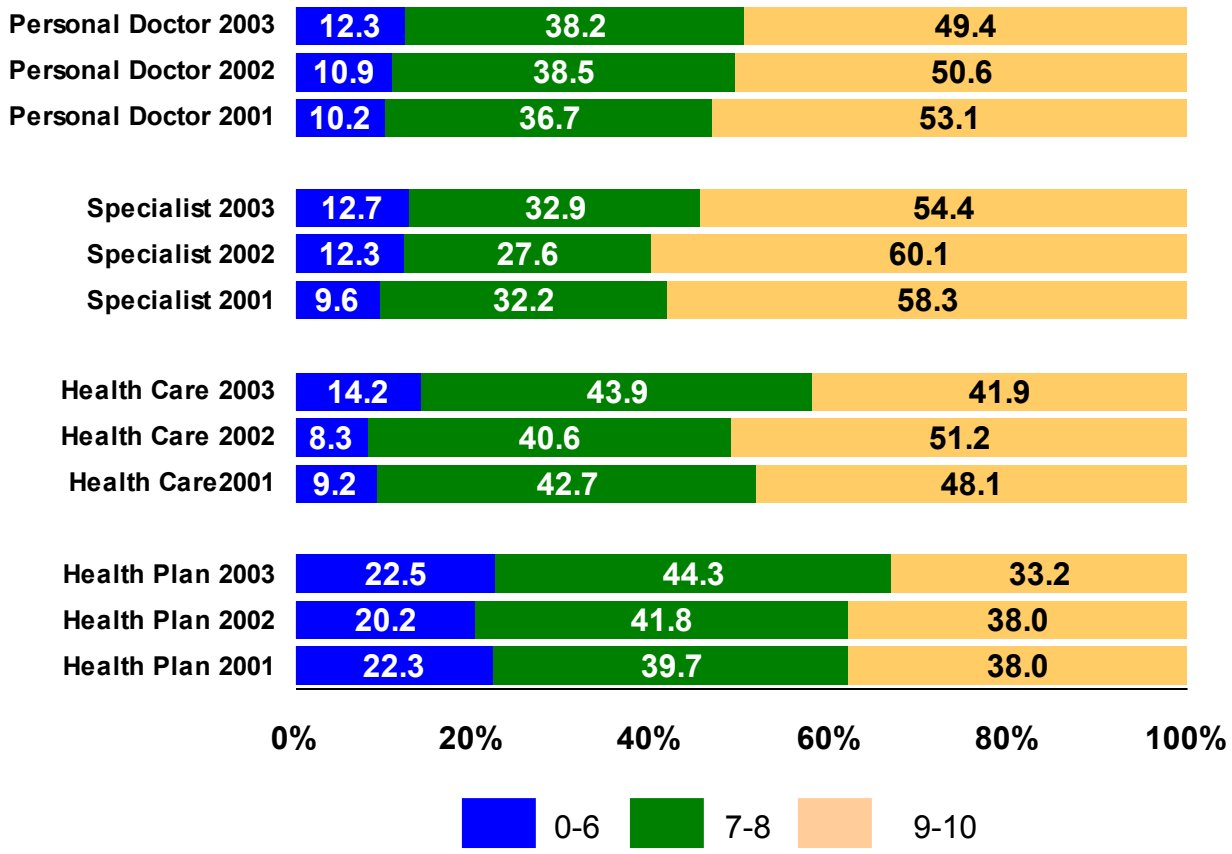
Summary of Delaware Findings

- Overall, as the previous section would suggest, Delawareans rate their doctors, specialists, health care, and health plans highly. **Figure 2** uses three years of data and shows that, on the whole, Delaware respondents give their health plans, health care, personal doctors, and specialists relatively high ratings. Recently, however, the data suggest ratings have either stayed the same or decreased during the past year. Delaware is worse off in all four ratings and has decreased in all but three composite questions.

- Respondents rate their health plans lower than they rate their personal doctors, specialists, and overall health care. Approximately 49% of respondents give the most positive ratings to their doctors, and 54.4% give similar, high ratings to their specialists. While 41.9% percent of respondents give the most positive ratings to their health care, just 33.2% of respondents give their health plans the most positive ratings. Though these numbers are positive, there has been a decrease in all four areas since 2002, some by more than 5%. In sum, Delaware is headed in the

wrong direction and may need to look at the CAHPS suggestions for improvement. For a more detailed breakdown of each rating by region and plan type, see **Table 1** and refer to **Appendix A**.

Figure 2.
Summary of Delaware Ratings, 2001 – 2003



- **Table 1** summarizes three years of ratings data. Specifically, the table presents year-to-year differences in overall ratings of personal doctor, specialists, quality of health care, and quality of health plan by plan type and region.

- For each of the cell entries, the "Yes" or "No" signifies whether or not the findings for that particular year are statistically significant. "No" indicates that there is no statistically significant difference in ratings by plan type or region; "Yes" indicates that there is categorical statistical independence, with a parenthetical insert to explain the nature of the difference. Thus, for quality of health care by region in 2002, there is a statistically significant difference. "K<NCC/Sussex" indicates that more respondents from New Castle and Sussex gave the most positive ratings for their health care, as compared to those from Kent County. Likewise, "MC<FFS" means that more respondents in traditional fee-for-service plans gave the most positive ratings for their health plan (in both 2001 and 2002), however not in 2003, as compared to those in managed care. The threshold for statistical significance is marked by the α=0.05 level.

- Bold font for "No" or "Yes" reflects changes in statistical significance from the previous year's data. Thus, for 2002 quality of health care by plan type, the bold "No" indicates that while there is no statistically significant difference in health care ratings in 2002, CAHPS data in 2001 indicated that such a difference did, in fact, exist.

Table 1.
Summary of Ratings by Plan Type and Region
Respondents Age 18-64, 2001 – 2003

Overall Rating of:	Statistically Significant By:	
	Plan Type (Managed Care, Traditional Fee For Service)	**Region** (New Castle, Kent, Sussex)
Personal Doctor	2002: No 2003: No	2002: No 2003: No
Specialists Seen	2002: No 2003: No	2002: No 2003: No
Quality of Health Care	**2002: No** 2003: No	**2002: Yes (K<NCC/Sussex)** **2003: No**
Quality of Health Plan	**2002: Yes (MC< FFS)** **2003: No**	2002: No 2003: No

Bold font reflects changes in statistical significance from previous year's data

- Generally, consumer reports of experiences with various aspects of health care remained consistent between 2002 and 2003 (see **Figure 3A** and **3B**). From 2002 to 2003, the percentage of respondents reporting the most positive experiences did not fluctuate significantly; however, some areas did change by more than $\pm$10% for certain categories. In fact, for *getting needed care* and *getting care quickly*, the percent decrease was around 10% and 16%, respectively. Further, in the three-year period from 2001 to 2003, there have not been any significant positive changes in any of the categories for Delaware.

- As was the case in 2002, the most positive experiences are reported for statements relating to *getting needed care*, for which 75.9% percent of respondents report the most-positive responses in 2003. In contrast, the least-positive experiences are reported for statements related to *getting care quickly*. Only 46.1% of respondents, down from 62.4% last year, give the most positive responses of statements assessing *getting care quickly*. **Figures 3A** and **3B** show the differences between these composites. For a more detailed breakdown of each composite by region and plan type, refer to **Appendix A**.

Figure 3A.
Summary of Consumer Reports on Experiences-Part 1, 2001 – 2003

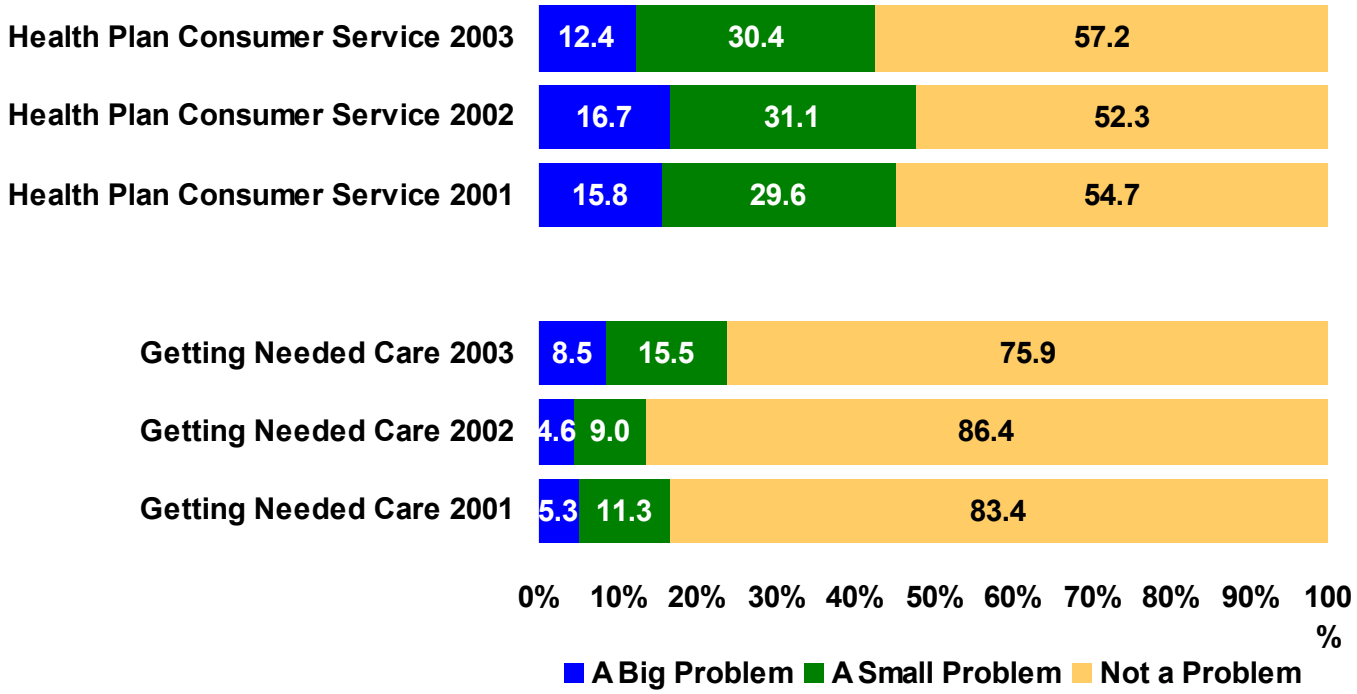
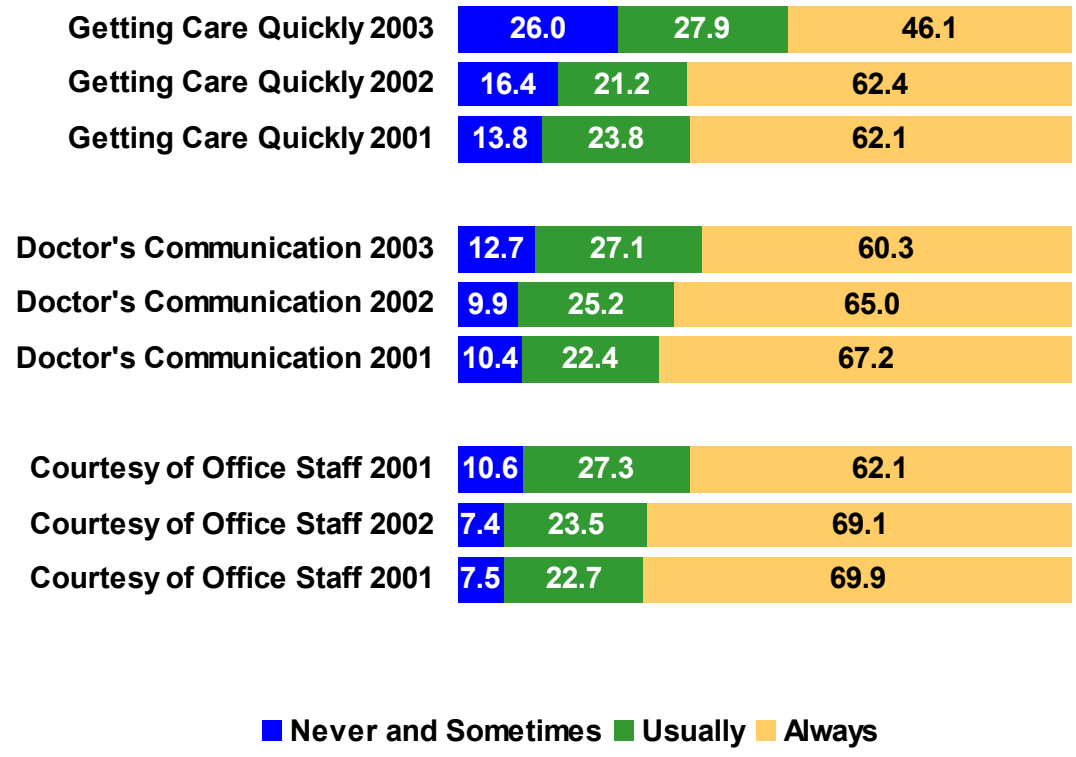


