Oregon Health Plan Report of Results for

Fee-For-Service (Adult Population)

2023 (MY2022) CAHPS® 5.1H Medicaid Member Experience Survey

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INTRODUCTION

The Oregon Health Authority (OHA) contracts with managed care organizations, also known as Coordinated Care Organizations (CCOs), to provide health care services. Understanding the experience of people who are Oregon Health Plan (OHP) members is important to clinicians, policy makers, patients and consumers, quality monitors and regulators, provider organizations, health plans, community collaboratives, and those who are responsible for monitoring and evaluating the quality of and access to health care services.

Introduced by the Agency for Healthcare Research and Quality (AHRQ) in the mid-1990s, the Consumer Assessment of Healthcare Providers and Systems (CAHPS) program encompasses the full range of standardized surveys that ask consumers and patients to report on and evaluate their experiences with health care. These surveys cover topics that are important to consumers, such as accessibility of services and communication skills of providers.

OHA conducts annual CAHPS surveys asking members to report on and evaluate their experiences with health care. These surveys cover topics that are important to consumers and focus on aspects of quality that consumers are best qualified to assess, such as the communication skills of providers and ease of access to health care services. The survey results help inform decisions for those involved with providing care to OHP members and to improve the quality of health care services.

The survey measures member satisfaction with the experience of care and gives a general indication of how well the health plan meets members' expectations. Surveyed members are asked to rate various aspects of the health plan based on their experience with the plan during the previous 6 months. In addition, the survey collects data on Effectiveness of Care measures, including influenza vaccinations and smoking cessation measures.

WHAT'S NEW IN 2023

2023 SURVEY FIELDING UPDATES

SAMPLE SIZE

To increase the number of completed surveys for analysis, OHA increased the overall sample budget from 48,000 in 2022 to 92,000 in 2023. This year OHA's methodology used a sample size of 2,250 for Adult Medicaid samples, 2,250 for Child Medicaid samples, and 700 for Child Medicaid with Chronic Conditions samples.

SURVEY INSTRUMENTS

NCQA did not make any substantive changes to the HEDIS/CAHPS survey instruments or survey administration protocols this year and therefore, no changes were made to the core HEDIS/CAHPS survey question items.

OHA added and updated various questions to further understand the background of members enrolled in Oregon Health Plans. This includes further details on the longevity of conditions that members may be suffering from, the primary languages that members speak at home, and the gender and sexuality preferences of members.

UPDATES TO THE 2023 OHA CAHPS SURVEY RESULTS REPORT

The following updates were made for the 2023 CAHPS Results Reports:

- Updates to the *Member Profile and Analysis of Plan Ratings by Member Segment* section for a revised gender identity survey item.
- Additional analyses of *Access to Dental Care* and *Impact of COVID-19 Pandemic on Getting Needed Care*.
- Refreshed CSS *Key Driver Model* using CSS's Book-of-Business data collected over the past two years.
- An updated *Health Plan Quality Improvement Resource Guide*.

ABOUT THIS REPORT

The key features of this 2023 CAHPS report, prepared by CSS for FFS, are highlighted below.

- Survey results presented in this report were calculated following the NCQA guidelines published in *HEDIS Measurement Year 2022, Volume 3: Specifications for Survey Measures* unless otherwise noted. At least 30 valid responses must be collected for a measure result to be reportable by OHA. If the rate denominator is less than 30, a measure result of "NR" (i.e., not reportable) is displayed throughout the report, indicating that the results are not reportable by OHA. Also, if the numerator for any displayed category is less than 3, the "NR" label will be applied.

- Throughout the report, the 2023 FFS survey results are compared to the 2023 State OHP Average. The 2023 State OHP Average is calculated by pooling Adult Medicaid survey responses across CCOs surveyed by the Oregon Health Authority.

- *Executive Summary* provides a high-level overview of survey findings. This section highlights the areas where FFS performs significantly above or below the State Oregon Health Plan benchmarks. If prior-year survey results are available, any statistically significant improvements or declines on key survey measures are also noted. Top organizational priorities for quality improvement based on CSS's *Key Driver Analysis* are identified.

- *Summary of Survey Results* presents the 2023 FFS survey scores on key measures, including question summary rates, global proportions, and changes in rates and global proportion scores from the previous year (if applicable); and comparisons to relevant State Oregon Health Plan benchmarks. Statistically significant differences in scores are noted.

- *Detailed Performance Charts* are provided for the rating questions, composite measures, and individual survey items representing the various CAHPS domains of care. The 2023 FFS QSRs and global proportions are compared to the 2023 State OHP Average on all measures. Where available, a three-year trend in scores is also shown.

- A one-page summary of the *Effectiveness of Care* measures includes comparisons to prior-year results (if available) as well as to the 2023 State OHP Average rates. All rates are calculated according to the NCQA guidelines, but are presented regardless of their eligibility for NCQA reporting.

- *Member Profile and Analysis of Ratings by Member Segment* compares the 2023 FFS respondent profile to the relevant State Oregon Health Plan distribution(s) of demographic characteristics and utilization variables. Variation in *Rating of Health Plan* measure by member segment is examined.

- *Access to Dental Care* compares the 2023 FFS respondent profile to the relevant State Oregon Health Plan distribution(s) for access to dental care survey items.

- *Impact of COVID-19 Pandemic on Getting Needed Care* examines the 2023 FFS respondent profile of how often respondents delayed getting various health services over time.

- *Key Driver Analysis* identifies key member experience touch points that appear to drive the overall *Rating of Health Plan*. The CSS *Key Driver Model* quantifies the contribution of each key driver to the overall member assessment of the plan. The 2023 FFS results on each key driver are compared to the highest score among all the Adult CCOs contributing to the 2023 State OHP Average, yielding a measure of available room for improvement in each area. The result is then weighted by the key driver's contribution to the overall *Rating of Health Plan* score. Opportunities for improvement are prioritized based on the expected improvement in the FFS *Rating of Health Plan* score due to improved performance on the key driver measure. A separate section of the report provides some helpful resources for health plan quality improvement.

- The *Appendix* includes:

  - Score calculation guidelines and methodology;

  - A glossary of terms; and

  - A copy of the survey instrument.

EXECUTIVE SUMMARY

CSS administered the Adult Medicaid version of the 2023 CAHPS Health Plan Survey for the Oregon Health Authority on behalf of Fee-For-Service, hereafter referred to as FFS between January 4 and April 5, 2023.

The final survey sample for FFS included 2,250 members. During the survey fielding period, 277 sample members completed the survey. After final survey eligibility criteria were applied, the resulting response rate was 12.74 percent.

This Executive Summary focuses on key CAHPS performance metrics, including year-over-year changes in results and comparisons to relevant State Oregon Health Plan benchmarks. Also identified are top organizational priorities for quality improvement based on CSS's *Key Driver Analysis*.

RESULTS ON KEY SURVEY MEASURES

The findings presented in this section are based on the rates of FFS Adult sample members rating their experience favorably (i.e., 8, *9,* or *10* for the overall rating questions and *Usually* or *Always* for all other CAHPS measures).

STATISTICALLY SIGNIFICANT IMPROVEMENTS OR DECLINES COMPARED TO 2022

Reportable Rate IMPROVED	Reportable Rate DECLINED
No statistically significant improvements	No statistically significant declines

STATISTICALLY SIGNIFICANT DIFFERENCES FROM STATE OREGON HEALTH PLAN

Reportable Rate ABOVE Benchmark	Reportable Rate BELOW Benchmark
2023 State OHP Average	
None	Customer Service (by 8.31 points)

TOP PRIORITIES FOR QUALITY IMPROVEMENT

CSS's *Key Driver Analysis* identifies the key member experience touch points that shape members' overall assessment of the health plan, as captured by the *Rating of Health Plan* question at the end of the survey. To the extent that the plan can improve these experiences, the overall rating of the plan will reflect these gains. Below are the top five quality improvement opportunities that will result in the largest incremental gains in the *Rating of Health Plan* measure for FFS.

Top Priorities for Quality Improvement
1. Improving health plan provider network (highly-rated personal doctors)
2. Improving the ability of the health plan customer service to provide necessary information or help
3. Improving member access to care (getting an appointment for urgent care as soon as needed)
4. Improving health plan provider network (highly-rated specialists)
5. Improving member access to care (having a personal doctor)

The remainder of this report examines these and other findings in greater detail.

SURVEY RESULTS AT A GLANCE

An overview of summary measures is presented in Exhibit 1. This includes CAHPS ratings and composites and comparisons to the State Oregon Health Plan results, and prior year data (where available).

EXHIBIT 1. 2023 FFS ADULT MEDICAID OHA CAHPS SURVEY: RESULTS AT A GLANCE

CAHPS 5.0H Survey Measures		Global Proportions and Question Summary Rates					Valid Responses			2023 State OHP Average	
		2021		2022		2023	2021	2022	2023		
		Rate	Point Change	Rate	Point Change	Rate				Rate	Point Diff.
Overall Ratings (% 8, 9, or 10)	Q8. Rating of All Health Care	68.71%	[+4.02]	67.74%	[+4.99]	**72.73%**	147	93	**176**	69.70%	[+3.03]
	Q18. Rating of Personal Doctor	76.19%	[+4.98]	78.38%	[+2.79]	**81.17%**	168	111	**223**	79.54%	[+1.63]
	Q22. Rating of Specialist Seen Most Often	80.00%	[-1.74]	70.97%	[+7.29]	**78.26%**	90	62	**115**	78.88%	[-0.62]
	Q28. Rating of Health Plan	61.50%	[+3.52]	70.16%	[-5.14]	**65.02%**	200	124	**243**	70.40%	[-5.38]
Overall Ratings (% 9 or 10)	Q8. Rating of All Health Care	48.98%	[-0.12]	35.48%	[+13.38] ★	**48.86%**	147	93	**176**	47.59%	[+1.27]
	Q18. Rating of Personal Doctor	58.33%	[+6.69]	59.46%	[+5.56]	**65.02%**	168	111	**223**	62.92%	[+2.10] ★
	Q22. Rating of Specialist Seen Most Often	67.78%	[-3.43]	58.06%	[+6.28]	**64.35%**	90	62	**115**	62.64%	[+1.71]
	Q28. Rating of Health Plan	45.00%	[+1.09]	50.00%	[-3.91]	**46.09%**	200	124	**243**	51.55%	[-5.46]
Getting Needed Care (% Always or Usually)	***Getting Needed Care Composite***	77.18%	[+1.34]	69.60%	[+8.92]	**78.52%**	123	82	**147**	77.04%	[+1.48]
	Q9. Easy to get needed care	81.63%	[-1.06]	79.79%	[+0.78]	**80.57%**	147	94	**175**	81.13%	[-0.56]
	Q20. Easy to see specialists	72.73%	[+3.74]	59.42%	[+17.05] ★	**76.47%**	99	69	**119**	72.95%	[+3.52]
Getting Care Quickly (% Always or Usually)	***Getting Care Quickly Composite***	78.20%	[-1.23]	74.36%	[+2.61]	**76.97%**	108	68	**133**	76.52%	[+0.45]
	Q4. Got urgent care as soon as needed	81.58%	[-1.36]	80.36%	[-0.14]	**80.22%**	76	56	**91**	78.05%	[+2.17]
	Q6. Got routine care as soon as needed	74.82%	[-1.11]	68.35%	[+5.36]	**73.71%**	139	79	**175**	74.99%	[-1.27]
How Well Doctors Communicate* (% Always or Usually)	***How Well Doctors Communicate Composite***	92.21%	[+3.97]	91.30%	[+4.87]	**96.18%**	119	92	**170**	92.27%	[+3.91]
	Q12. Doctor explained things	93.28%	[+2.61]	90.22%	[+5.66]	**95.88%**	119	92	**170**	93.48%	[+2.40]
	Q13. Doctor listened carefully	94.96%	[+1.51]	91.30%	[+5.17]	**96.47%**	119	92	**170**	91.67%	[+4.80] ★
	Q14. Doctor showed respect	92.37%	[+4.69]	91.30%	[+5.75]	**97.06%**	118	92	**170**	93.89%	[+3.17]
	Q15. Doctor spent enough time	88.24%	[+7.06] ★	92.39%	[+2.90]	**95.29%**	119	92	**170**	90.04%	[+5.25] ★
Customer Service (% Always or Usually)	***Customer Service Composite***	73.15%	[+8.36]	84.38%	[-2.87]	**81.51%**	54	32	**73**	89.82%	[-8.31] ★
	Q24. Provided needed information/help	62.96%	[+8.27]	78.13%	[-6.89]	**71.23%**	54	32	**73**	84.11%	[-12.88] ★
	Q25. Treated with courtesy/respect	83.33%	[+8.45]	90.63%	[+1.16]	**91.78%**	54	32	**73**	95.52%	[-3.74]
Additional Content Areas	Q17. Coordination of Care (% Always or Usually)	86.67%	[-1.98]	74.65%	[+10.04]	**84.68%**	75	71	**111**	82.68%	[+2.00]
Effectiveness of Care Measures	Flu Vaccinations for Adults	46.51%	[-7.88]	48.08%	[-9.44]	**38.64%**	172	104	**220**	34.24%	[+4.40]
	Advising Smokers and Tobacco Users to Quit	64.44%	[-6.11]	NR	[---]	**58.33%**	45	27	**36**	67.06%	[-8.73]
	Discussing Cessation Medications	47.73%	[+0.84]	NR	[---]	**48.57%**	44	27	**35**	48.05%	[+0.52]
	Discussing Cessation Strategies	48.89%	[-3.17]	NR	[---]	**45.71%**	45	27	**35**	41.44%	[+4.28]