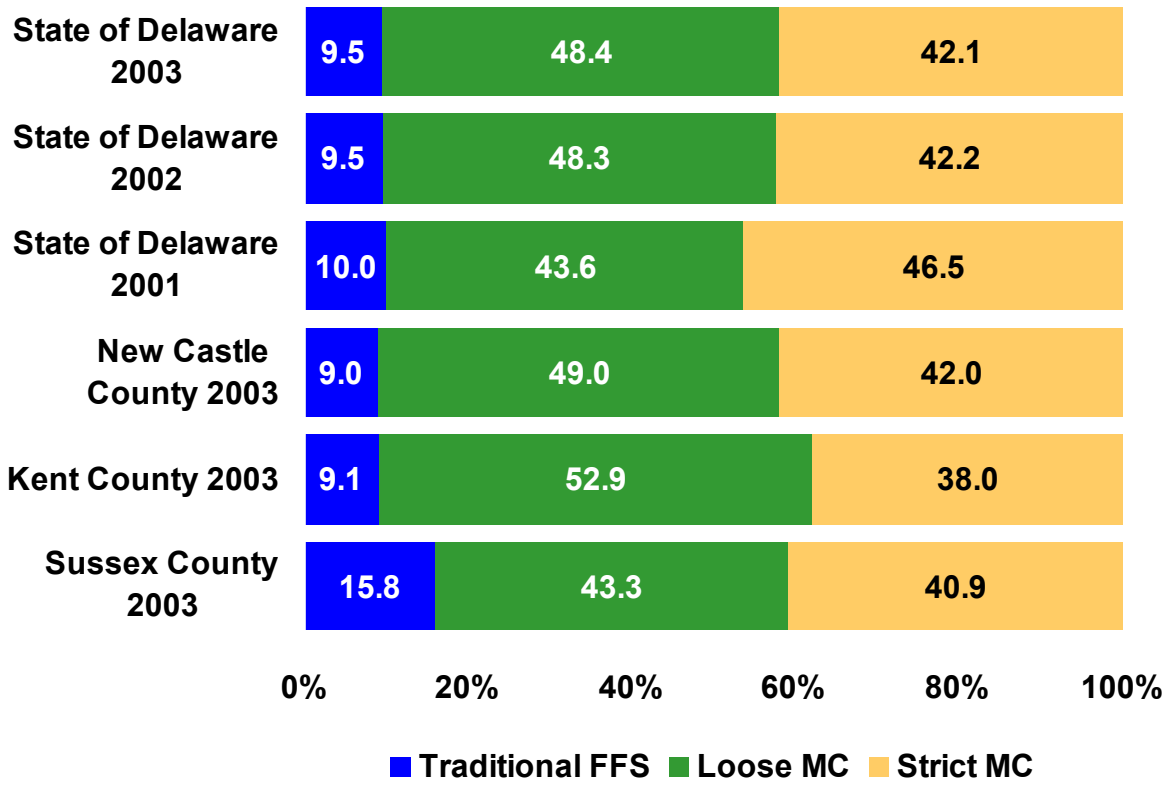
Figure 3B.
Summary of Consumer Reports on Experiences-Part 2, 2001 – 2003



Health Plan Enrollment

- Slightly under ten percent of adults with health insurance report participation in traditional fee-for-service plans (see **Figure 4**).
- Managed care continues to dominate the health insurance market, with about 90.5% of insured enrolled in managed care. Of managed care participants, 48.4% are enrolled in "loose" managed care plans, with the remaining 42.1% in "strict" managed care plans.
- Enrollment in health plans continues to change. First, enrollment in traditional fee-for-service continues its decline, shrinking from 12% in 1999 to 9.5% in 2003. Second, the composition of the corresponding increase in managed care is also evolving. Last year, 42.2% of managed care participants were enrolled in "strict" managed care plans. That percentage continued to stay constant, underscoring the popularity of more loosely managed plans such as PPOs. A recent *Health Affairs* article explains this trend, suggesting that growth in PPO participation has been fueled by enrollee flight from the undesirable features of strict managed care plans.[5]

Figure 4.
Summary of Health Plan Enrollment By Region



[5] Robert E. Hurley, et al. "The Puzzling Popularity of the PPO." *Health Affairs*. 2004. Vol 23, Issue 2, 56-68.

Differences Across Health Plan Types

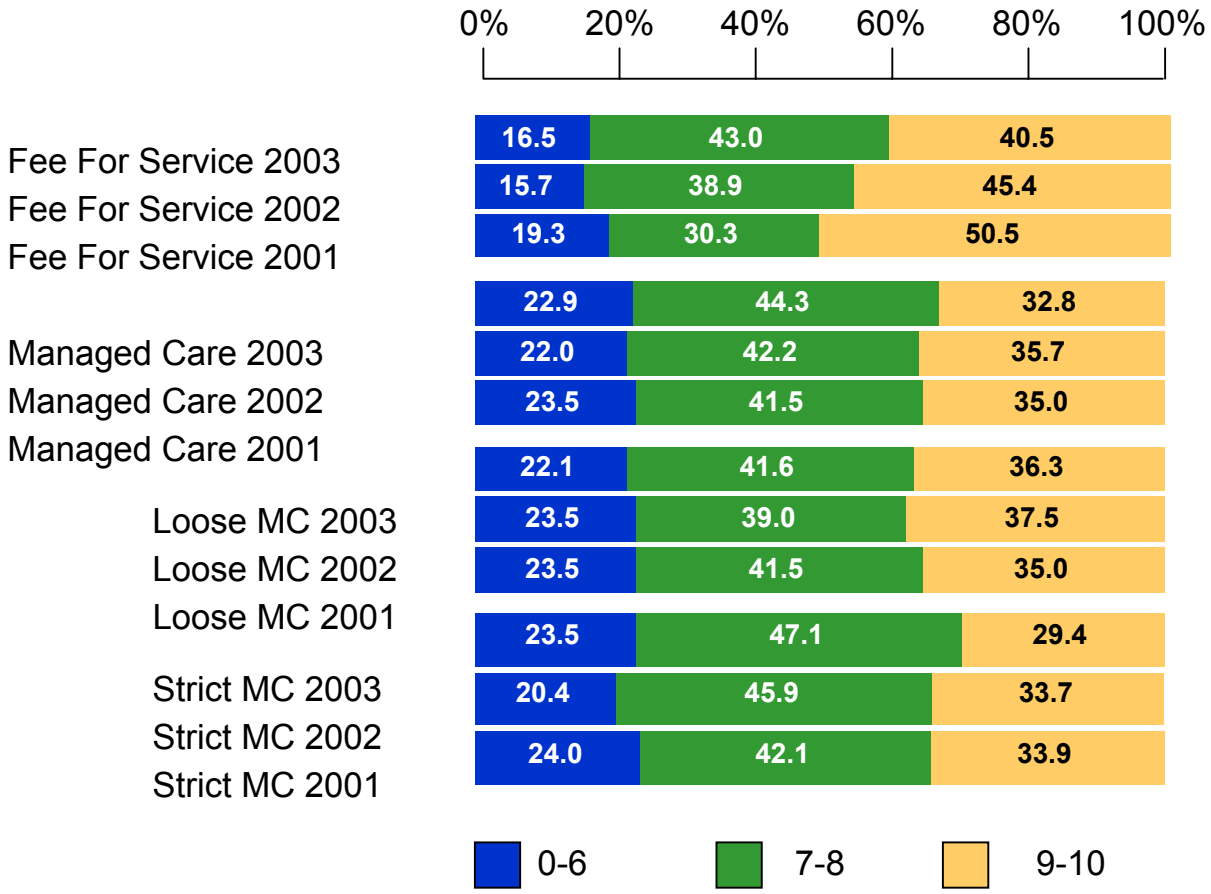
- Ratings of overall health care and health plan satisfaction vary by plan type. Respondents in traditional fee-for-service (FFS) plans rate their health care higher than persons in managed care plans. While 50.8% of fee-for-service respondents give their health care the most positive ratings, just 42.4% of managed care respondents report the most positive ratings (see Appendix A, **Figure A-9**). These differences in plan ratings among plan types are not statistically significant (see **Table 1**).

- As was the case in 2002, differences between ratings of participants in loose managed care plans and participants in strict managed care plans are fairly narrow; however, the gap is widening. For example, 36.3% of participants in loose plans and 29.4% in strict plans rated their health plans "9-10" (see **Figure 5**). For personal doctor ratings, 50.0% of participants in loose plans and 47.1% in strict plans gave the most positive ratings. This finding is suggestive of a larger national trend documented by policy groups such as the Center for Studying Health System Change. Simply, consumer backlash against managed care has forced managed care to "manage less" and relax its control over care. A less-restrictive model of managed care has emerged, characterized by broader provider choice, fewer requirements for authorizations, and reduced use of risk contracting.

- From 2001 to 2003, ratings of health plans decreased among participants of managed care plans. In strict managed care plans 33.9% of respondents gave the most positive ratings to their health plan in 2001 (see **Figure 5**). In 2003, that figure fell to 29.4%. Similarly, participants in FFS plans have had the same experience, with a decrease in satisfaction. While 50.5% of FFS respondents gave their health plans the most positive ratings in 2001, that percentage decreased to 40.5% in 2003.

Figure 5.
Summary of Health Plan Ratings by Plan Type,
2001 – 2003

Using 0 to 10, where 0 is the worst possible and 10 is the best possible, how would you rate your health plan?

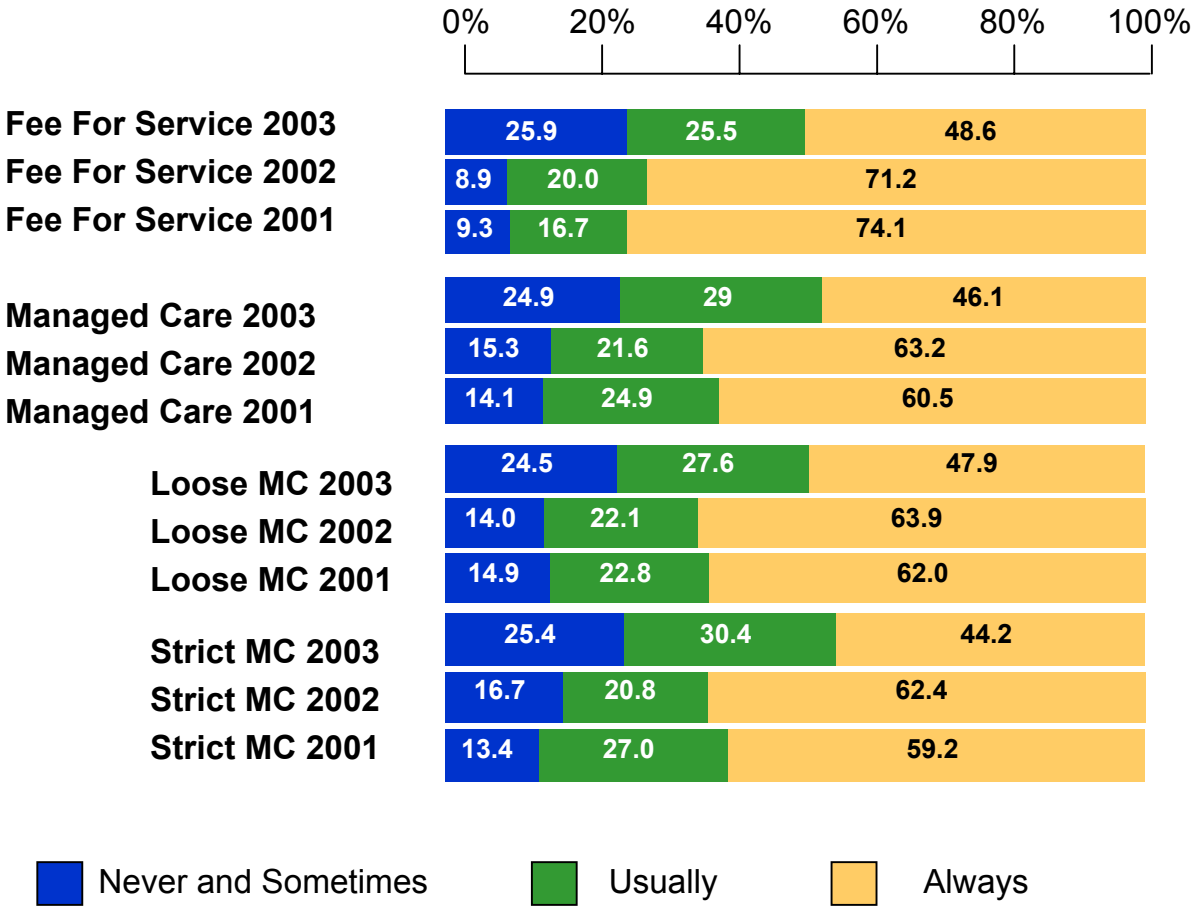


- Reports on consumers' specific experiences with care, not surprisingly, also vary by plan type. Compared to their managed care peers, a larger percentage of respondents in traditional FFS plans give the most positive responses to questions related to *getting care quickly*. **Figure 6** shows that there was a huge decrease (from 71.2% in 2002 to 48.6% in 2003) of FFS participants who gave the most positive responses to questions regarding the receipt of needed medical care in a timely manner, while there was a similar drop from 63.2% to 47.3% of managed care participants, who rate their care most positively.

- As was the case with customer-satisfaction ratings, the percentage differences between reports on specific experiences with care between participants in loose and strict managed care plans are small. **Figure 6** shows that 47.9% of participants in loose managed care plans give the most positive ratings, and 44.2% in strict plans do the same. In fact, across all five categories of specific experiences with care, the average margin between the most positive responses from loose and strict participants is no more than about 5%. See **Appendix A**, Figures **A-7** through **A-10**, for the remaining charts examining experiences with care by plan type.

Figure 6.
Summary of Experiences with *Getting Care Quickly* by Plan Type, 2001 - 2003

Combines responses to four questions regarding how often consumer received various types of care in a timely manner.

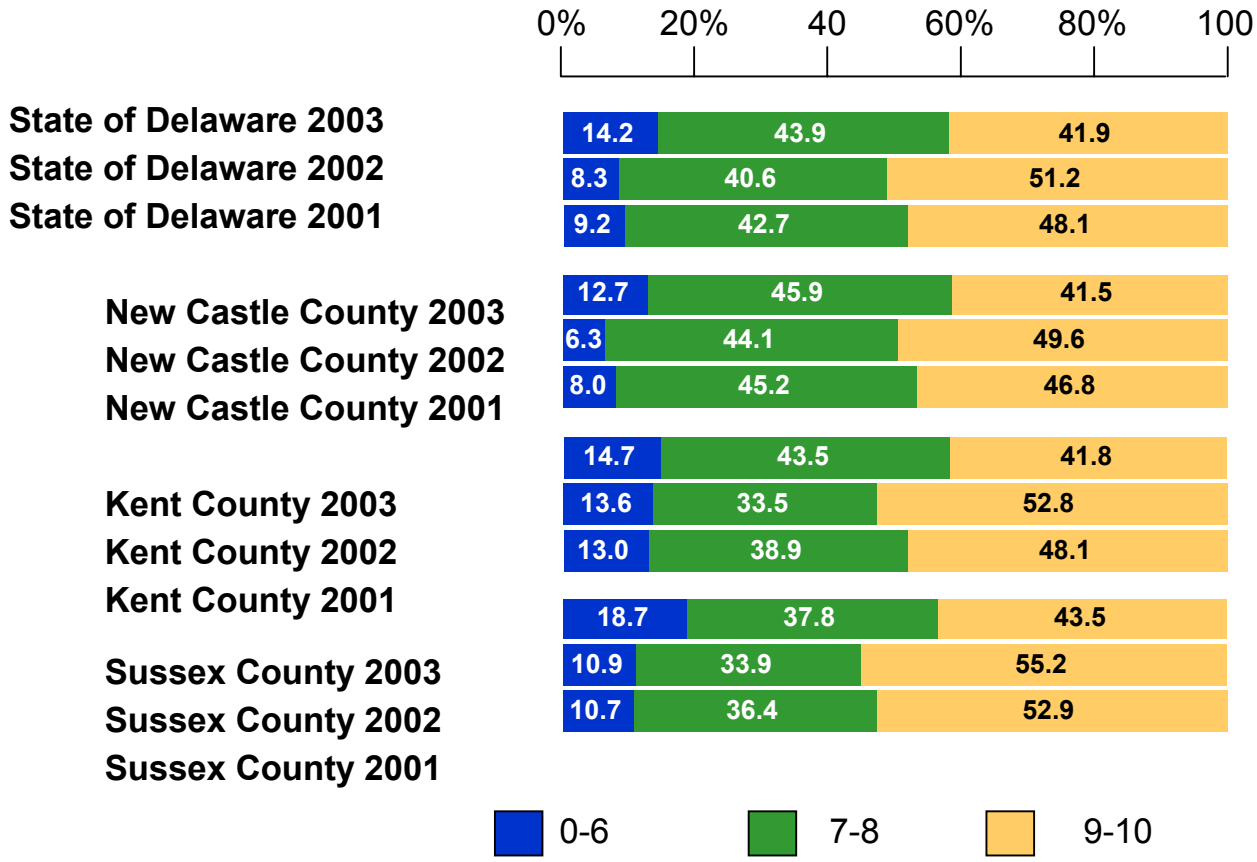


Differences Across Regions

Ratings of overallhealth care satisfaction vary by region; however, these variations are very small and are not statistically significant. More respondents in Sussex County give their health care at least a 9, "the most positive" ratings, compared to respondents in New Castle County and Kent County. **Figure 7** shows the differences in healthcare ratings by region. In contrast, 87.4% of New Castle respondents rate their overall health care at least "7," just 85.3% of Kent respondents rated positively, and an even lower rating of 81.3% was reported by Sussex respondents. See **Appendix A**, **Figures A1** and **A2**, for charts examining personal doctor and specialist ratings by region.

Figure 7.
Summary of Health Care Ratings by Region,
2001 - 2003

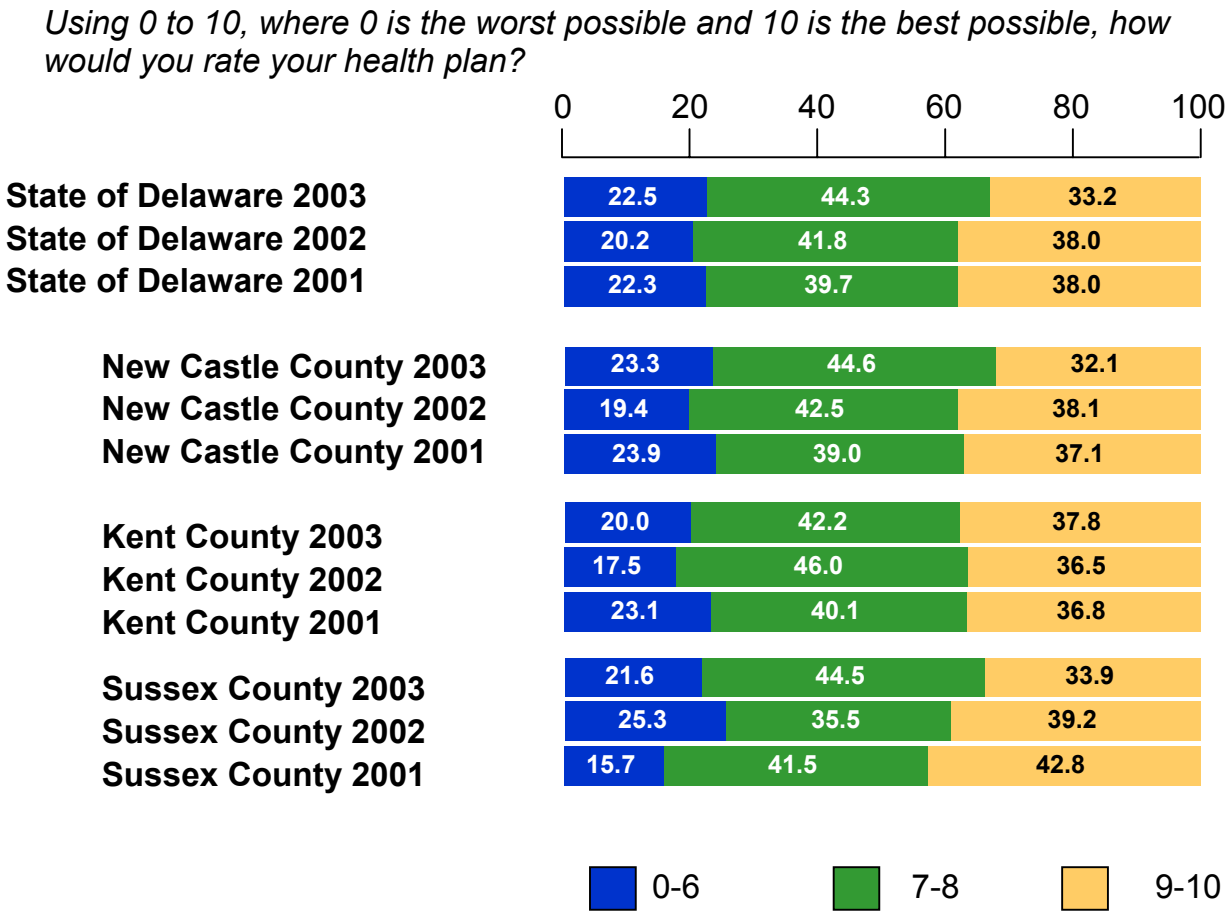
Using 0 to 10, where 0 is the worst possible and 10 is the best possible, how would you rate all your health care?



- In 2003, more Sussex County residents than respondents in other counties gave the most positive ratings to their health plans, specialists, and personal doctors. The margins, however, are small and are decreasing in all categories between the regions. Also as health plan ratings have decreased, specialist ratings have increased. **Figure 8** shows that the percentage of Sussex respondents giving the most positive ratings to their health plans decreased to 33.9% from 39.2%. In the case of personal doctor ratings, the percentage of Sussex respondents rating "9-10" rose from 49.4% to 53.5% (see **Appendix A**, **Figure A1**).

- From 2002 to 2003, ratings of health plans, doctors, health care, and specialists all decreased, some by almost 10%. Overall, there have been only four questions regarding the quality of health in Delaware for which ratings have increased. Delaware's trend is not consistent with the national trend of improving health care and health statistics. Each region has similar trend data, consistent with that of the overall state. In terms of health plan ratings, New Castle County, Sussex County and the State of Delaware's have all decreased, while Kent County's has increased.

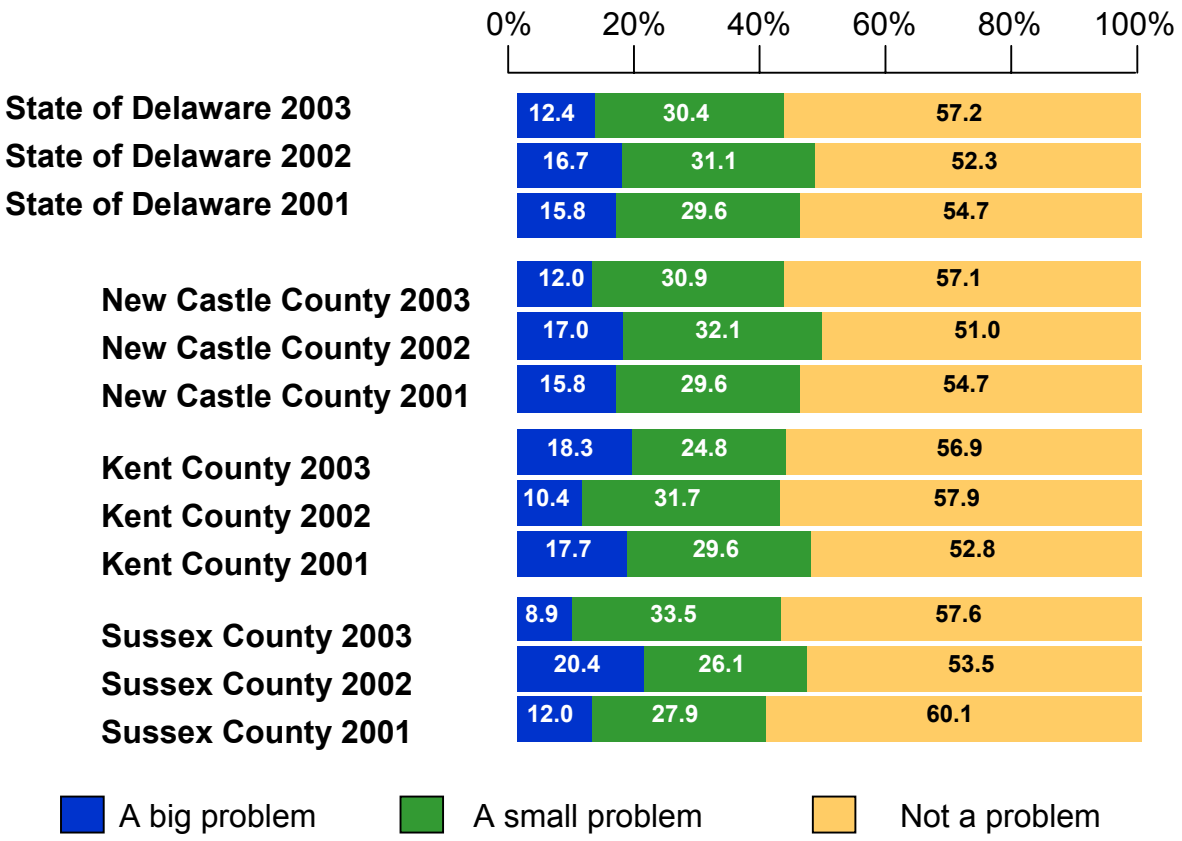
Figure 8.
Summary of Health Plan Ratings by Region,
2001 - 2003



As satisfactory ratings vary by region, so too do reports on specific experiences with care. By A slight margin, compared to New Castle and Kent County residents, more Sussex County residents give the most positive reports for *health plan customer service*. **Figure 9** shows the summary of experiences with *health plan customer service* by region. Also noteworthy is the increase in the percentage of overall Delaware respondents who give the most positive reports; however, Kent County has reported an increase in "big problems" by eight percentage points. This upward trend counters that of health plan, health care, personal doctor, and specialist ratings which have seen steady decline (see **Figure 8**, **Appendix A, Figures A1** and **A2**). Notably, Sussex County has had more than a ten percentage points decrease in "big problems" this past year.

Figure 9.
Summary of Experiences with *Health Plan Customer Service* by Region, 2001 - 2003

Combines responses to four questions regarding how much of a problem, if any, consumers had with various aspects of their health plans' customer service.



About the Delaware Survey

Since 1997, the Delaware Health Care Commission has contracted with the College of Human Services, Education & Public Policy (CHEP) at the University of Delaware to administer the CAHPS survey. CAHPS is an independent survey on consumer satisfaction with the Delaware healthcare system, providing information for assessing the health care experiences of Delaware's consumers. The survey data are collected over 12 months, with approximately 150 monthly surveys conducted throughout Delaware of adults aged 18 and older. Respondents without health insurance, as well as those who are insured, are included in the survey panel.

Delaware survey respondents are grouped as enrollees in traditional fee-for-service (FFS), loose managed care, or strict managed care plans based on their responses to three questions regarding the degree of access they have to health care. Respondents are asked if they must (1) select doctors from a list, (2) select a primary care physician, and (3) obtain referrals. Answering "yes" to all these items would place a

respondent in strict managed care. Loose managed care is defined by "yes" responses to some, but not all, questions. Traditional FFS plans are identified by three "no" responses. This methodology is based on the approach used by the Kaiser Family Foundation/Harvard surveys such as the 1997 National Survey of Americans on Managed Care.