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Calculation and Reporting of Results

All rates were calculated by CSS following NCQA specifications.

The number of valid responses (n) collected for the past three consecutive years are reported. At least 30 valid responses must be collected for a measure result to be reportable by OHA. If n is less than 30, "NR" and "[...]" are displayed in a lighter color, indicating that the rate and point change results are not reportable by OHA. Also, if the numerator for any displayed category is less than 3, the "NR" label will be applied.

Rate Comparisons and Statistical Significance Testing

Comparisons to prior-year and benchmark rates were calculated prior to rounding and rounded for display. Differences in rates were tested for statistical significance using a t-test for proportions at the 95% confidence level. Statistically significant differences between the current-year rate and the comparison rate are marked with a ★ symbol.

SURVEY METHODOLOGY

SURVEY PROTOCOL AND TIMELINE

CSS administered the Adult Medicaid version of the 2023 CAHPS Health Plan Survey for the Oregon Health Authority on behalf of FFS using a mixed methodology of internet, mail, and telephone. The Oregon Health Authority's mixed methodology consisted of the following milestones:

- A prenotification letter with an invitation to complete the survey online mailed on January 4;
- An initial questionnaire with cover letter mailed on January 11;
- A replacement questionnaire with cover letter mailed on February 8;
- A telephone follow-up phase targeting non-respondents, with up to four telephone follow-up attempts spaced at different times of the day and on different days of the week, which started on March 6; and
- Close of data collection on April 5, 2023.

SURVEY MATERIALS

The survey instruments (both English and Spanish) used for FFS are provided in the Appendix. CSS designed the survey following instructions from OHA and the NCQA specifications detailed in *HEDIS Measurement Year 2022, Volume 3: Specifications for Survey Measures* and *Quality Assurance Plan for HEDIS MY 2022 Survey Measures*. The materials referred to Oregon Health Plan and included the Oregon Health Authority logo on all the mailing materials.

Each survey package included a postage-paid business reply envelope. Besides the core CAHPS questions, the survey included 45 additional questions added by OHA. These included questions on mobility impairment, cultural competency, access to dental care, telemedicine, COVID-19, access to interpreter services, and SOGI/REALD demographics. All mailings included a duplex English and Spanish cover letter. Members received either an English or Spanish survey based on language information provided by Oregon Health Authority. Members had the option to request the survey in the other language using a telephone request line.

The website URL and a personal web ID was listed in the prenotification letter and second survey package cover letter to complete the survey online.

SAMPLE SELECTION

CSS followed Oregon Health Authority's instructions to generate the survey sample for FFS. For the Adult Medicaid survey (general population), sample-eligible members were defined as plan members who were 18 years old or older as of November 30, 2022; were currently enrolled; had been continuously enrolled for six months (with no more than one enrollment break of 45 days or less); and whose primary coverage was through Medicaid.

Prior to sampling, CSS carefully inspected the member file(s) and noted any errors or irregularities found (such as incomplete contact information or subscriber numbers). Once the quality assurance process had been completed, CSS processed member addresses through the USPS National Change of Address (NCOA) service to ensure that the mailing addresses were up to date. The final sample was generated following the NCQA systematic sampling methodology, with no more than one member per household selected to receive the survey. The exception to this rule was any CCO that failed to meet the desired sample size in which case more than one member per household could be selected. CSS assigned each sampled member a unique identification number, which was used to track their progress throughout the data collection process.

The Oregon Health Authority chose to oversample for targeted race and ethnicity groups to ensure these groups were appropriately represented in the state sample. Data for those sample members only appear in the State OHP results and not the individual CCO results. Therefore, the final combined survey sample for FFS included 2,250 members.

DATA CAPTURE

Returned mail questionnaires were recorded using optical scanning. If the scanning technology was unable to identify the specific response option selected with a predefined degree of certainty, trained data entry operators were employed to ensure that each such response was accurately recorded. Responses from online questionnaires were stored on CSS internal servers.

Computer Assisted Telephone Interviewing (CATI) technology was used to electronically capture survey responses obtained during telephone interviews. Members were able to complete the survey in either English or Spanish. CATI supervisors maintained quality control by monitoring the telephone interviews and response capture by interviewers in real time and auditing recorded interviews. At least 10 percent of the interviews were monitored by supervisors.

Due to the multiple outreach attempts, multiple survey responses could be received from the same sample member. In those cases, only one survey response (the most complete survey) was included in the final analysis dataset.

MEMBER DISPOSITIONS AND RESPONSE RATE

During the survey fielding period, 277 sample members completed the survey. After final survey eligibility criteria were applied, the resulting response rate was 12.74 percent. Additional detail on sample member status at the end of data collection (dispositions) is provided in Exhibit 2.

EXHIBIT 2. 2023 FFS ADULT MEDICAID OHA CAHPS SURVEY: SAMPLE MEMBER DISPOSITIONS AND RESPONSE RATE

Disposition	Total		2023 State OHP Average
	Number	% Initial Sample	
Initial Sample	2,250	100.00%	---
Disposition			
Complete and Eligible - Mail	119	5.29%	8.59%
Complete and Eligible - Phone	111	4.93%	5.15%
Complete and Eligible - Internet	47	2.09%	2.47%
Complete and Eligible - Total	277	12.31%	16.21%
Does not meet Eligible Population criteria	53	2.36%	1.24%
Incomplete (but Eligible)	18	0.80%	0.86%
Ineligible	22	0.98%	0.46%
- Language barrier	1	0.04%	0.15%
- Mentally or physically incapacitated	18	0.80%	0.52%
- Deceased	3	0.13%	0.17%
Refusal	171	7.60%	6.48%
Nonresponse after maximum attempts	1,681	74.71%	73.42%
Added to Do Not Call (DNC) list	28	1.24%	0.95%
Response Rate*		**12.74%**	**16.55%**

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*Response rate = Complete and Eligible Surveys/[Complete and Eligible + Incomplete (but Eligible) + Refusal + Nonresponse after maximum attempts + Added to Do Not Call (DNC) List]

SATISFACTION WITH THE EXPERIENCE OF CARE

PATIENT EXPERIENCE OF CARE MEASURES

GLOBAL RATINGS

CAHPS Health Plan Survey (version 5.1H) includes four global rating questions that utilize the scale of *0* to *10*, representing the lowest and highest possible rating. Results are reported as the proportion of members selecting one of the top three ratings (*8*, *9*, or *10*).

- ***Rating of Personal Doctor*** (*0* = worst personal doctor possible; *10* = best personal doctor possible)
- ***Rating of Specialist Seen Most Often*** (*0* = worst specialist possible; *10* = best specialist possible)
- ***Rating of All Health Care*** (*0* = worst health care possible; *10* = best health care possible)
- ***Rating of Health Plan*** (*0* = worst health plan possible; *10* = best health plan possible)

CAHPS COMPOSITES

NCQA calculates results for several CAHPS composite measures. CAHPS composites combine results from related survey questions into a single measure to summarize health plan performance in the areas listed below.

- ***Getting Needed Care*** combines two survey questions that address member access to care. Both questions use a *Never*, *Sometimes*, *Usually*, or *Always* response scale, with *Always* being the most favorable response. Results are based on the proportion of members answering the following questions as *Usually* or *Always*.
  - *In the last 6 months, how often was it easy to get the care, tests, or treatment you needed?*
  - *In the last 6 months, how often did you get an appointment to see a specialist as soon as you needed?*

- ***Getting Care Quickly*** combines responses to two survey questions that address timely availability of both urgent and check-up/routine care. The questions use a *Never*, *Sometimes*, *Usually*, or *Always* scale, with *Always* being the most favorable response. Results are based on the proportion of members selecting *Usually* or *Always* in response to the following questions:
  - *In the last 6 months, when you needed care right away, how often did you get care as soon as you needed?*
  - *In the last 6 months, how often did you get an appointment for a check-up or routine care as soon as you needed?*
- ***How Well Doctors Communicate*** combines responses to four survey questions that address physician communication. The questions use a *Never*, *Sometimes*, *Usually*, or *Always* scale, with *Always* being the most favorable response. Results are reported as the proportion of members answering the following questions as *Usually* or *Always*:
  - *In the last 6 months, how often did your personal doctor explain things in a way that was easy to understand?*
  - *In the last 6 months, how often did your personal doctor listen carefully to you?*
  - *In the last 6 months, how often did your personal doctor show respect for what you had to say?*
  - *In the last 6 months, how often did your personal doctor spend enough time with you?*
- ***Customer Service*** combines responses to two survey questions that ask about member experience with the health plan's customer service. The questions use a *Never*, *Sometimes*, *Usually*, or *Always* scale, with *Always* being the most favorable response. Results are reported as the proportion of members selecting *Usually* or *Always* in response to the following questions:
  - *In the last 6 months, how often did your health plan's customer service staff give you the information or help you needed?*
  - *In the last 6 months, how often did your health plan's customer service staff treat you with courtesy and respect?*
- ***Coordination of Care*** is based on a single survey question, which uses a *Never*, *Sometimes*, *Usually*, or *Always* scale (with *Always* being the most favorable response). Results are based on the proportion of members selecting *Usually* or *Always* in response to the question below:
  - *In the last 6 months, how often did your personal doctor seem informed and up-to-date about the care you got from these doctors or other health providers?*

CALCULATION AND REPORTING OF RESULTS

QUESTION SUMMARY RATES AND COMPOSITE GLOBAL PROPORTIONS

Question Summary Rates express the proportion of respondents selecting the desired response option(s) on a survey question. Examples include percent selecting *Usually* or *Always* or percent rating *9* or *10*.

Composite Global Proportions express the proportion of respondents selecting the desired response option(s) from a predefined set of two or more related questions on the survey. The proportions are calculated by first determining the relevant proportion on each survey question contributing to the composite and then averaging these proportions across all questions in the composite.

Throughout the report, all question summary rates and composite global proportions are rounded to two decimal places for display purposes (e.g., 0.23456 is displayed as 23.46%). However, all calculations involving rates and proportions, including statistical significance testing, are carried out prior to rounding. For more details on the calculations please refer to *HEDIS Measurement Year 2022, Volume 3: Specifications for Survey Measures* or consult Appendix A.

SMALL NUMBER SUPPRESSION

The numerator for an individual question is the number of valid responses selecting the desired response option(s) while the denominator is the total number of valid responses to that question. The numerator for a composite is the average number of responses selecting the desired response option(s) across all questions in the composite; the denominator is the average number of responses across all questions in the composite (note: composite numerators and denominators are rounded for display purposes).

At least 30 valid responses must be collected for a measure result to be reportable by OHA. If the rate denominator is less than 30, a measure result of “NR” (i.e., not reportable) is displayed throughout the report, indicating that the results are not reportable by OHA. Also, if the numerator for any displayed category is less than 3, the “NR” label will be applied.

COMPARISONS TO BENCHMARKS AND PRIOR-YEAR RESULTS

Throughout the report, the 2023 FFS results are compared to the 2023 State OHP Average as well as to the highest and lowest performing CCO. The 2023 State OHP Average is calculated by pooling Adult Medicaid survey responses across CCOs surveyed by the Oregon Health Authority.

If available, prior-year survey results are provided for comparison and year-to-year changes in results are tested for statistical significance. All the statistical tests are carried out at the 95% confidence level (i.e., there is a 95% probability that the observed difference is not due to chance).

SUMMARY OF SURVEY RESULTS

A high-level FFS performance overview on key survey measures is provided in Exhibit 3. These include overall ratings, composite global proportions, and summary rates for additional measures. Where applicable, changes in scores over time and comparisons to benchmarks are reported and tested for statistical significance.

EXHIBIT 3. 2023 FFS ADULT MEDICAID OHA CAHPS SURVEY: PATIENT EXPERIENCE MEASURES

Survey Measures	Your Organization						2023 State OHP Average	
	2023		2022		2021			
	Rate	(n)	Rate	Point Change	Rate	Point Change	Rate	Point Diff.
Overall Ratings (% 8, 9, or 10)								
Rating of Personal Doctor	**81.17%**	**(223)**	78.38%	[+2.79]	76.19%	[+4.98]	79.54%	[+1.63]
Rating of Specialist Seen Most Often	**78.26%**	**(115)**	70.97%	[+7.29]	80.00%	[-1.74]	78.88%	[-0.62]
Rating of All Health Care	**72.73%**	**(176)**	67.74%	[+4.99]	68.71%	[+4.02]	69.70%	[+3.03]
Rating of Health Plan	**65.02%**	**(243)**	70.16%	[-5.14]	61.50%	[+3.52]	70.40%	[-5.38]
Overall Ratings (% 9 or 10)								
Rating of Personal Doctor	**65.02%**	**(223)**	59.46%	[+5.56]	58.33%	[+6.69]	62.92%	[+2.10] ★
Rating of Specialist Seen Most Often	**64.35%**	**(115)**	58.06%	[+6.28]	67.78%	[-3.43]	62.64%	[+1.71]
Rating of All Health Care	**48.86%**	**(176)**	35.48%	[+13.38] ★	48.98%	[-0.12]	47.59%	[+1.27]
Rating of Health Plan	**46.09%**	**(243)**	50.00%	[-3.91]	45.00%	[+1.09]	51.55%	[-5.46]
Composite Measures								
Getting Needed Care	**78.52%**	**(147)**	69.60%	[+8.92]	77.18%	[+1.34]	77.04%	[+1.48]
Getting Care Quickly	**76.97%**	**(133)**	74.36%	[+2.61]	78.20%	[-1.23]	76.52%	[+0.45]
How Well Doctors Communicate	**96.18%**	**(170)**	91.30%	[+4.87]	92.21%	[+3.97]	92.27%	[+3.91]
Customer Service	**81.51%**	**(73)**	84.38%	[-2.87]	73.15%	[+8.36]	89.82%	[-8.31] ★
Additional Content Areas								
Coordination of Care	**84.68%**	**(111)**	74.65%	[+10.04]	86.67%	[-1.98]	82.68%	[+2.00]

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Calculation and Reporting of Results

All rates were calculated by CSS following NCQA specifications. The number of valid responses collected this year for each measure (n, or measure denominator) is reported in parentheses.

At least 30 valid responses must be collected for a measure result to be reportable by OHA. If n is less than 30, "NR" and "[...]" are displayed in a lighter color, indicating that the rate and point change results are not reportable by OHA. Also, if the numerator for any displayed category is less than 3, the "NR" label will be applied.

Rate Comparisons and Statistical Significance Testing

Comparisons to prior-year and benchmark rates were calculated prior to rounding and rounded for display. Differences in rates were tested for statistical significance using a t-test for proportions at the 95% confidence level. Statistically significant differences between the current-year rate and the comparison rate are marked with a ★ symbol.

DETAILED PERFORMANCE CHARTS

Detailed charts are provided for CAHPS composite global proportions and question summary rates. The charts have the following features:

TREND IN RESULTS

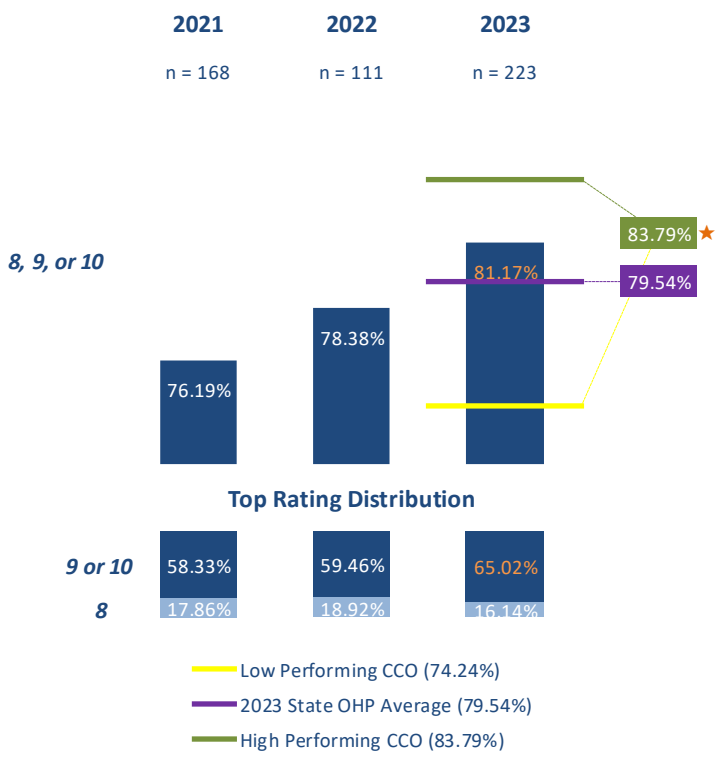
- Survey scores are trended over three consecutive years of data collection, if available. A result may not be available if the survey was not administered in a given year, if the measure is new, or if the measure is not deemed appropriate for trending. In such cases, “no data” appears in place of the score.
- Where appropriate, changes in the distribution of favorable ratings over time are shown in the *Top Rating Distribution* panel of the chart (i.e., percent responding *8* vs. percent responding *9* or *10,* or percent responding *Usually* vs. percent responding *Always*).
- The number of valid responses (*n*) appears above each bar. At least 30 valid responses must be collected for a measure result to be reportable by OHA. If n is less than 30, "NR" appears in place of n, indicating that the results are not reportable by OHA. Also, if the numerator for any displayed category is less than 3, the “NR” label will be applied.
- Statistical comparisons are conducted between the current-year and each of the prior-year rates, if available. Differences in rates are tested for statistical significance at the 95% confidence level. Statistically significant differences are indicated with a ★ symbol next to the comparison score. For example, ★ appearing next to the 2022 rate denotes a statistically significant difference between the 2023 and 2022 rates.

COMPARISONS TO BENCHMARKS

- The horizontal lines displayed on the charts correspond to the 2023 State OHP Average as well as to the highest and lowest performing CCO. If the 2023 score is significantly different from any of these benchmark scores at the 95% confidence level, ★ appears next to the relevant score.

Rating of Personal Doctor

Percent Responding 8, 9, or 10



30730

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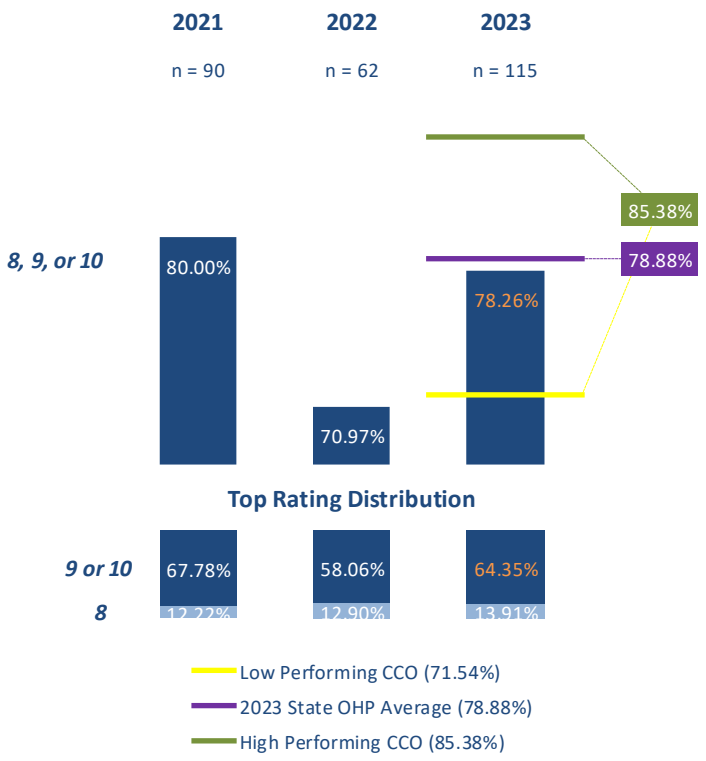
Tests of statistical significance were conducted for the following reportable rates: *(8 + 9 + 10)* and *(9 + 10)*. Statistically significant differences, tested at the 95% confidence level, between your organization's **current-year rate** and a comparison rate (prior-year, or national rate) are marked with a ★ symbol next to the comparison rate.