The format of the Delaware CAHPS data reporting changed in 2001 and has remained consistent since 2003. These changes ensure consistency with the CAHPS standards and allow Delaware's results to be compared to the NCBD. In years past, the overall average ratings were presented for each aspect of health plans and health care. Now, according to national guidelines, the percentage of respondents who give the most positive rating is calculated for each aspect. Likewise, composites have been created to group results in meaningful ways: ratings of 1–6, 7–8, and 9–10, respectively, are compiled. These groupings, or categories, better highlight rating differences and maintain consistency with NCBD methods. To ensure representative sampling and to adjust for sampling biases due to sociodemographic differences between respondents and non-respondents, responses are weighted based on the latest U.S. Census data for county of residence, age, and gender.

About CAHPS and the National CAHPS Benchmarking Database

CAHPS was created by the Agency for Healthcare Research and Quality (AHRQ) and further developed by Harvard Medical School, RAND and the Research Triangle Institute. These organizations developed the CAHPS methodology and survey instrument, which was tailored subsequently for Delaware. In 2002, AHRQ designated Harvard Medical School, RAND, and American Institutes for Research (AIR) as the new group of organizations charged with the continued evolution of CAHPS products. The 2002 CAHPS II grant introduces the survey to new areas of research, including nursing homes, providers, and hospitals.

CAHPS usage is taking off. The CAHPS user group has expanded into a major source of consumer information in the United States. Utilization of CAHPS has grown rapidly from four early users and three demonstration sites in 1997 to an active network of CAHPS users in 46 states. As of 2004, only Montana, South Carolina, South Dakota, and Wyoming still forego use of CAHPS. Users also include federal agencies, such as the Centers for Disease Control and Centers for Medicaid and Medicare. Some accrediting organizations such as the National Committee on Quality Assurance (NCQA) score accreditation by using two tools, the Health Plan Employer Data Information Set (HEDIS) and CAHPS.

In addition the CAHPS development team has added to its survey products in order to address a variety of healthcare services and healthcare delivery systems. There are six ambulatory care surveys either currently available or in the development stage, as well as three facility surveys. The ambulatory care surveys are focused on various issues, such as the health plan survey, a clinician and group survey, a survey of behavioral health, a mobility impairment survey, and a Native American Indian survey. The facility surveys are geared toward analyzing hospitals, in-center hemodialysis centers, and nursing home care facilities. These three surveys are the first of their kinds and were created at the request of the Centers for Medicare and Medicaid Services. The facility surveys allow patients to report on their experiences in various areas of the health care field. The comprehensive list of surveys that CHAPS provides is constantly evolving and growing as the needs for quality measures and accountability grows in the healthcare field. For more information on the types of surveys that CHAPS provides, visit www.cahps-sun.org/Products/ProductIntro.asp.

As the usage of CAHPS grew, AHRQ (Agency for Healthcare Research and Quality) supported the development of the National CAHPS Benchmarking Database (NCBD) to serve as the repository for all CAHPS data. The NCBD is intended to function as a national database that can be used for benchmarking healthplan performance and conducting research. The NCBD includes summary data from all sponsors of

CAHPS surveys that elect to participate in the benchmarking database. Medicare, Medicaid, and commercially insured populations are included in the database. The central purpose of the NCBD is to facilitate comparisons of CAHPS survey results by survey sponsors. By compiling CAHPS survey results from a variety of sponsors into a single national database, the NCBD enables purchasers and plans to compare their own results to relevant national benchmarks in order to identify performance strengths as well as opportunities for improvement.

Recently, the National CAHPS Benchmarking Database joined an elite group of data sources at the pinnacle of the national healthcare measurement movement. Congressional legislation mandating that AHRQ produce an annual report on the quality of health care in the United States has finally born fruit. Referenced earlier in the report, the National Healthcare Quality Report (NHQR) is intended to track quality over time. NHQR relies on data that is clinically important, scientifically sound, readily available, reliable, valid, and regularly collected at both the national and state levels. The NCBD data met each of these standards; NCBD data were thus included to generate estimates for the safety, effectiveness, timeliness, and patient-centeredness measures that were part of the IOM-advised quality framework adopted by AHRQ.

In this report, we compare Delaware's population, which includes Medicaid and commercially insured respondents, to the NCBD data for both commercial and Medicaid recipients. The comparisons between Delaware and national data are useful, but there are some limitations. Delaware includes small employer data and the uninsured, while the NCBD does not report such information. Likewise, the Delaware report focuses on adults aged 18-64 while the NCBD includes adults aged 65 and older in its analysis. These differences should be taken into account when comparing Delaware findings to the NCBD.

Explanation of Consumers' Reports on Their Experiences with Care

Integral to CAHPS design is an assessment of consumer experiences with quality of care rather than simple satisfaction measurement, a function of expectations. Therefore, most CAHPS survey questions ask respondents to report on their experiences with various aspects of their health care. These questions are combined into groups that relate to the same aspect of care or service. Five major report groups summarize consumer experiences in the following areas:

- *Getting needed care*
- *Getting care quickly*
- *How well doctors communicate*
- *Courteous and helpful office staff*
- *Customer service*

The five major report groups represent composite scores for related items. Appendix B shows the specific question items calculated for each composite category. Composites are calculated by taking an average of the most positive scores for individual question items within the composite. For example, the percentages of respondents who give the most positive response for each item relating to experience with *getting needed care* are added, and then that sum is divided by 4, the number of questions within the composite category.

Explanation of Consumers' Ratings of Their Health Care

CAHPS gathers information from four separate ratings to report on important aspects of care. The four questions prompt respondents to rate their experiences within the last year with: their personal doctors, specialists, health care received from all doctors and health care providers, and health plans. Appendix B shows the specific questions asked for each rating category. Ratings are scored on a 0-to-10 scale, where "0"

is the worst possible and "10" is the best possible. Ratings are analyzed and collapsed into three categories representing the percentages of consumers who give ratings of 0-6, 7-8, or 9-10, respectively.

Conclusion

The 2003 CAHPS report suggests that, overall, like the national database reports, Delaware residents give overall high marks to their health plans, health care, and health providers. Relative to the National CAHPS Benchmarking Database, Delaware's 2003 results are below average in all four major categories—health plans, health care, specialist, and personal doctors. This is a change from 2002, when Delaware beat the national benchmark in health care and specialists. Likewise, with reports on experiences with care, Delaware reports more positively for *doctor's communication* and *getting needed care* but is trailing the NCBD with respect to *all other services*. With *health plan customer service*, for example, fewer Delaware respondents than the national benchmarks give the most positive reports for *health plan customer service* (national 58% vs. DE 55.6%). Moreover, reports on *health plan customer service* have not improved between 2002 and 2003, widening the discrepancy between Delaware and NCBD data. These findings suggest that customer service continues to be a problem area for Delaware's health plans.

Within Delaware, there was evidence of steady improvement in ratings of specialists and health care over the past few years. However, in 2003 we saw those numbers start to decrease. Also, Delawareans' reports of *getting needed care* have continued their slight upward trend. At the very least, some aspects of *doctor's communication*, *getting care quickly*, and *courteous and helpful office staff* have not worsened—and have increased slightly. The mediocrity of these findings should be taken to suggest that there is still room for quality improvement and the downward trend of these statistics warrant some change.

It is more instructive for stakeholders to use this report as a template for quality improvement. Quality information without a discussion of how to use these findings to improve quality is itself inadequate. To that end, a consortium of leading healthpolicy researchers co-authored *The CAHPS Improvement Guide: Practical Strategies for Improving the Patient Care Experience*. This guide, which cites the growing use of CAHPS to measure healthcare quality, outlines strategies for improving care, complete with very specific examples of quality improvement in action. These strategies include:

- For improvement in *getting needed care* CAHPS scores, plans could provide more sophisticated and interactive provider directories. Directories that do not keep up with provider network changes or fail to give patients enough information to select a provider that would best meet their needs are barriers to care. More current directories, with more information on the providers' backgrounds and comparative performance data, are a start. The directories could also include direct links to providers' Web sites, where patients could find specific information such as office hours and office locations. These reforms would steer patients more efficiently to the most appropriate providers and lower barriers to needed care.

- Improvement strategies for *getting care quickly* include open-access scheduling, providing Internet access for routine health information and advice, and encouraging providers to adopt e-mail to facilitate greater communication. Those latter two suggestions are intuitive. Rapid, real-time electronic responses to non-urgent queries could greatly increase patients' satisfaction with *getting care quickly*. Open-access scheduling—a method of scheduling in which all patients can receive an appointment on the day they call—could significantly reduce delays in patient care, though its implementation does pose formidable logistical challenges.

- Several common-sense approaches can be used to improve *how well doctor's communicate.* Chief among these are seminars and workshops to enhance physicians' communication skills. Such training would invite doctors to improve their effectiveness as both managers of health care and health educators of patients. Providers may then allocate a greater percentage of appointment time to increasing the patient's knowledge of their own health, fostering better compliance with treatment and, ultimately, better health outcomes.

- To improve *health plan customer service* marks, the *Improvement Guide* calls for health plans to assume the more customer-oriented service model that is prevalent in other industries. That is, health plans need to institutionalize feedback, response, and recovery processes. Formal systems must be in place to synthesize the information that patients provide into an overall picture of how they are delivering health care to the consumer. "Listening posts," for example, include surveys and focus groups that frame the issue of customer service for health plan staff.

In Delaware, as noted above, consumers give *health plan customer service* and *getting care quickly* the least positive reports. Consumers' reports have not improved in 2003, and they continue to lag behind national benchmarks. Providers, payers, and policymakers would do well to take note of the *Improvement Guide's* recommendations for improving this aspect of health care delivery. The implementation of service-recovery programs and service standards might go a long way toward making up this quality deficit. What if health plan representatives were to 1) apologize, 2) listen and ask open questions, 3) fix the problem quickly, 4) offer atonement, 5) follow up, and 6) keep promises when confronted by an angry patient? What if providers committed to the higher standard of granting same-day appointments to 90% of patients who call or committed to keeping reception-area waits to under 10 minutes? Positive reports of *health plan customer service and getting care quickly* in Delaware would undoubtedly increase.

The experiences of some health plans, as sketched by NCQA in its *Quality Profiles*, are illustrative of what can be accomplished by making a commitment to improve *health plan customer service.* "Many health plans have made," notes NCQA, "wholesale benefit design changes as a result of satisfaction feedback." The development is one that is both welcome and long overdue, as "patient satisfaction with care and service has moved to a more central place in most organizations' thinking about quality improvement." One plan, attacking a major source of consumer ire, simplified its referral process, eliminating some prior authorization rules, then trained its staff and physicians on the new process. Another plan, having learned from semiannual telephone surveys that enrollees were extremely dissatisfied with their plan's referral process, instituted both a "Referral Bypass Program" and a "Rapid Referral Program," both designed to dramatically decrease the time it takes enrollees to access specialist care.

A third health plan took a more comprehensive approach to improving its overall consumer satisfaction. The growth of this plan prompted it to restructure its customer service department and establish a director-level position specifically for customer service. In addition, the plan enhanced its measurement efforts, created a team approach to customer service, and implemented a "plan, do, check, act" process. The plan found that, based on findings from CAHPS survey questions, they needed to improve in (1) help when calling customer service and (2) problems finding or understanding written materials. To remedy these issues, the plan installed a phone system upgrade and expanded efforts to make member guides and certificates of coverage more readable. They also established e-mail access to customer service for members, and established monthly service metrics for each department.

Again, the experiences of these plans and customer service models in other industries could serve as models for Delaware's health plans to stake their own improvements in centering health care experience around the patient. A more specific, concise report on the uninsured will follow soon. This report compares the uninsured experiences with and ratings of health care to those of the insured population.

Appendix A: Figures

Figure A-1.
Summary of Personal Doctor Rating by Region,
2001 - 2003

Using 0 to 10, where 0 is the worst possible and 10 is the best possible, how would you rate your personal doctor or nurse?