Rating of Specialist Seen Most Often

Percent Responding 8, 9, or 10



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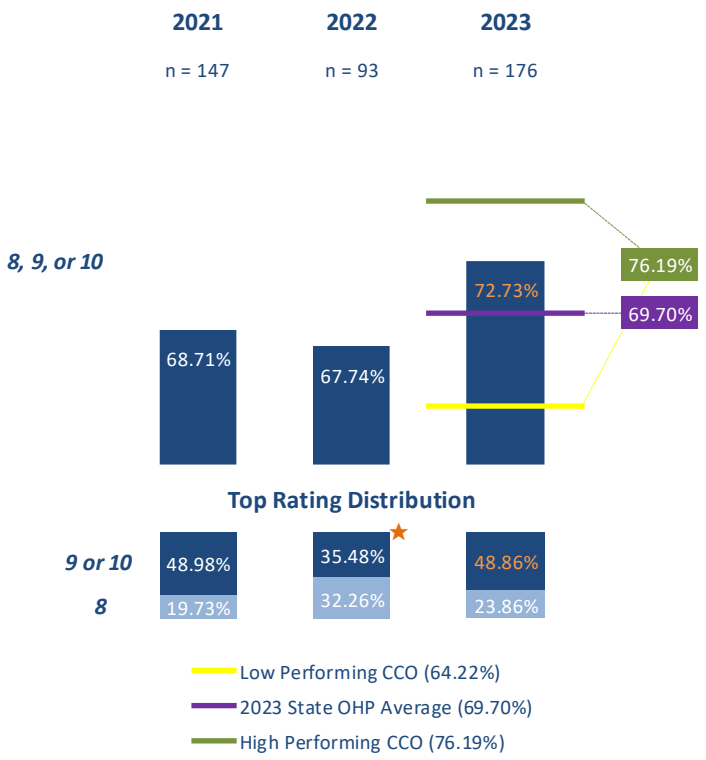
Rating of All Health Care

Percent Responding 8, 9, or 10



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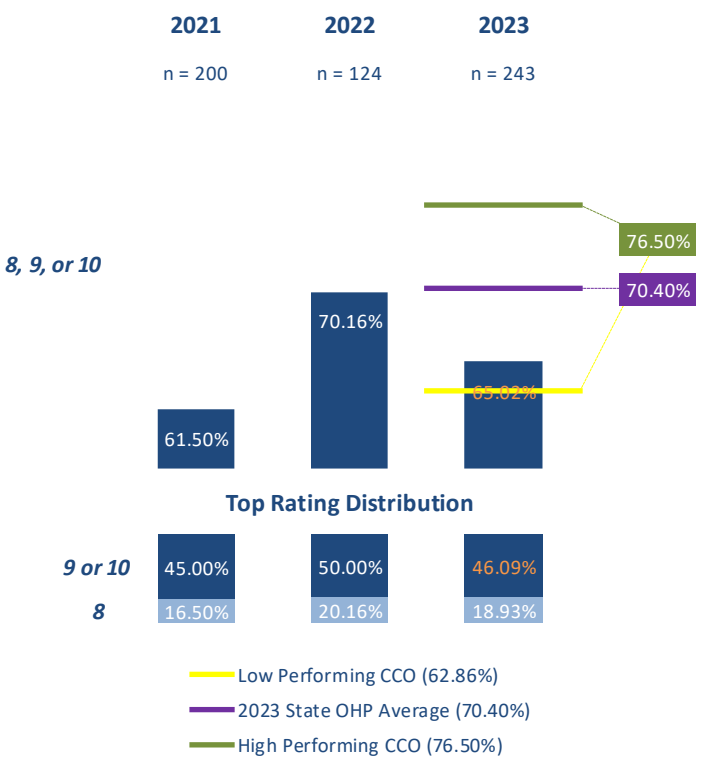
Tests of statistical significance were conducted for the following reportable rates: *(8 + 9 + 10)* and *(9 + 10)*. Statistically significant differences, tested at the 95% confidence level, between your organization's **current-year rate** and a comparison rate (prior-year, or national rate) are marked with a ★ symbol next to the comparison rate.

Rating of Health Plan

Percent Responding 8, 9, or 10



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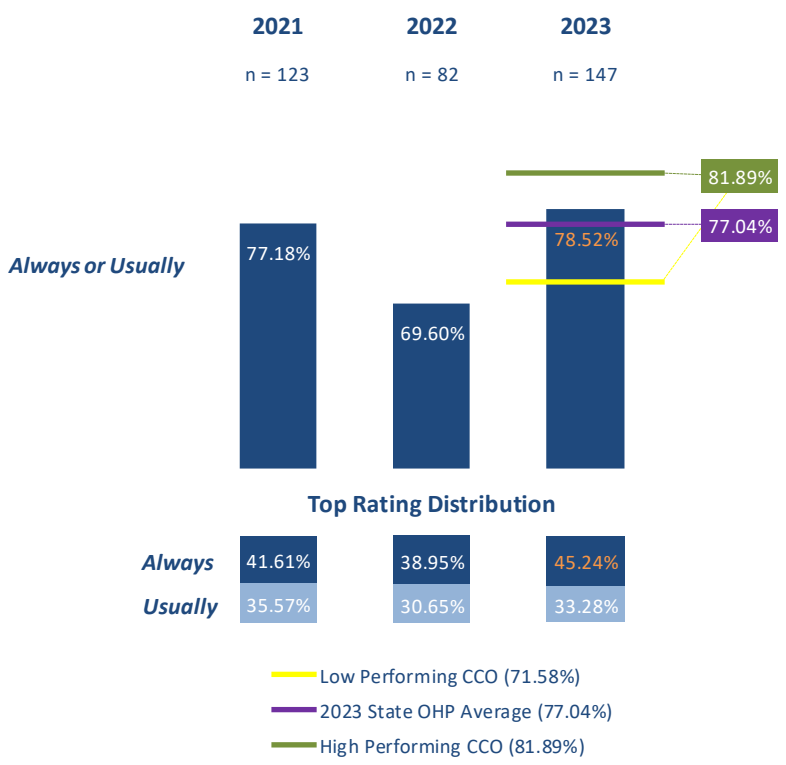
Tests of statistical significance were conducted for the following reportable rates: *(8 + 9 + 10)* and *(9 + 10)*. Statistically significant differences, tested at the 95% confidence level, between your organization's **current-year rate** and a comparison rate (prior-year, or national rate) are marked with a ★ symbol next to the comparison rate.

Getting Needed Care (Composite)

Percent Responding Always or Usually



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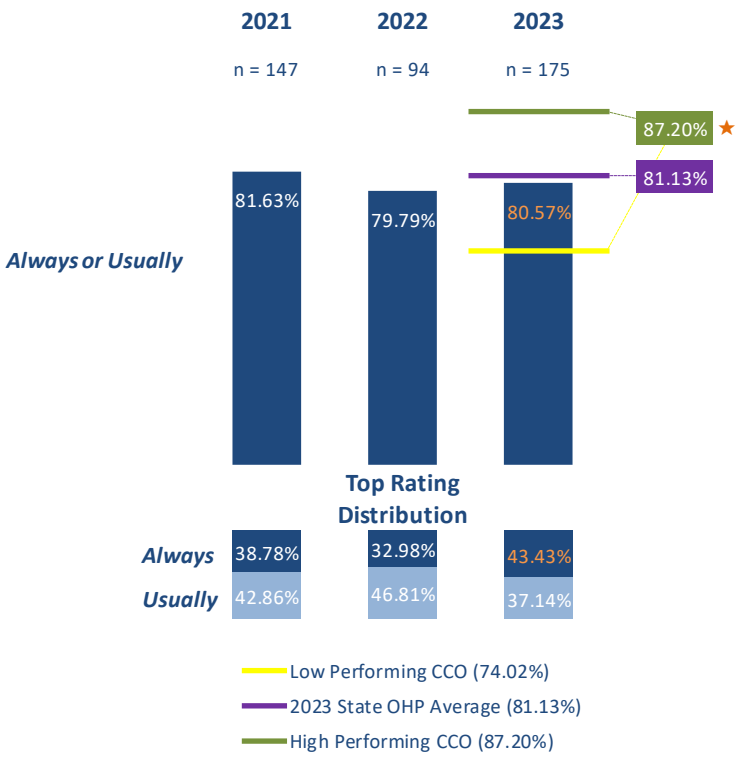
Tests of statistical significance were conducted for the following reportable rates: *(8 + 9 + 10)* and *(9 + 10)*. Statistically significant differences, tested at the 95% confidence level, between your organization's **current-year rate** and a comparison rate (prior-year, or national rate) are marked with a ★ symbol next to the comparison rate.

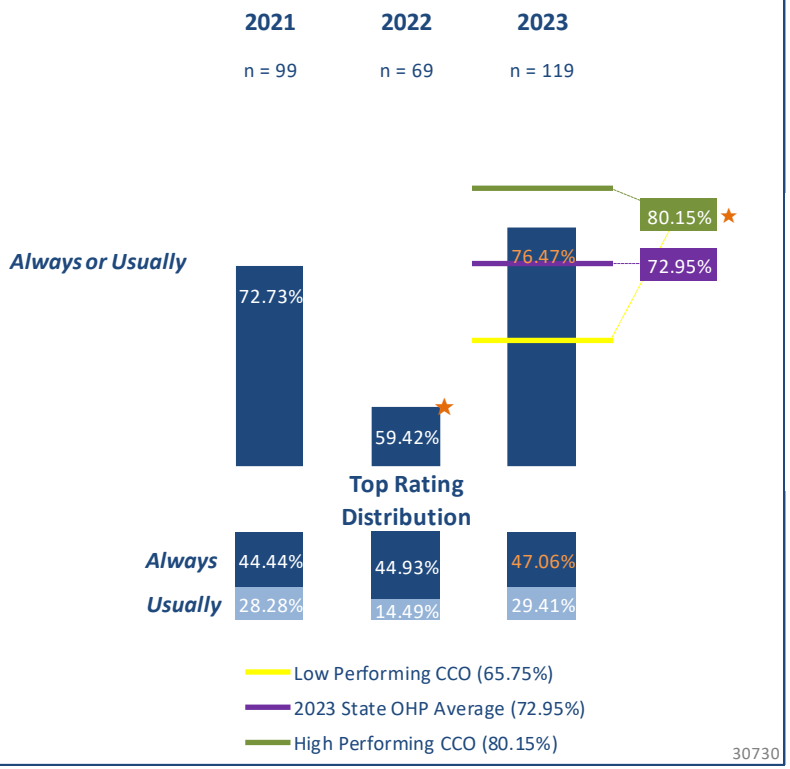
Getting Needed Care (Contributing Items)

Percent Responding Always or Usually

Q9. In the last 6 months, how often was it easy to get the care, tests, or treatment you needed?



Q20. In the last 6 months, how often did you get an appointment with a specialist as soon as you needed?



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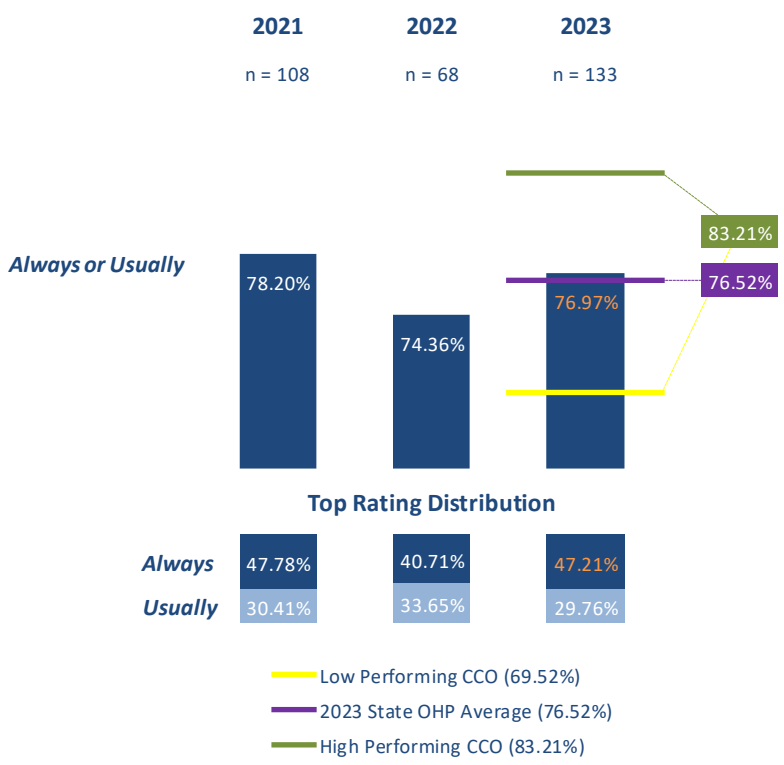
Getting Care Quickly (Composite)

Percent Responding Always or Usually



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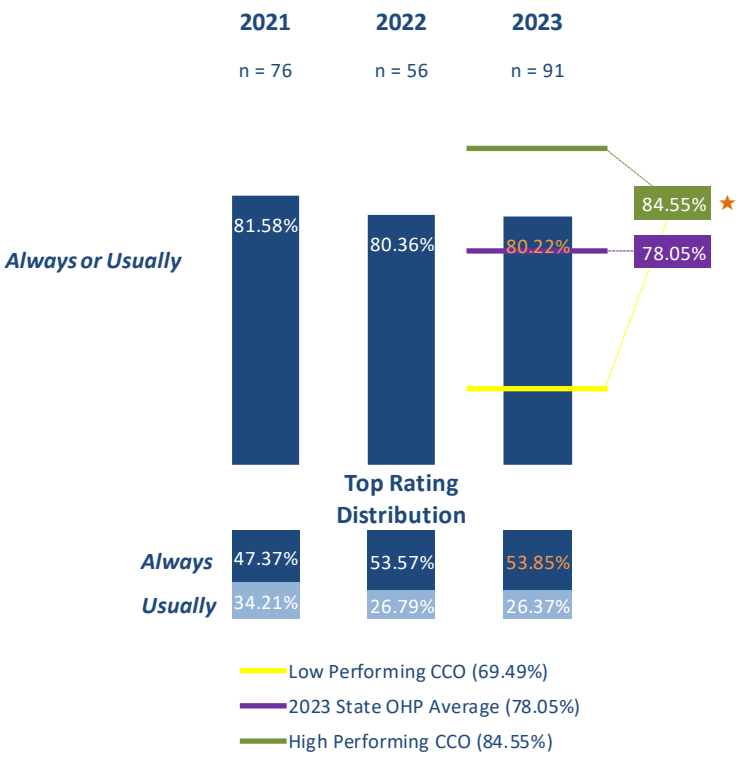
Tests of statistical significance were conducted for the following reportable rates: *(8 + 9 + 10)* and *(9 + 10)*. Statistically significant differences, tested at the 95% confidence level, between your organization's **current-year rate** and a comparison rate (prior-year, or national rate) are marked with a ★ symbol next to the comparison rate.

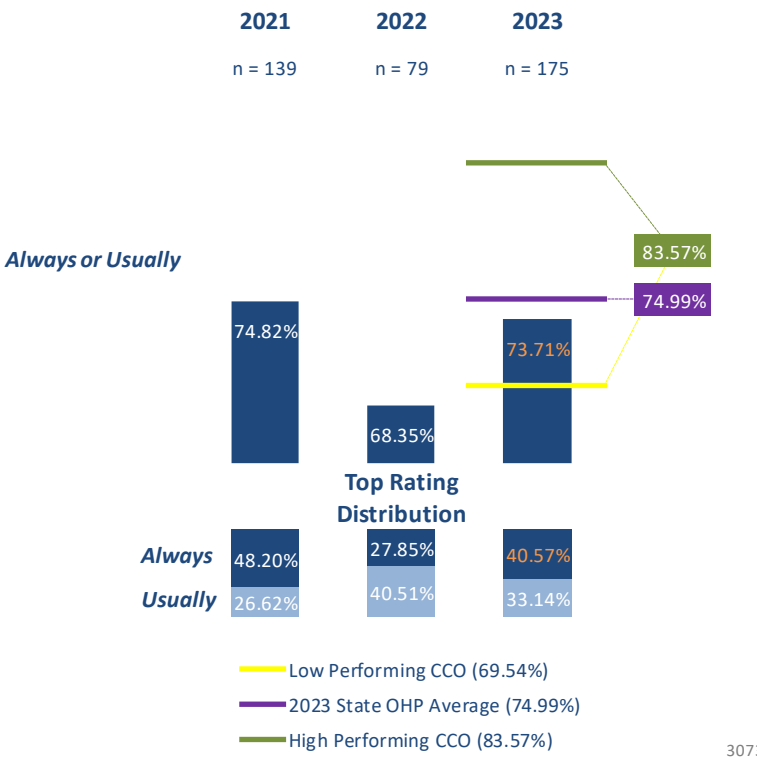
Getting Care Quickly (Contributing Items)

Percent Responding Always or Usually

Q4. In the last 6 months, when you needed care right away, how often did you get care as soon as you needed?



Q6. In the last 6 months, how often did you get an appointment for a check-up or routine care as soon as you needed?



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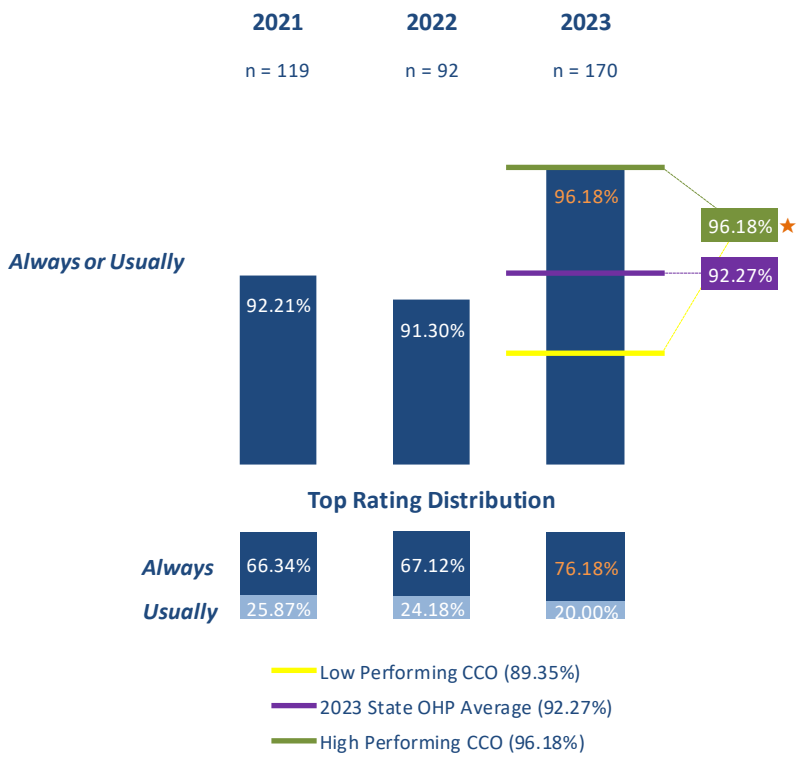
How Well Doctors Communicate (Composite)

Percent Responding Always or Usually



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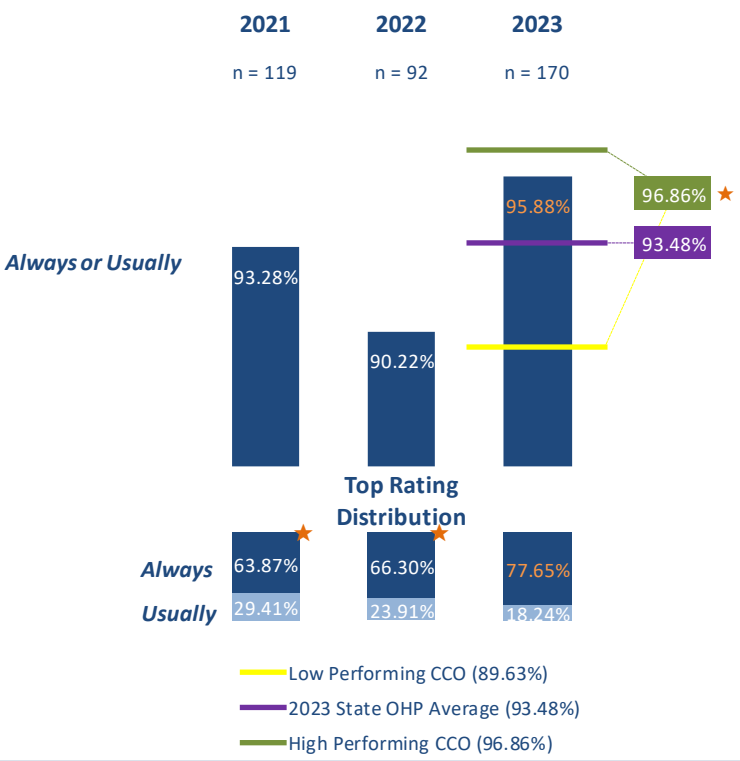
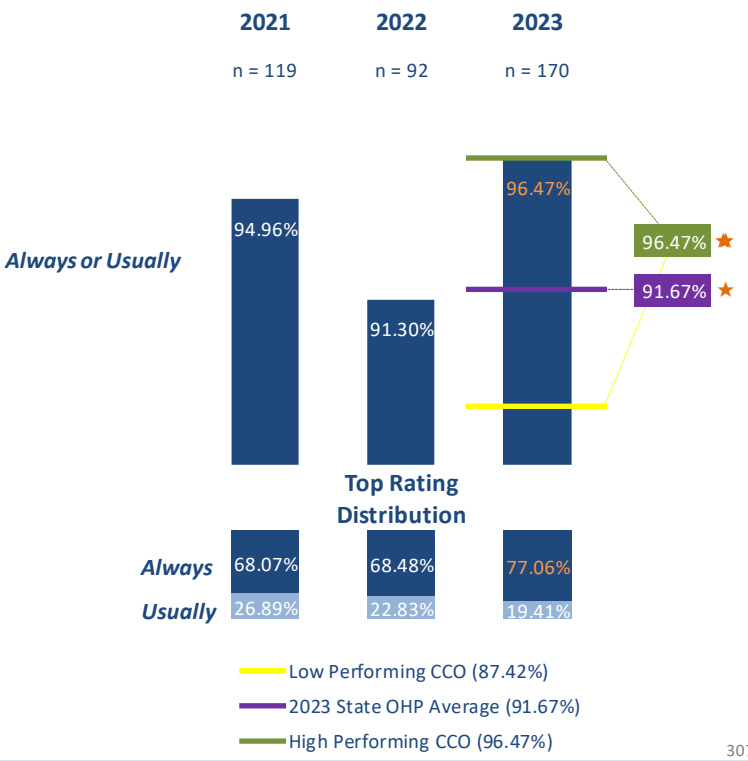
How Well Doctors Communicate (Contributing Items)

Percent Responding Always or Usually

Q12. In the last 6 months, how often did your personal doctor explain things in a way that was easy to understand?