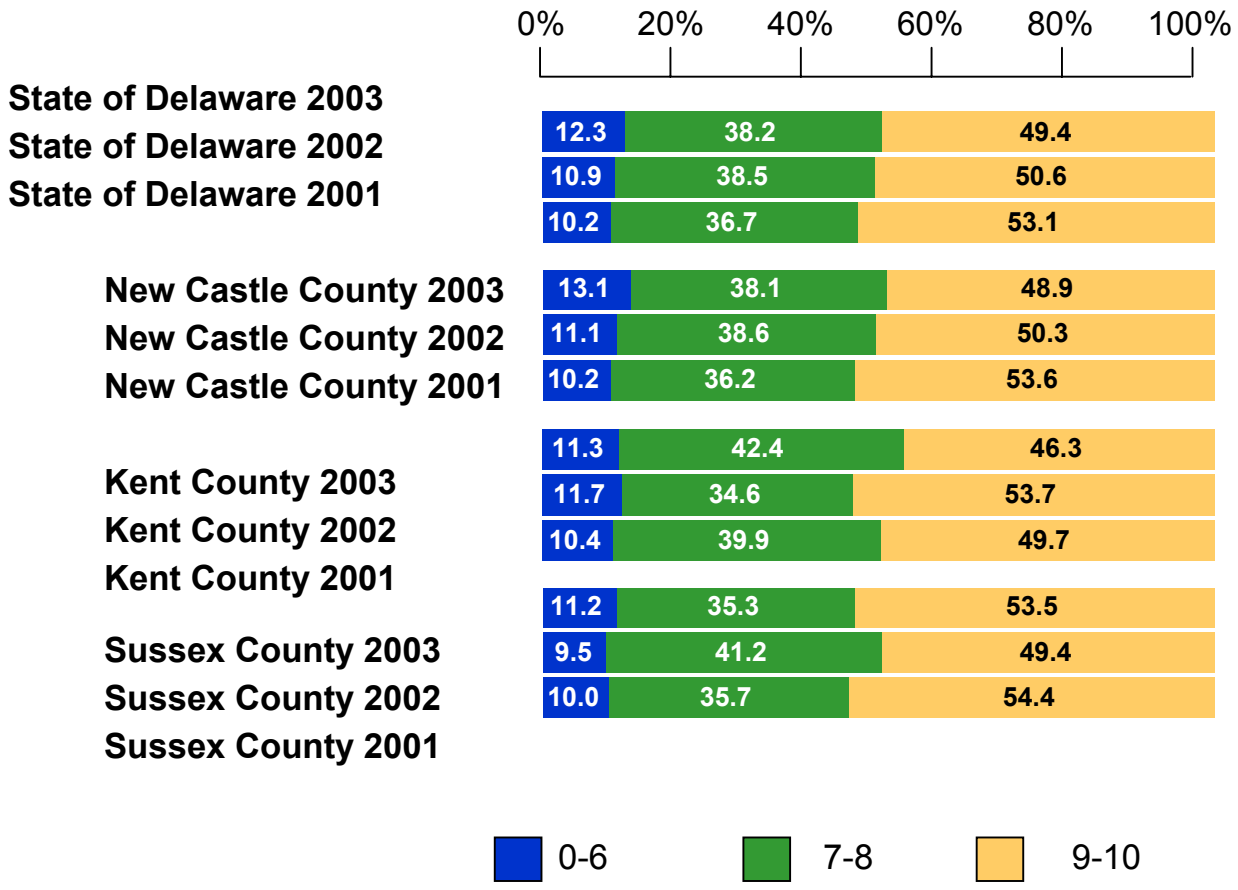


Figure A-2.
Summary of Specialist Ratings by Region,
2001 - 2003

Using 0 to 10, where 0 is the worst possible and 10 is the best possible, how would you rate your specialist?

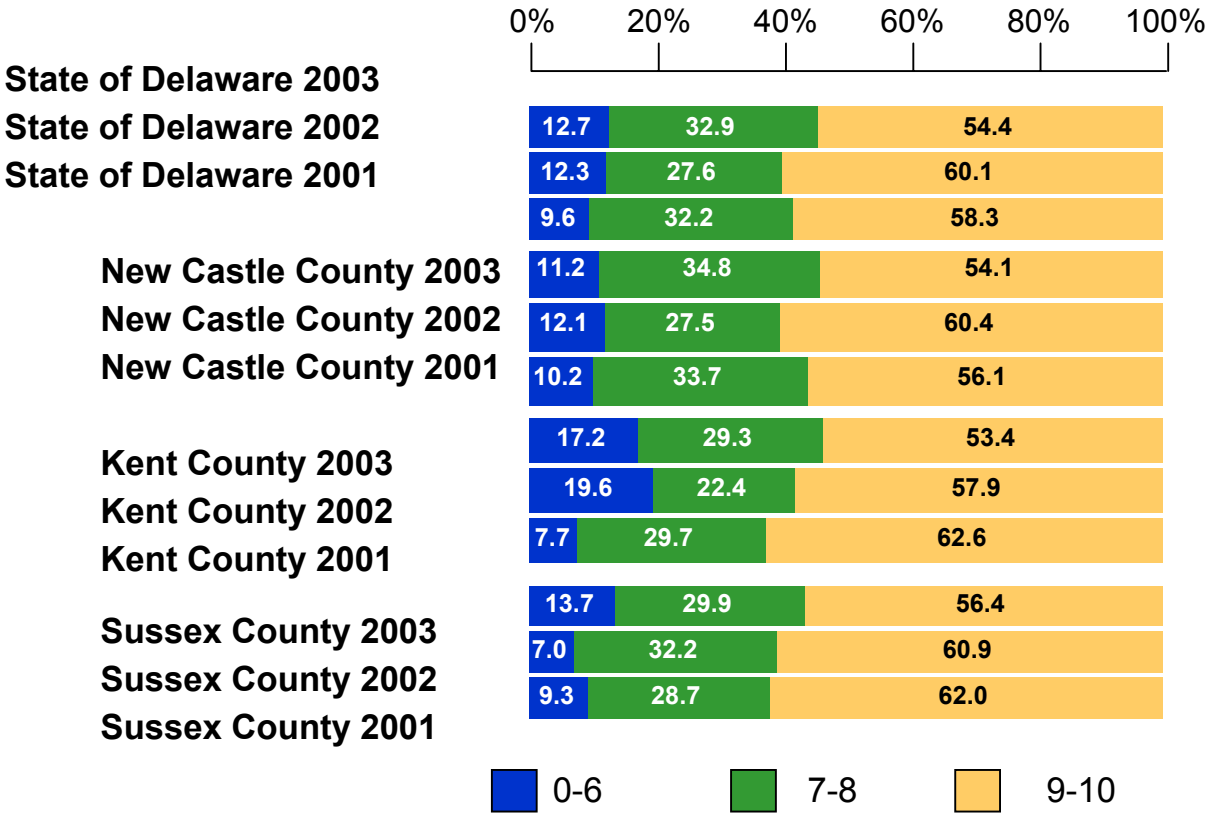


Figure A-3.
Summary of Experiences with *Getting Needed Care* by Region, 2001 – 2003

Combines responses to four questions regarding how much of a problem, if any,

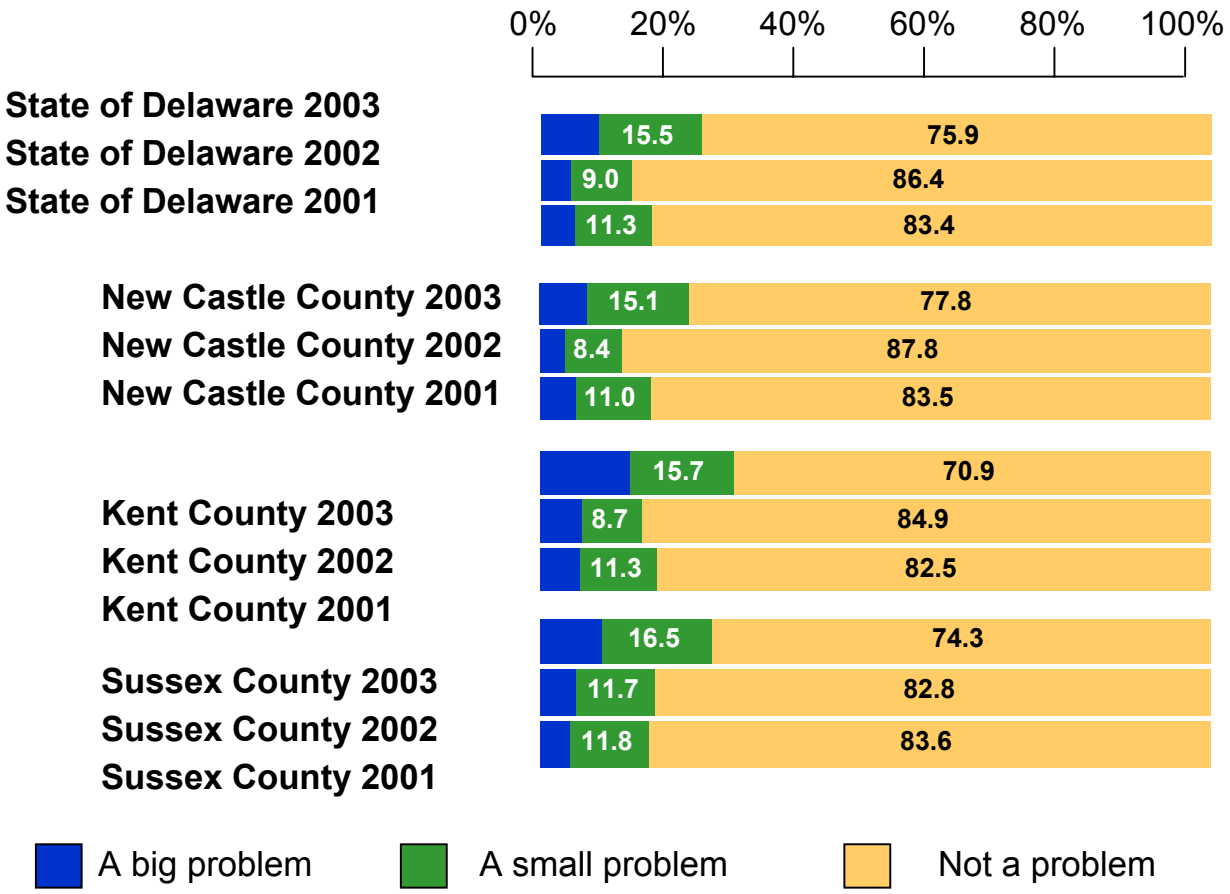


Figure A-4.
Summary of Experience with *Getting Care Quickly* by Region, 2001 - 2003

Combines responses to four questions regarding how often consumer received various types of care in a timely manner.

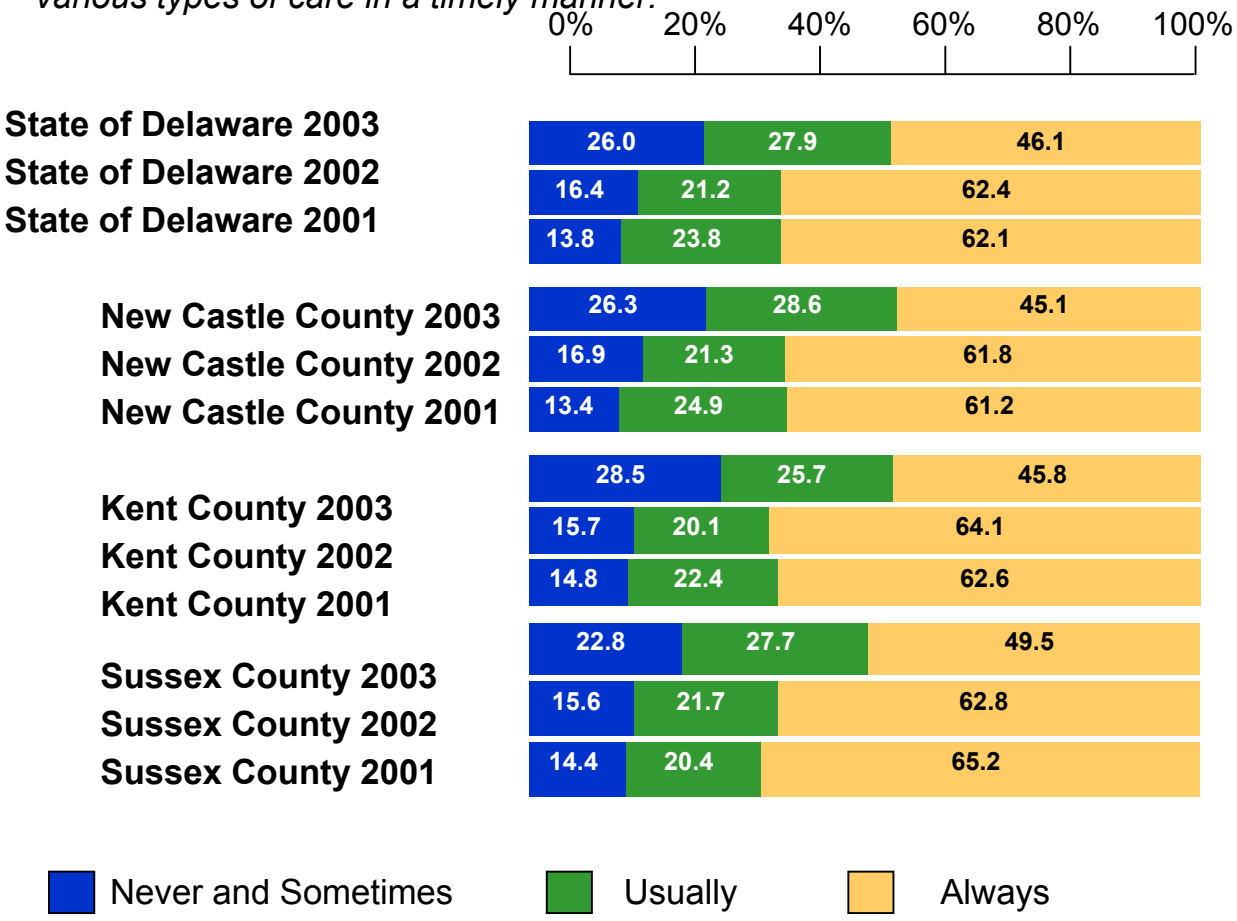


Figure A-5.
Summary of Experiences with *Doctor's Communication* by Region, 2001 – 2003

Combines responses to four questions regarding how often doctors communicated well with consumers.

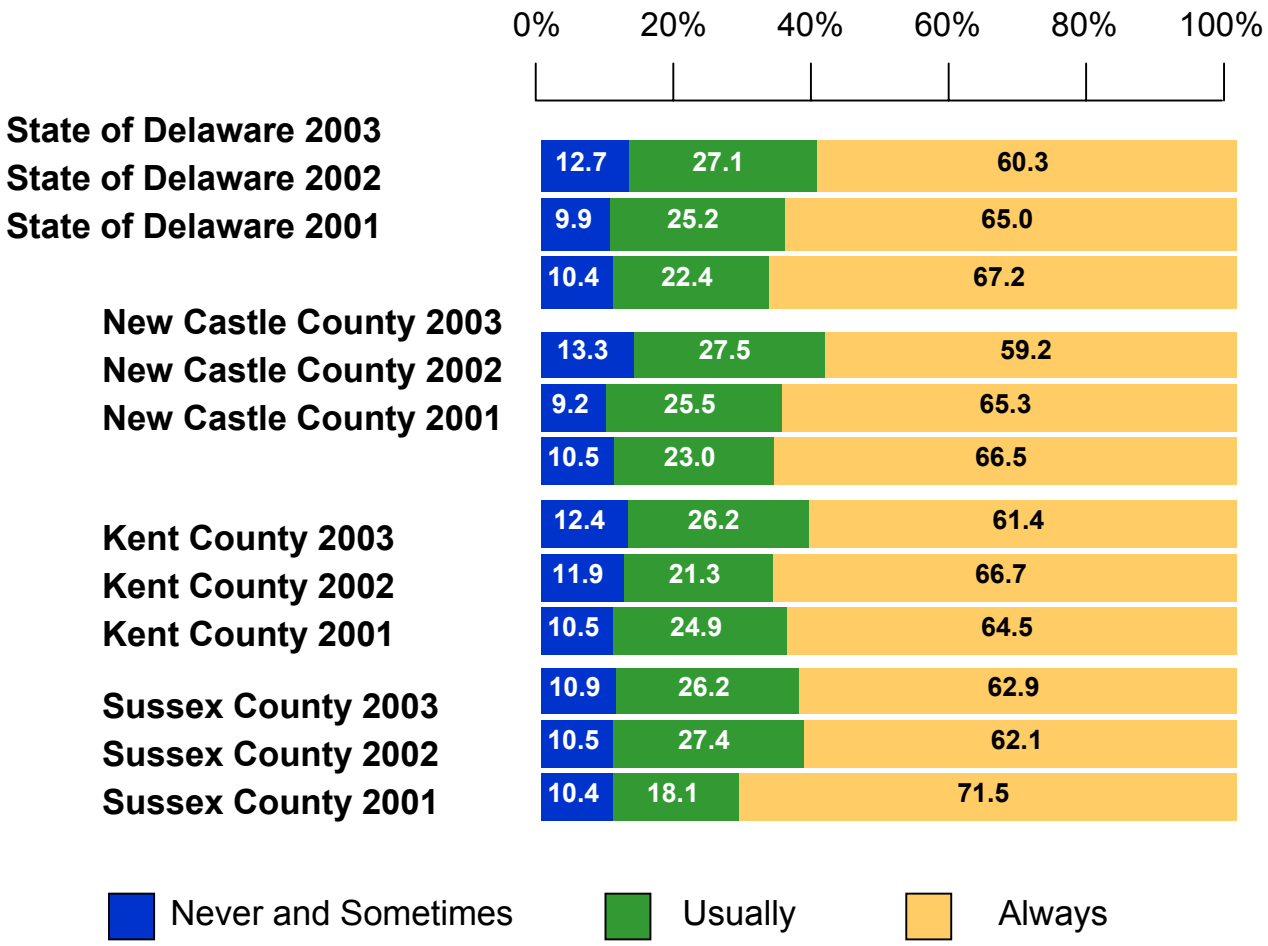


Figure A-6.
Summary of Experiences with *Courtesy of Office Staff* by Region, 2001 - 2003

Combines responses to four questions regarding how often office staff were courteous and helpful.

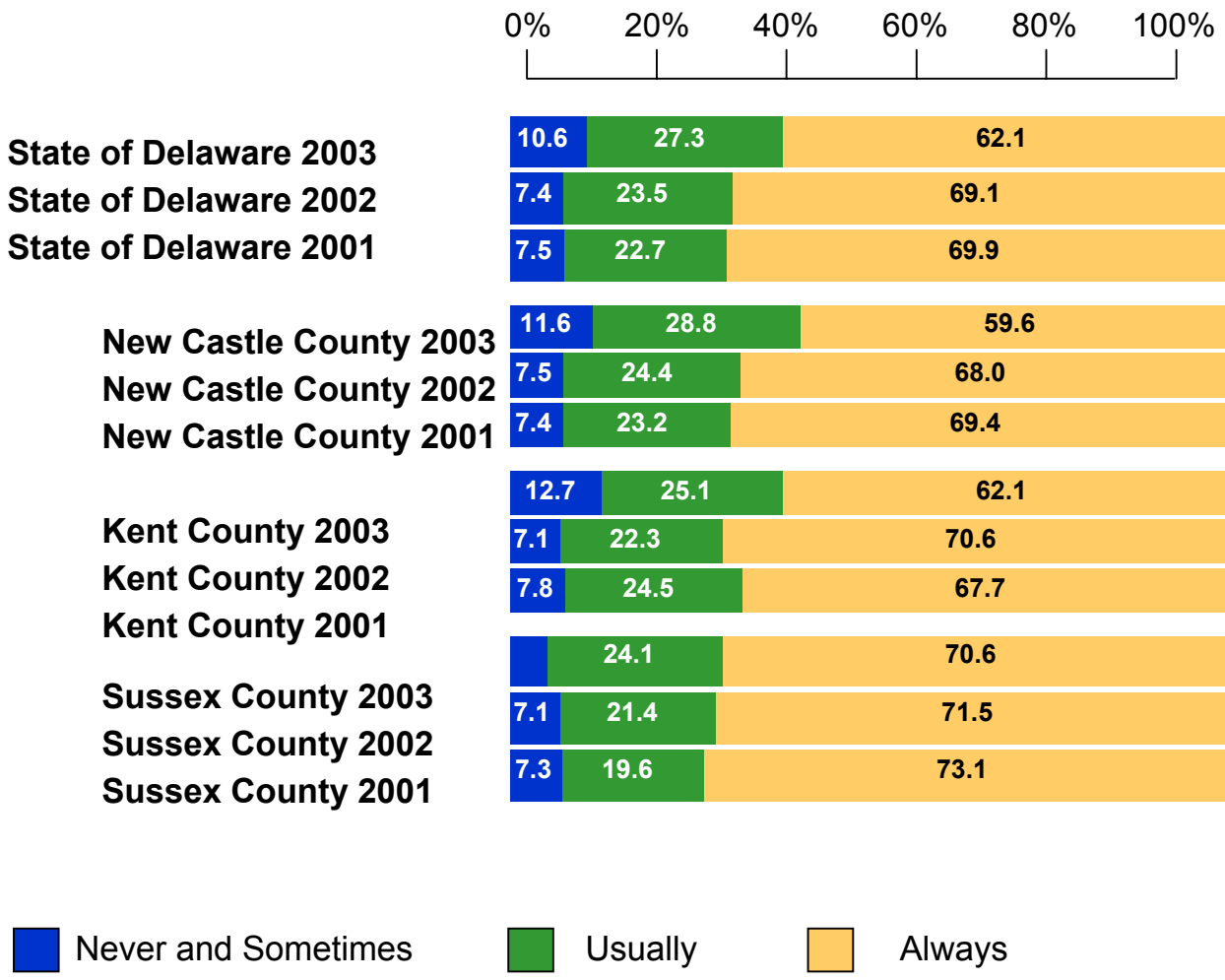


Figure A-7.
Summary of Personal Doctor Ratings by Plan Type,
2001 - 2003

Using 0 to 10 where 0 is the worst possible and 10 is the best possible, how would you rate your personal doctor or nurse?

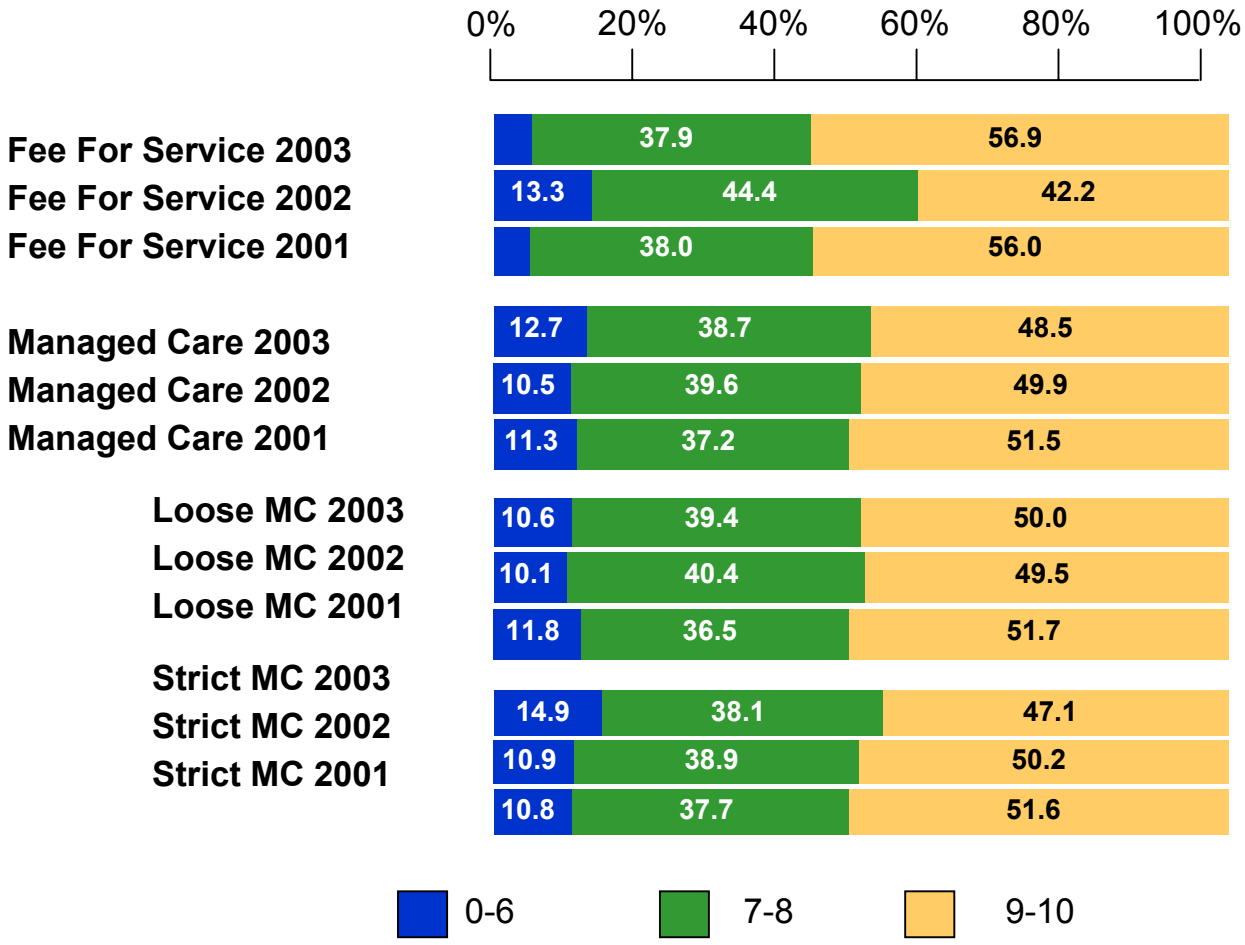


Figure A-8.
Summary of Specialist Ratings by Plan Type,
2001 - 2003

Using 0 to 10 where 0 is the worst possible and 10 is the best possible, how would you rate your specialist?

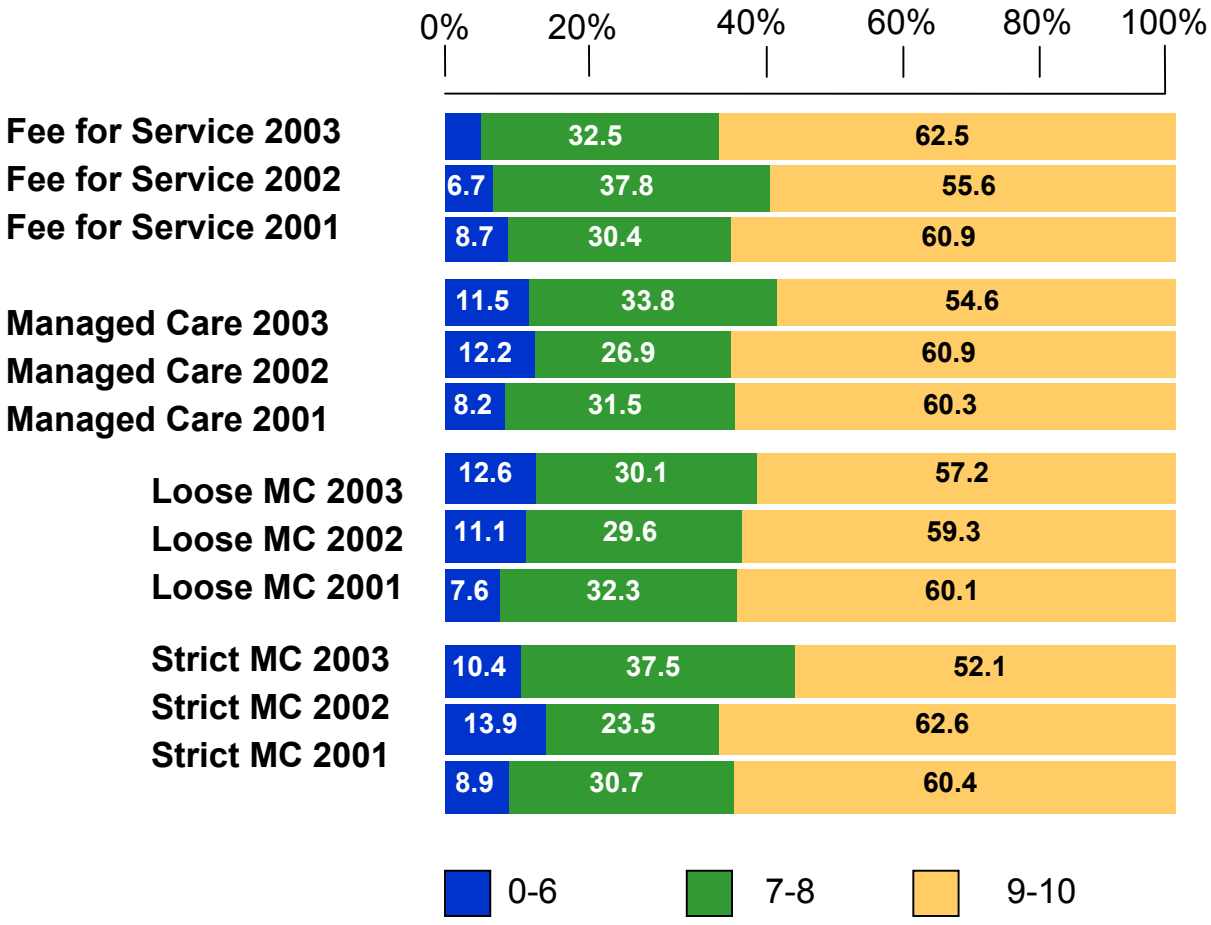


Figure A-9.
Summary of Health Care Ratings by Plan Type,
2001 - 2003

Using 0 to 10, where 0 is the worst possible and 10 is the best possible, how would you rate all your health care?