Q13. In the last 6 months, how often did your personal doctor listen carefully to you?



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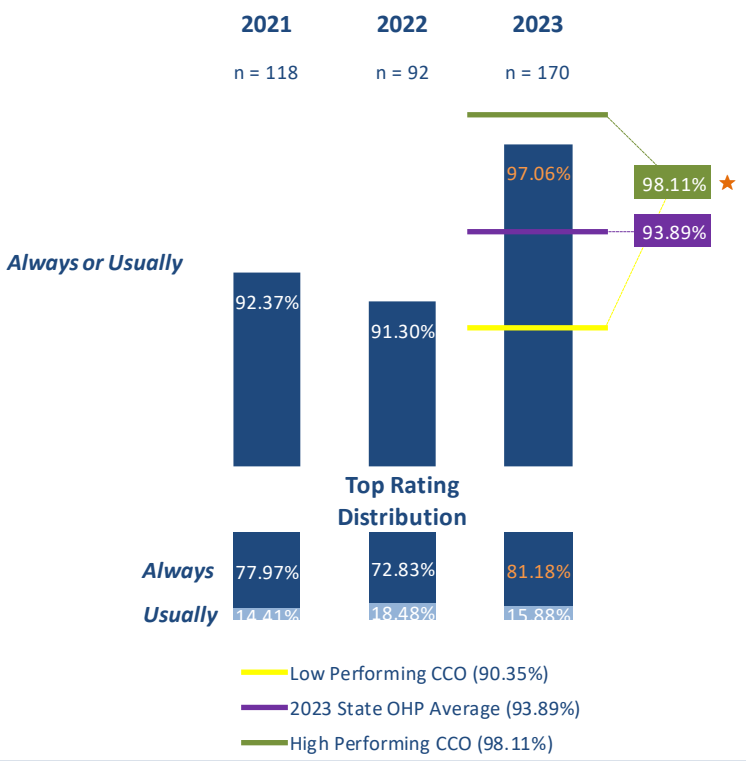
Tests of statistical significance were conducted for the following reportable rates: *(8 + 9 + 10)* and *(9 + 10)*. Statistically significant differences, tested at the 95% confidence level, between your organization's **current-year rate** and a comparison rate (prior-year, or national rate) are marked with a ★ symbol next to the comparison rate.

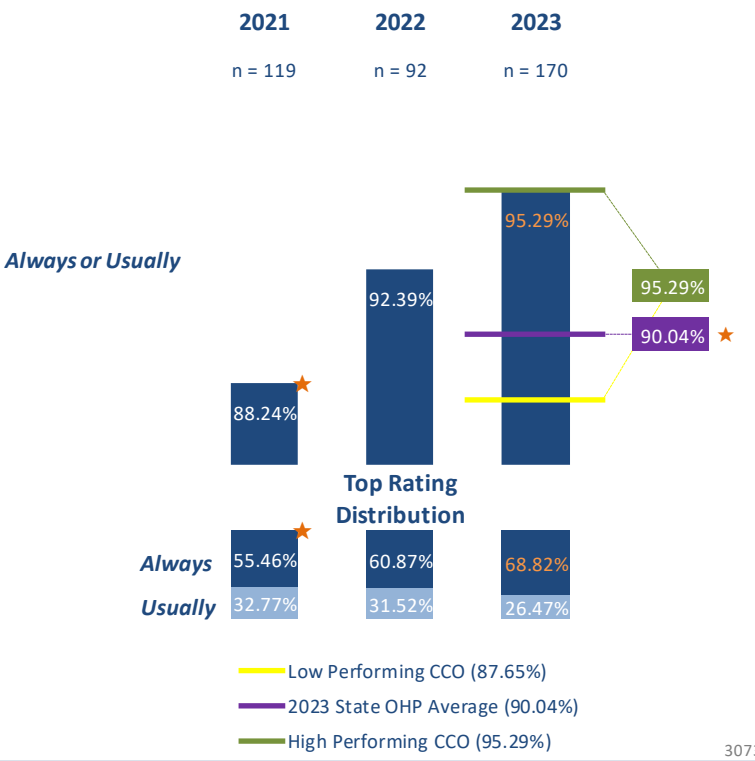
How Well Doctors Communicate (Contributing Items)

Percent Responding Always or Usually

Q14. In the last 6 months, how often did your personal doctor show respect for what you had to say?



Q15. In the last 6 months, how often did your personal doctor spend enough time with you?



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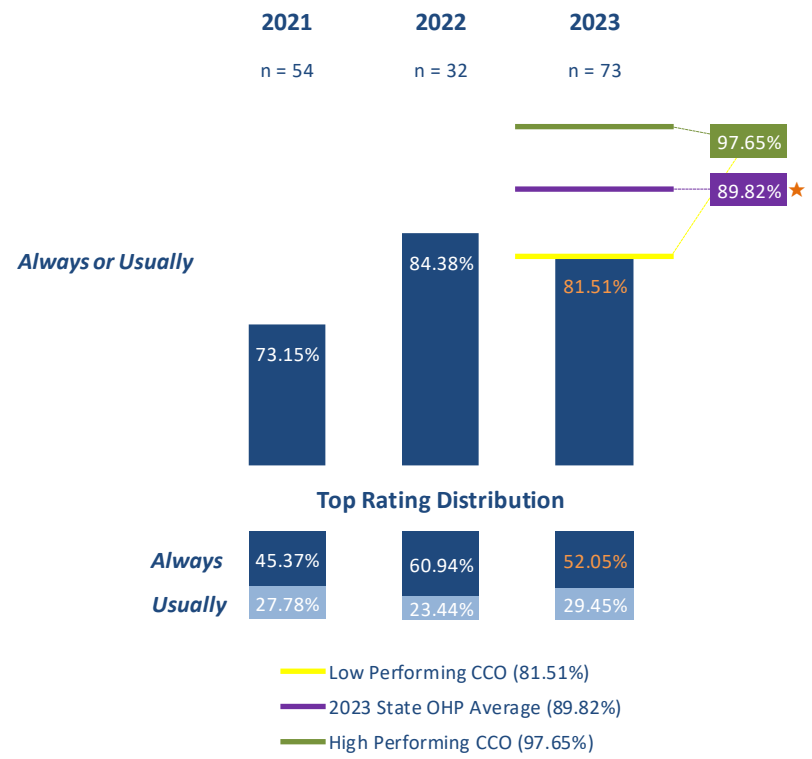
Customer Service (Composite)

Percent Responding Always or Usually



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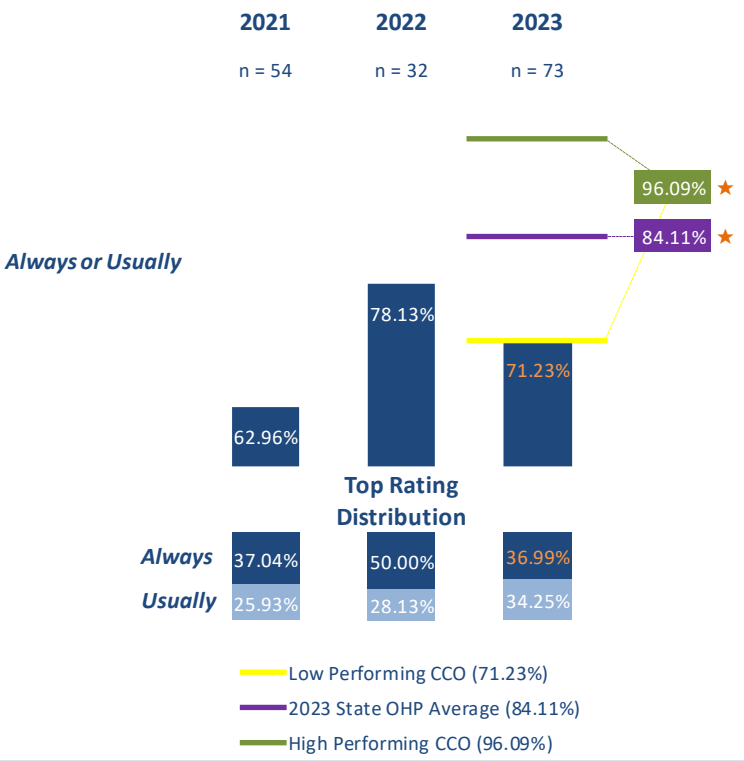
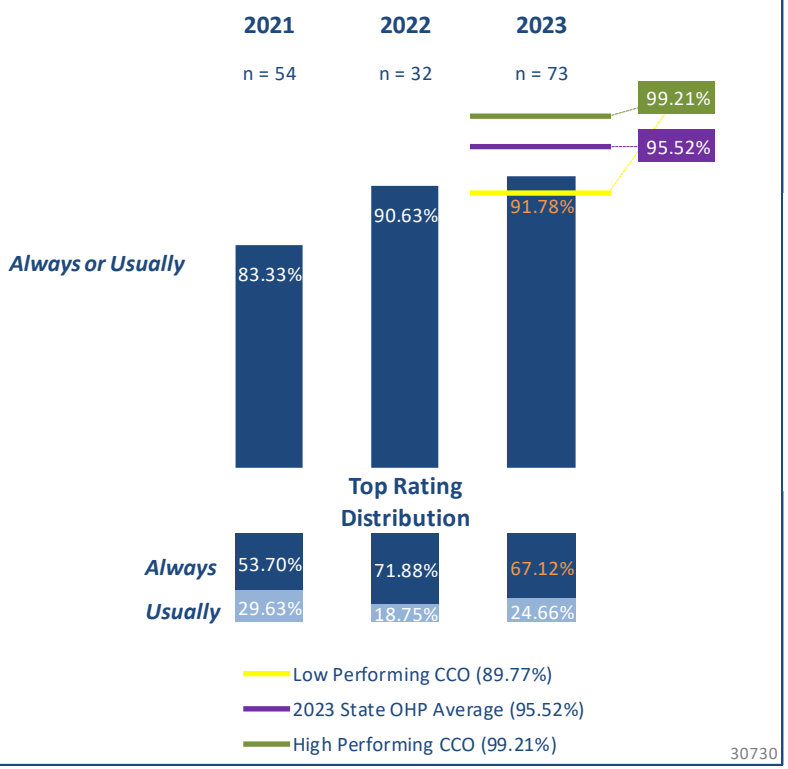
Customer Service (Contributing Items)

Percent Responding Always or Usually

Q24. In the last 6 months, how often did your health plan's customer service give you the information or help you needed?



Q25. In the last 6 months, how often did your health plan's customer service staff treat you with courtesy and respect?