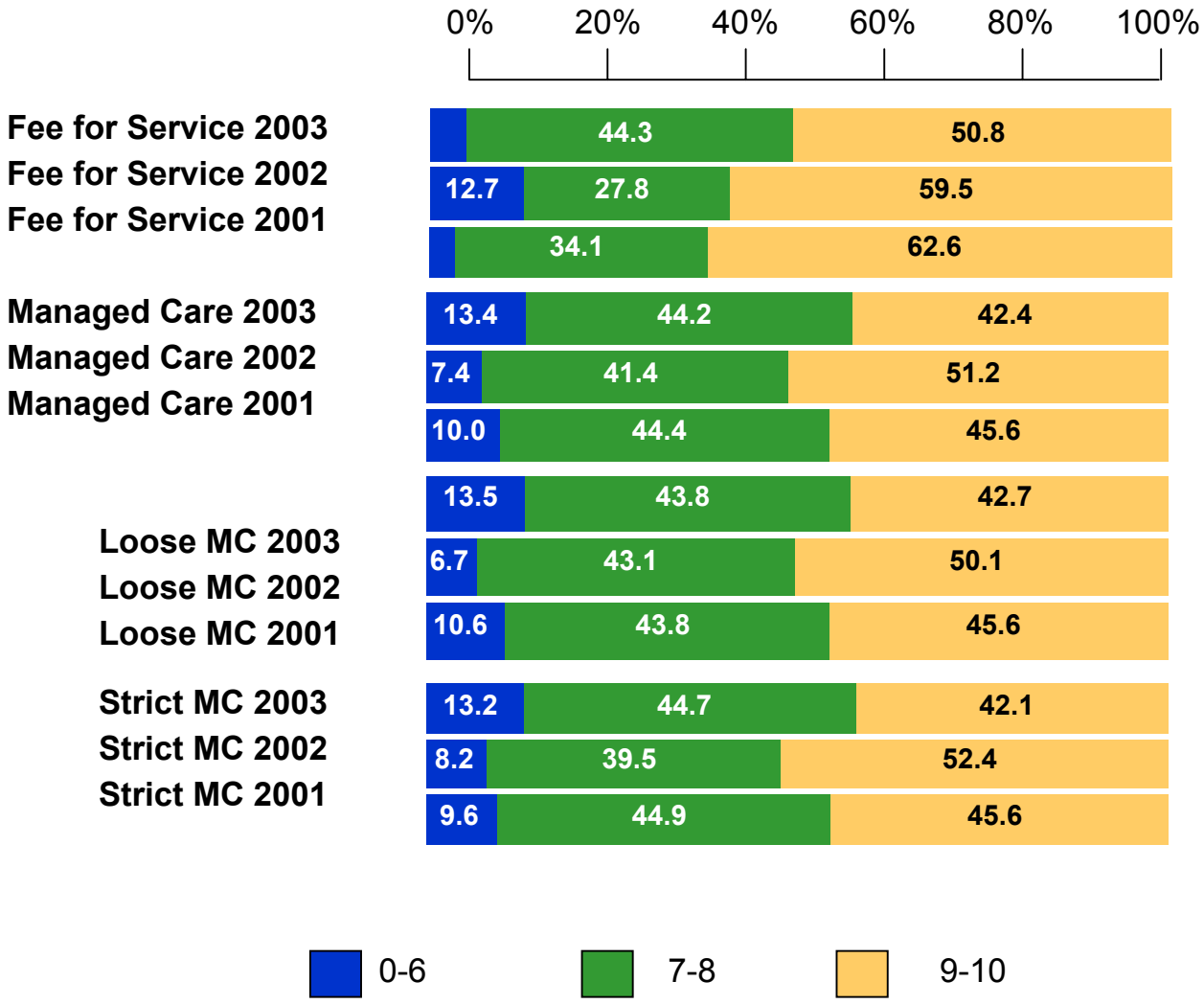


Figure A-10.
Summary of Experiences with *Getting Needed Care* by Plan Type, 2001 - 2003

Combines responses to four questions regarding how much of a problem, if any, consumers had with various aspects of getting needed care.

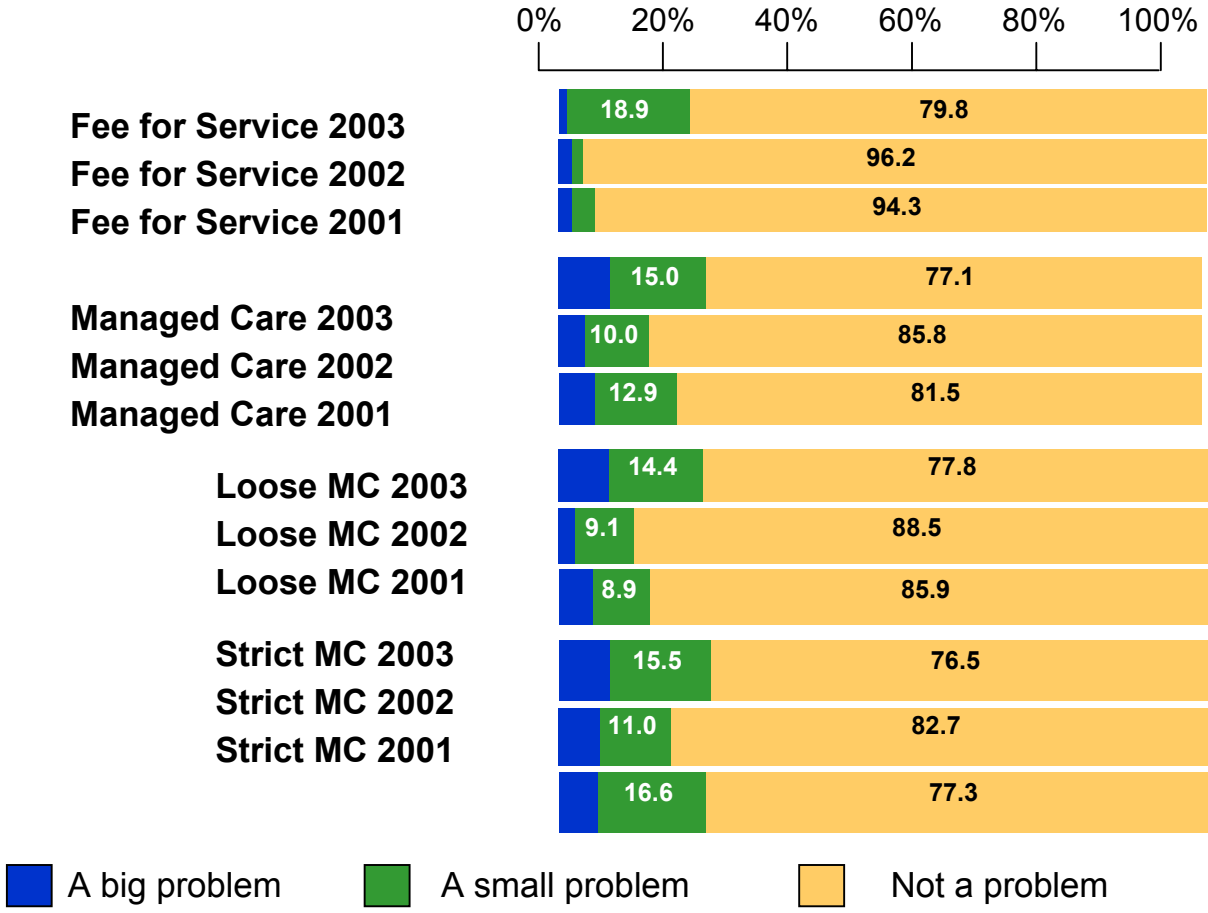


Figure A-11.
Summary of Experiences with *Health plan Customer Service* by Plan Type, 2001 – 2003

Combines responses to four questions regarding how much of a problem, if any, consumers had with various aspects of their health plans' customer service.

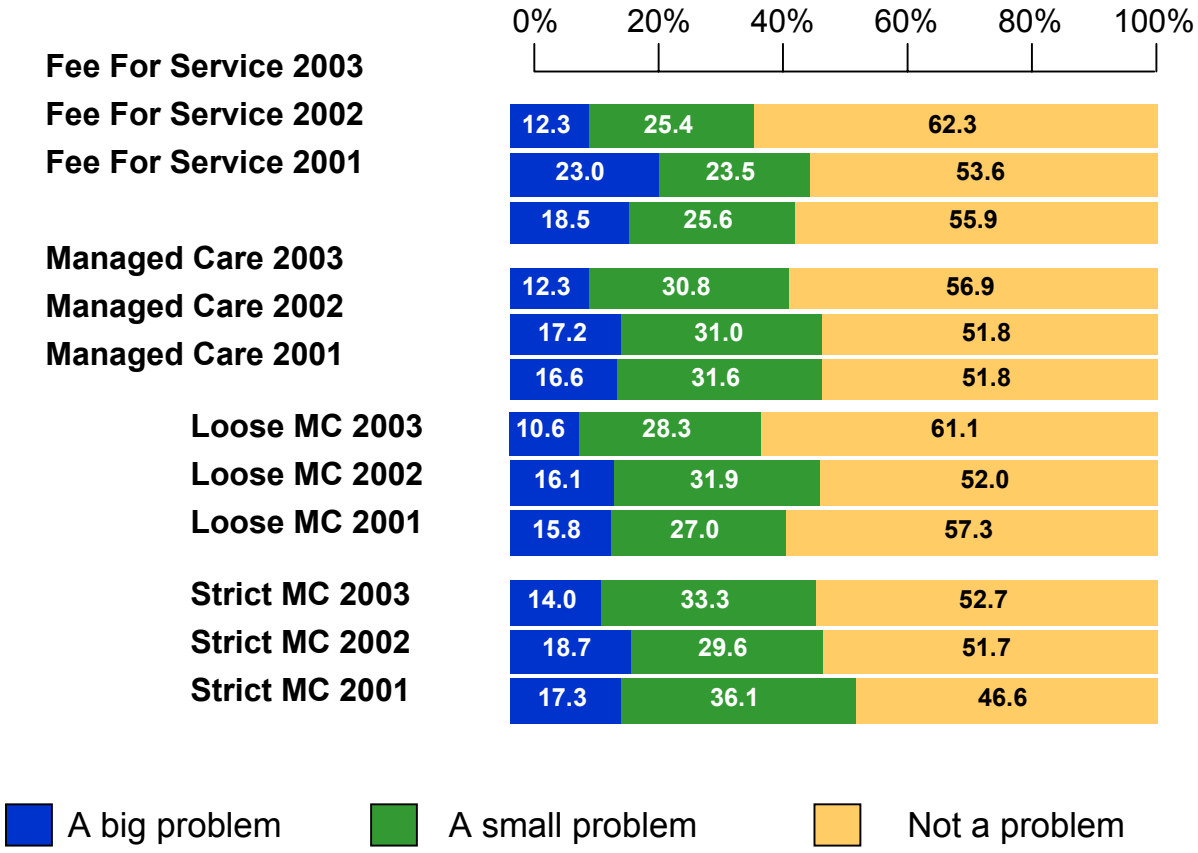


Figure A-12.
Summary of Experiences with *Doctor's Communication* by Plan Type, 2001 - 2003

Combines responses to four questions regarding how often doctors communicated well with consumers.

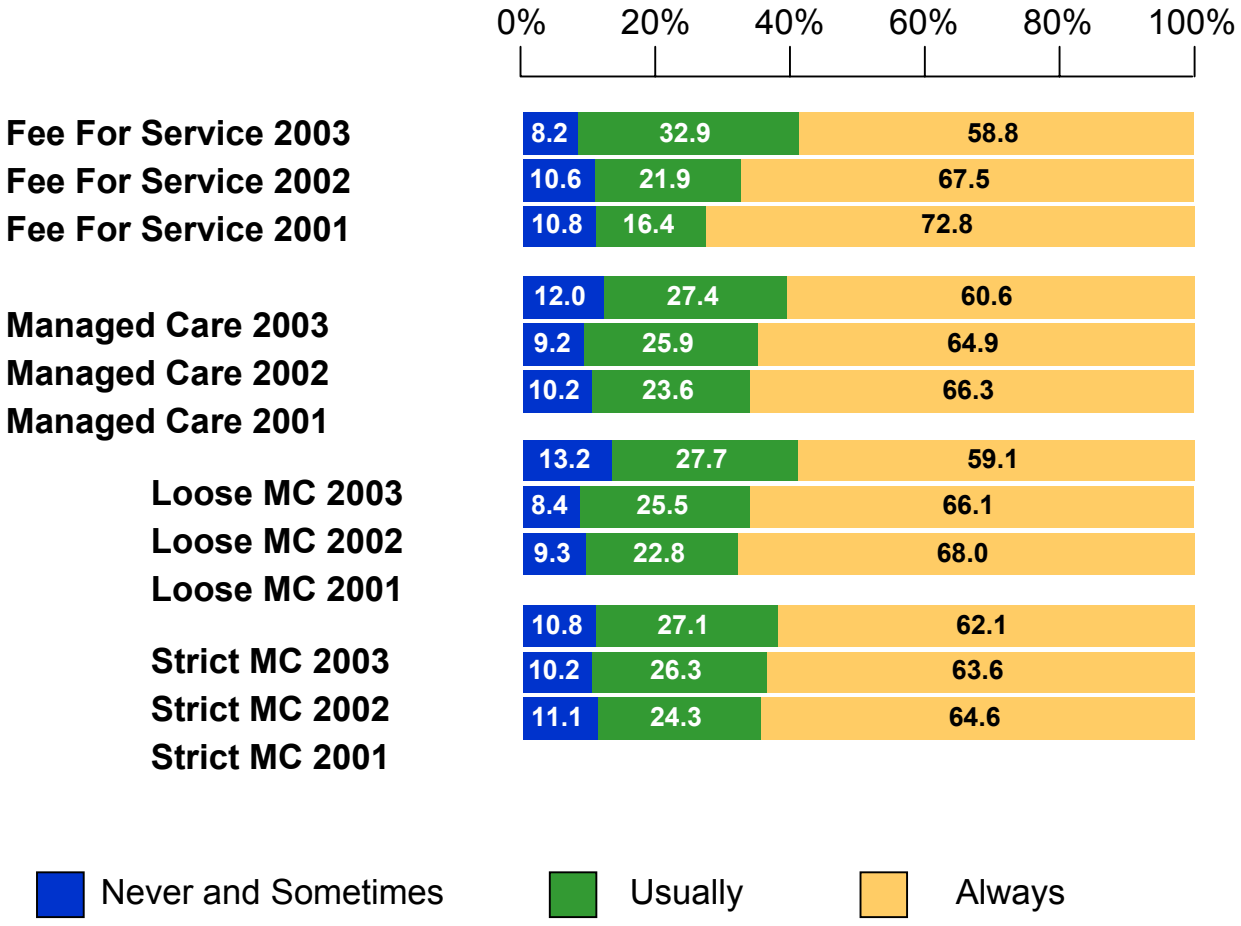


Figure A-13.
Summary of Experiences with *Courtesy of Office Staff* by Plan Type, 2001 - 2003

Combines responses to four questions regarding how often office staff were courteous and helpful.

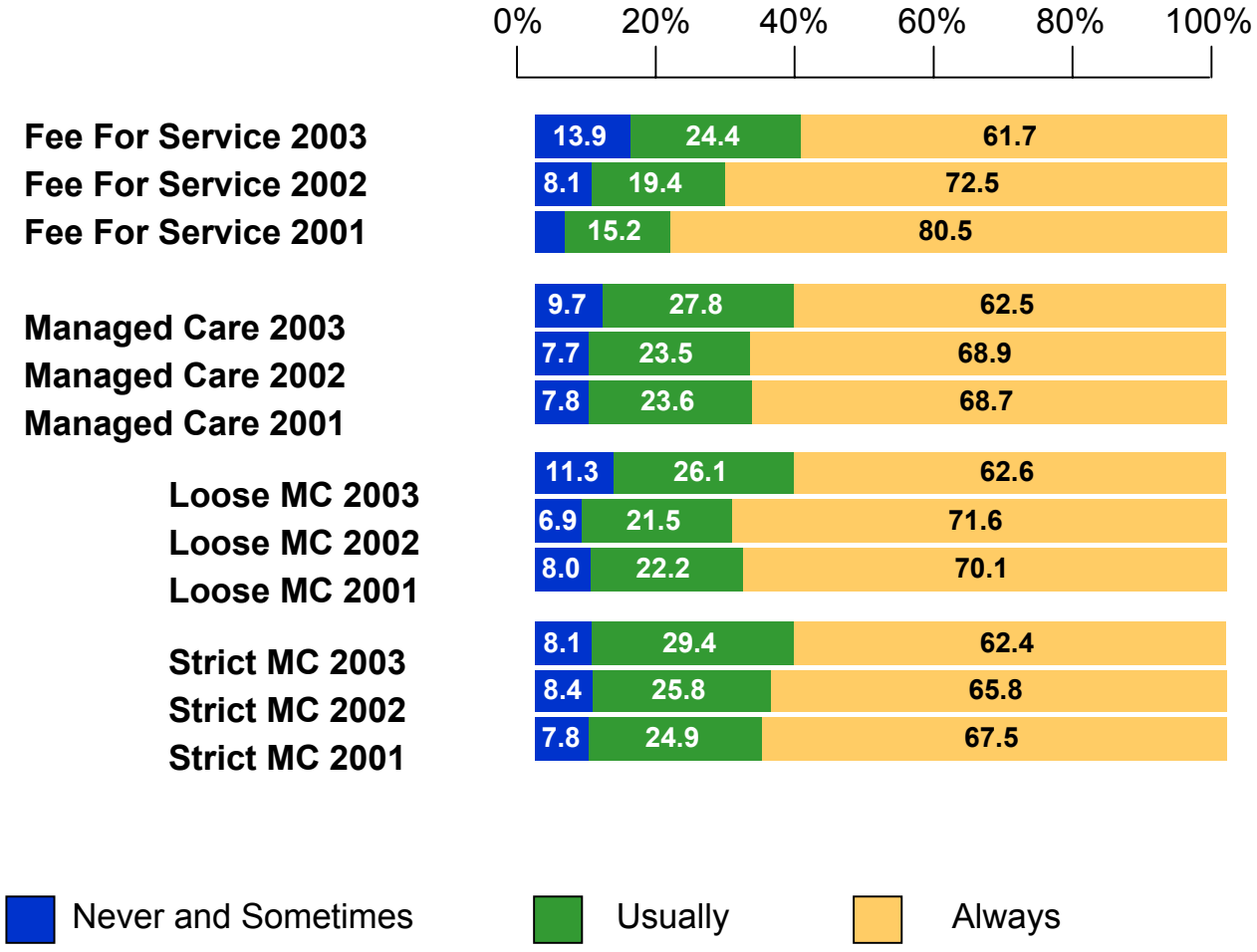


Figure A-14: Summary of CAHPS Composite Scores with Individual Questions: Delaware CAHPS vs. National CAHPS Benchmarking Data

Consumer Reports and Items		Response Categories	*% rating the most positive response*		
			DE	NCBD*	% Difference
Getting Needed Care			**76**	**74**	**2**
Q7:	With the choices your health plan gave you, how much of a problem, if any, was it to get a personal doctor or nurse you are happy with?	A big problem, A small problem, Not a problem	76	70	6
Q9:	In the last 12 months, how much of a problem, if any, was it to get a referral to a specialist that you needed to see?	A big problem, A small problem, Not a problem	77	76	1
Q22:	In the last 12 months, how much of a problem, if any, was it to get the care you or a doctor believed was necessary?	A big problem, A small problem, Not a problem	83	84	(1)
Q24:	In the last 12 months, how much of a problem, if any, were delays in health care while you waited for approval from your health plan?	A big problem, A small problem, Not a problem	68	67	1
Getting Care Quickly			**46**	**45**	**1**
Q14:	In the last 12 months, when you called during regular office hours, how often did you get the help or advice you needed?	Never + Sometimes, Usually, Always	56	57	(1)
Q18:	In the last 12 months, how often did you get an appointment for regular or routine health care as soon as you wanted?	Never + Sometimes, Usually, Always	59	42	17
Q16:	In the last 12 months, when you needed care right away for an illness or injury, how often did you get care as soon as you wanted?	Never + Sometimes, Usually, Always	48	61	(13)
Q25:**	In the last 12 months, how often did you wait in the doctor's office or clinic more than 15 minutes past your appointment time?	Never + Sometimes, Usually, Always	21	19	2
Health Plan Customer Service			**57**	**64**	**(7)**
Q34:	In the last 12 months, how much of a problem, if any, was it to find or understand information in the written materials?	A big problem, A small problem, Not a problem	56	58	(2)
Q36:	In the last 12 months, how much of a problem, if any, was it to get the help you needed when you called your health plan's customer service?	A big problem, A small problem, Not a problem	51	64	(13)
Q38:	In the last 12 months, how much of a problem, if any, did you have with paperwork for your health plan?	A big problem, A small problem, Not a problem	65	71	(6)
Doctor's Communication			**60**	**58**	**2**
Q28:	In the last 12 months, how often did doctors or other health providers listen carefully to you?	Never + Sometimes, Usually, Always	61	59	2
Q29:	In the last 12 months, how often did doctors or other health providers explain things in a way you could understand?	Never + Sometimes, Usually, Always	64	63	1
Q30:	In the last 12 months, how often did doctors or other health providers show respect for what you had to say?	Never + Sometimes, Usually, Always	66	62	4
Q31:	In the last 12 months, how often did doctors or other health providers spend enough time with you?	Never + Sometimes, Usually, Always	50	49	1
Courteous and Helpful Office Staff			**62**	**64**	**(2)**
Q26:	In the last 12 months, how often did office staff at a doctor's office or clinic treat you with courtesy and respect?	Never + Sometimes, Usually, Always	72	72	0
Q27:	In the last 12 months, how often was office staff at a doctor's office or clinic as helpful as you thought they should be?	Never + Sometimes, Usually, Always	52	56	(4)

*Adult Commercial 2002 population.

**NCBD phrases this question as such: How often were customers taken to the exam room WITHIN 15 minutes of their appointment. Wording of question implies that that "always" is the most positive response, and "never" or "sometimes" are the least positive

Appendix B: Definition of Consumer Reports and Ratings

The following chart lists the question items and responses for each of the five CAHPS consumer reports presented in this report.

Consumer Reports and Items		Response Grouping for Presentation
Getting Needed Care		
Q7:	With the choices your health plan gave you, how much of a problem, if any, was it to get a personal doctor or nurse you are happy with?	A big problem, A small problem, Not a problem
Q9:	In the last 12 months, how much of a problem, if any, was it to get a referral to a specialist that you needed to see?	A big problem, A small problem, Not a problem
Q22:	In the last 12 months, how much of a problem, if any, was it to get the care you or a doctor believed was necessary?	A big problem, A small problem, Not a problem
Q24:	In the last 12 months, how much of a problem, if any, were delays in health care while you waited for approval from your health plan?	A big problem, A small problem, Not a problem
Getting Care Quickly		
Q14:	In the last 12 months, when you called during regular office hours, how often did you get the help or advice you needed?	Never + Sometimes, Usually, Always
Q18:	In the last 12 months, how often did you get an appointment for regular or routine health care as soon as you wanted?	Never + Sometimes, Usually, Always
Q16:	In the last 12 months, when you needed care right away for an illness or injury, how often did you get care as soon as you wanted?	Never + Sometimes, Usually, Always
Q25:	In the last 12 months, how often did you wait in the doctor's office or clinic more than 15 minutes past your appointment time?	Never + Sometimes, Usually, Always
Health Plan Customer Service		
Q34:	In the last 12 months, how much of a problem, if any, was it to find or understand information in the written materials?	A big problem, A small problem, Not a problem
Q36:	In the last 12 months, how much of a problem, if any, was it to get the help you needed when you called your health plan's customer service?	A big problem, A small problem, Not a problem
Q38:	In the last 12 months, how much of a problem, if any, did you have with paperwork for your health plan?	A big problem, A small problem, Not a problem
Doctor's Communication		
Q28:	In the last 12 months, how often did doctors or other health providers listen carefully to you?	Never + Sometimes, Usually, Always
Q29:	In the last 12 months, how often did doctors or other health providers explain things in a way you could understand?	Never + Sometimes, Usually, Always
Q30:	In the last 12 months, how often did doctors or other health providers show respect for what you had to say?	Never + Sometimes, Usually, Always
Q31:	In the last 12 months, how often did doctors or other health providers spend enough time with you?	Never + Sometimes, Usually, Always
Courteous and Helpful Office Staff		
Q26:	In the last 12 months, how often did office staff at a doctor's office or clinic treat you with courtesy and respect?	Never + Sometimes, Usually, Always
Q27:	In the last 12 months, how often was office staff at a doctor's office or clinic as helpful as you thought they should be?	Never + Sometimes, Usually, Always

The following chart presents the exact wording for each of the four ratings questions presented in this report.

Consumer Ratings		Response Grouping for Presentation
Overall Rating of Personal Doctor		
Q5:	Use any number on a scale from 0 to 10 where 0 is the worst personal doctor or nurse possible, and 10 is the best personal doctor or nurse possible. How would you rate your personal doctor or nurse now?	0-6, 7-8, 9-10
Overall Rating of Specialist		
Q11:	Use any number on a scale from 0 to 10 where 0 is the worst specialist possible, and 10 is the best specialist possible. How would you rate the specialist?	0-6, 7-8, 9-10
Overall Rating of Health Care		
Q32:	Use any number on a scale from 0 to 10 where 0 is the worst health care possible, and 10 is the best health care possible. How would you rate all your health care?	0-6, 7-8, 9-10
Overall Rating of Health Plan		
Q39:	Use any number on a scale from 0 to 10 where 0 is the worst health plan possible, and 10 is the best health plan possible. How would you rate all your health plan?	0-6, 7-8, 9-10