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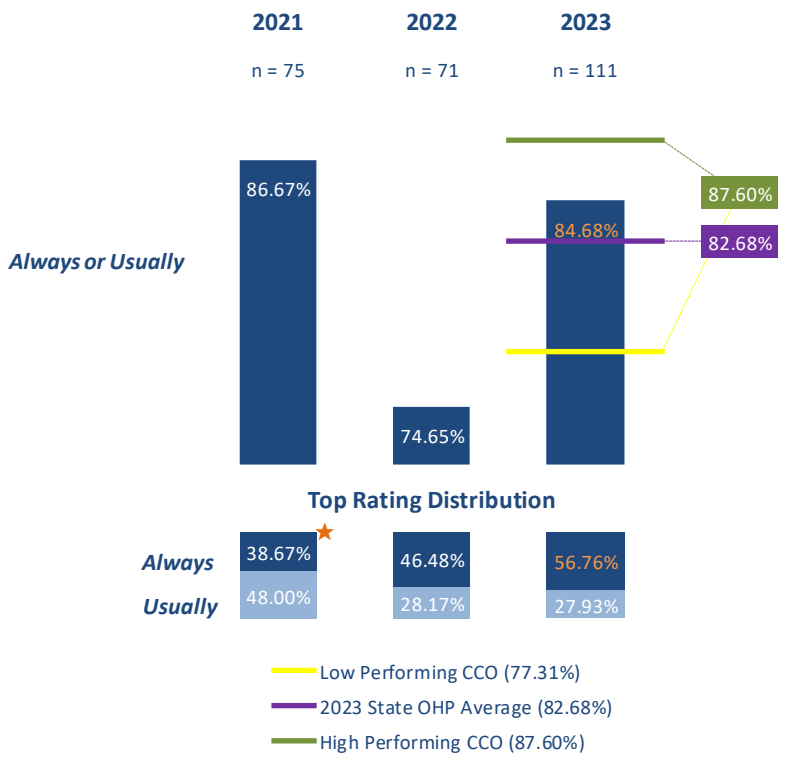
Coordination of Care (Single Item)

Percent Responding Always or Usually



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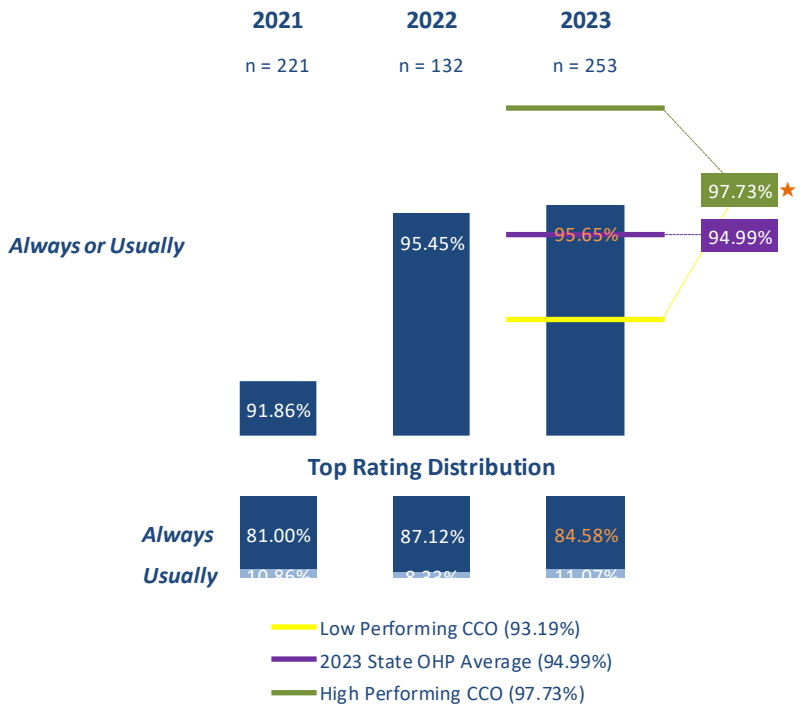
Tests of statistical significance were conducted for the following reportable rates: *(8 + 9 + 10)* and *(9 + 10)*. Statistically significant differences, tested at the 95% confidence level, between your organization's **current-year rate** and a comparison rate (prior-year, or national rate) are marked with a ★ symbol next to the comparison rate.

Forms from Plan Were Easy to Fill Out (Single Item)

Percent Responding Always or Usually

Q27. In the last 6 months, how often were the forms from your health plan easy to fill out? (Note: Respondents who did not have to fill out any forms from the health plan are counted as answering "Always".)



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Tests of statistical significance were conducted for the following reportable rates: *(8 + 9 + 10)* and *(9 + 10)*. Statistically significant differences, tested at the 95% confidence level, between your organization's **current-year rate** and a comparison rate (prior-year, or national rate) are marked with a ★ symbol next to the comparison rate.

EFFECTIVENESS OF CARE

The *Effectiveness of Care* domain for the Adult Medicaid product line includes the following measures: *Flu Vaccinations for Adults Ages 18–64 (FVA)* and *Medical Assistance with Smoking and Tobacco Use Cessation (MSC)*. The *FVA* measure is a single-year rate. The *MSC* measure is typically based on two years of data collection and is calculated using the NCQA rolling average methodology. For OHP, the *MSC* measure is calculated using a single-year rate. A brief description of each measure, as it appears in *HEDIS Measurement Year 2022, Volume 3: Specifications for Survey Measures, Section 2: Effectiveness of Care*, is reproduced below. Please refer to *Volume 3* for additional information on the measures, including rolling average calculation methodology and NCQA reporting rules.

EFFECTIVENESS OF CARE MEASURES

FLU VACCINATIONS FOR ADULTS AGES 18–64 (FVA)

Flu Vaccinations for Adults represents the percentage of members 18–64 years of age who received a flu vaccination between July 1 of the measurement year and the date when the survey was completed.

MEDICAL ASSISTANCE WITH SMOKING AND TOBACCO USE CESSATION (MSC)

The following components of this measure assess different facets of providing medical assistance with smoking and tobacco use cessation:

- *Advising Smokers and Tobacco Users to Quit* – a rolling average rate represents the percentage of current smokers or tobacco users who received advice to quit during the measurement year.
- *Discussing Cessation Medications* – a rolling average rate represents the percentage of current smokers or tobacco users who discussed or were recommended cessation medications during the measurement year.
- *Discussing Cessation Strategies* – a rolling average rate represents the percentage of current smokers or tobacco users who discussed or were provided cessation methods or strategies during the measurement year.

EFFECTIVENESS OF CARE RESULTS

A summary of FFS results on HEDIS Effectiveness of Care measures is provided in Exhibit 4. Comparisons to prior-year rates (if available) as well as to the 2023 State OHP Average rates with statistical significance tests are included.

EXHIBIT 4. 2023 FFS ADULT MEDICAID OHA CAHPS SURVEY: EFFECTIVENESS OF CARE MEASURES

Effectiveness of Care Measures	2023		Comparison between 2023 and…			
			2022		2023 State OHP Average	
	Rate	(n)	Rate	Point Change	Rate	Point Diff.
Flu Vaccinations for Adults (FVA)						
Flu Vaccinations for Adults	**38.64%**	**(220)**	48.08%	[-9.44]	34.24%	[+4.40]
Medical Assistance with Smoking and Tobacco Use Cessation (MSC)						
Advising Smokers and Tobacco Users to Quit	**58.33%**	**(36)**	NR	[---]	67.06%	[-8.73]
Discussing Cessation Medications	**48.57%**	**(35)**	NR	[---]	48.05%	[+0.52]
Discussing Cessation Strategies	**45.71%**	**(35)**	NR	[---]	41.44%	[+4.28]

30730

Calculation and Reporting of Results

Effectiveness of Care results were calculated by CSS following NCQA specifications with the exception that rates for the MSC measure were calculated using a single year rate methodology. The number of valid responses collected this year for each measure (n, or measure denominator) is reported in parentheses. At least 30 valid responses must be collected for a measure result to be reportable by OHA. If n is less than 30, "NR" and "[...]" are displayed in a lighter color, indicating that the rate and point change results are not reportable by OHA. Also, if the numerator for any displayed category is less than 3, the "NR" label will be applied.

Rate Comparisons and Statistical Significance Testing

Comparisons to prior-year and benchmark rates were calculated prior to rounding and rounded for display. Differences in rates were tested for statistical significance using a t-test for proportions at the 95% confidence level. Statistically significant differences between the current-year rate and the comparison rate are marked with a ★ symbol.

MEMBER PROFILE AND ANALYSIS OF RATINGS BY MEMBER SEGMENT

This section of the report presents a detailed profile of the FFS membership. In addition to member demographics and health status, responses to survey items that assess utilization of healthcare services are included.

A CCO's membership mix is shaped by multiple factors, most of which are beyond the scope of this survey. These include benefit design, geography, availability of health plan choices, and member self-selection into products that best meet their needs. CSS's analysis of industry data suggests that there is considerable variation in member demographic makeup and utilization patterns across plans. To the extent that various member segments have distinct healthcare needs, utilization patterns, expectations, experiences, as well as attitudes and perceptions, their assessments of the *same* health plan will likely differ.

Certain member characteristics (e.g., health status) appear to be directly related to differences in healthcare needs and utilization levels. For example, some plans have predominantly healthy members, whose interactions with care providers and the plan tend to be limited. By contrast, other plans serve populations with higher rates of illness. These members tend to have more frequent encounters with the healthcare system and as a result may become more experienced users of health plans. The ways in which members use the plan, the frequency of their interactions with providers and staff, and their overall level of familiarity with how the plan works may affect ratings.

In addition to health care needs and utilization patterns, demographic characteristics have been shown to influence survey responses. For example, all else being equal, older respondents and members of certain ethnic groups (e.g., Hispanic or Latino respondents) tend to rate their health care providers and plans more positively. By contrast, more educated members rate more critically, regardless of age or ethnicity.

While the interplay between these membership variables (often referred to as the plan's "case mix") and health plan ratings is complex, health plan ratings clearly vary across demographic groups and user segments. Understanding the plan's case mix can help managers to gain insight into possible sources of this variation.

The charts on the following pages compare the FFS membership profile to the relevant State Oregon Health Plan benchmark distribution on demographic characteristics and utilization patterns. The pie chart in the upper half of each panel contrasts the distribution of the FFS membership on a given member attribute (e.g., primary race, education level, number of doctor visits, etc.) with the 2023 State Oregon Health Plan distribution on the same attribute. The bar chart in the lower half of each panel shows how the overall rating of the plan varies by member segment.

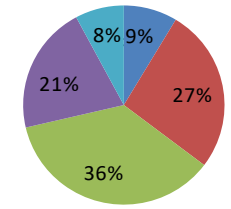
HEALTH STATUS AND DEMOGRAPHICS

The following characteristics are profiled in this section:

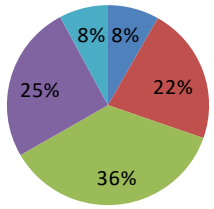
- Respondent's self-reported health status
- Respondent's self-reported mental or emotional health status
- Respondent's age
- Respondent's education level
- Respondent's primary racial or ethnic identity

Q31. In general, how would you rate your overall health?

Your Organization

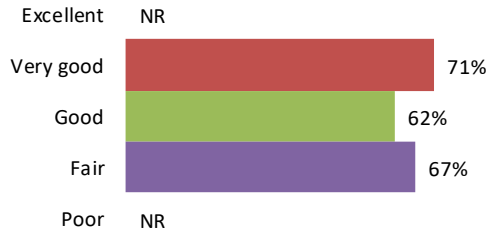


State OHP*



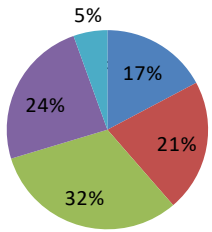
Excellent Very good Good Fair Poor

Percent of Your Organization's Members Rating Their Plan as 8, 9, or 10 by Response to Q31**

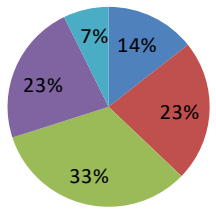


Q32. In general, how would you rate your overall mental or emotional health?

Your Organization

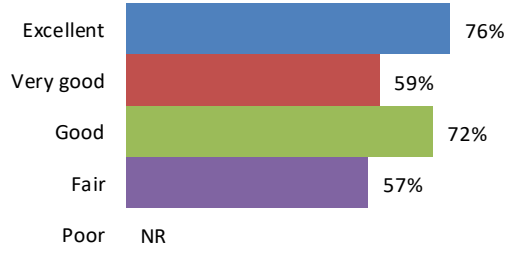


State OHP*



Excellent Very good Good Fair Poor

Percent of Your Organization's Members Rating Their Plan as 8, 9, or 10 by Response to Q32**



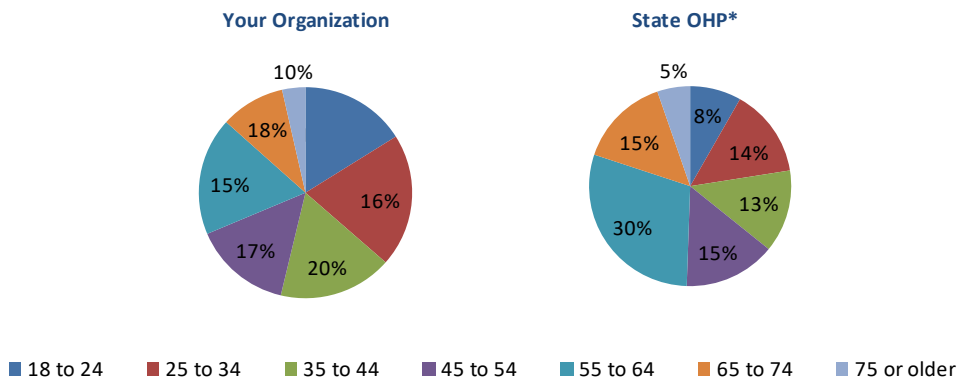
Note: all percentages are rounded for display. *Rating of Health Plan* score should be interpreted with caution if the size of the group (pie slice) is small. 30730

"NR" appears in place of the pie chart if the numerator for any displayed category is less than 3 or the number of attribute respondents is less than 30, indicating that the results are not reportable by OHA.

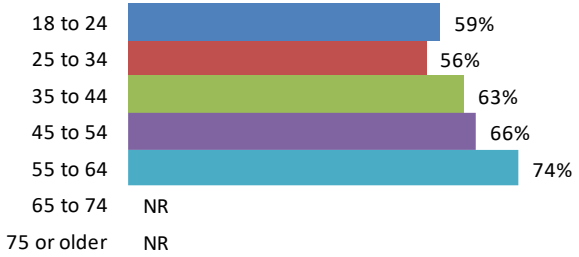
* Represents the combined distribution of responses to this question for all plans included in the 2023 State OHP Average.

** Includes members who answered the question and provided a valid response to Q28 (Rating of Health Plan). "No data" appears in place of the score if none of the group respondents provided a valid response to Q28 or if no one rated the plan as 8, 9, or 10. "NR" appears in place of the score if the number of respondents within group rating plan as 8-10 is less than 3 or the number of respondents within group rating plan 0-10 is less than 30.

Q38. What is your age?



Percent of Your Organization's Members Rating Their Plan as 8, 9, or 10 by Response to Q38**



Note: all percentages are rounded for display. *Rating of Health Plan* score should be interpreted with caution if the size of the group (pie slice) is small. 30730

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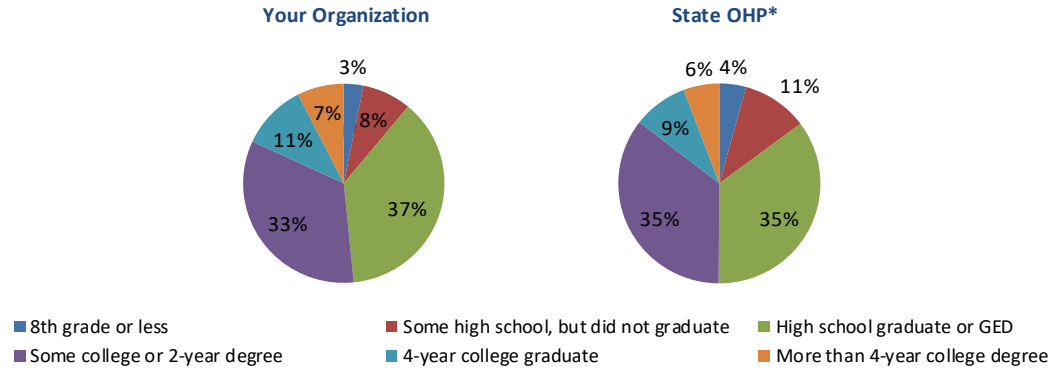
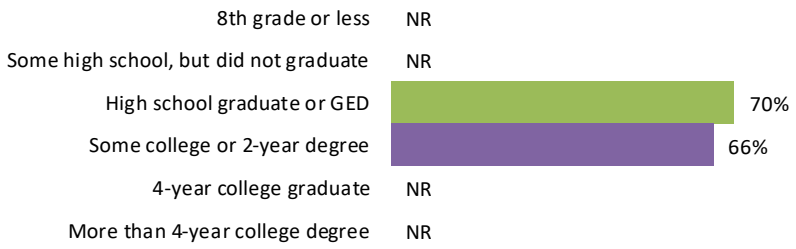
** Includes members who answered the question and provided a valid response to Q28 (Rating of Health Plan). "No data" appears in place of the score if none of the group respondents provided a valid response to Q28 or if no one rated the plan as 8, 9, or 10. "NR" appears in place of the score if the number of respondents within group rating plan as 8-10 is less than 3 or the number of respondents within group rating plan 0-10 is less than 30.

Q39. What is the highest grade or level of school that you have completed?



Percent of Your Organization's Members Rating Their Plan as 8, 9, or 10 by Response to Q39**



Note: all percentages are rounded for display. *Rating of Health Plan* score should be interpreted with caution if the size of the group (pie slice) is small. 30730

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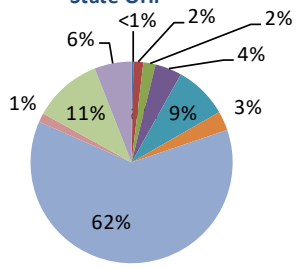
** Includes members who answered the question and provided a valid response to Q28 (Rating of Health Plan). "No data" appears in place of the score if none of the group respondents provided a valid response to Q28 or if no one rated the plan as 8, 9, or 10. "NR" appears in place of the score if the number of respondents within group rating plan as 8-10 is less than 3 or the number of respondents within group rating plan 0-10 is less than 30.

Q61. If you checked more than one category above, is there one you think of as your primary racial or ethnic identity?

Your Organization

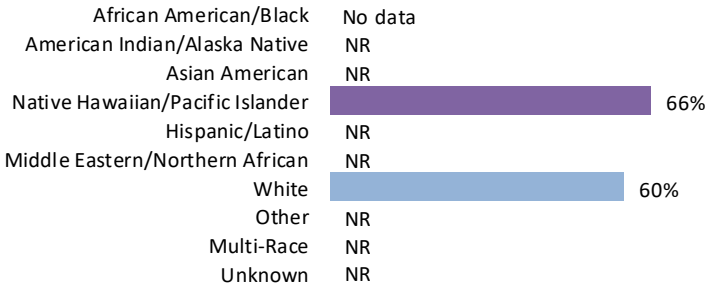
NR

State OHP*



African American/Black
American Indian/Alaska Native
Asian American
Native Hawaiian/Pacific Islander
Hispanic/Latino
Middle Eastern/Northern African
White
Other
Multi-Race
Unknown

Percent of Your Organization's Members Rating Their Plan as 8, 9, or 10 by Response to Q61**



Note: all percentages are rounded for display. *Rating of Health Plan* score should be interpreted with caution if the size of the group (pie slice) is small. 30730

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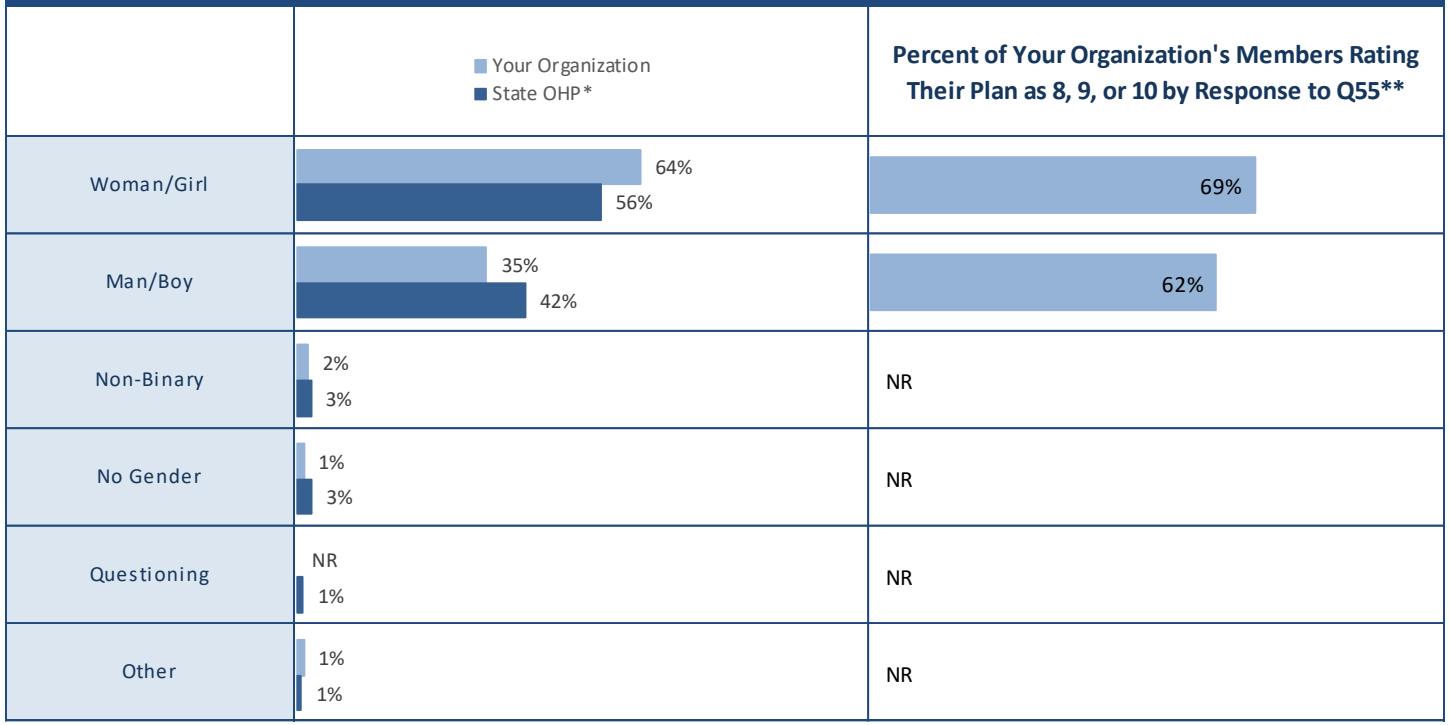
ALONE OR IN COMBINATION (AOIC) REPORTING OF GENDER IDENTITY

The gender identity survey items were adapted from the Equity and Inclusion Division of OHA's draft recommendation of Sexual Orientation and Gender Identity (SOGI) demographic questions. Respondents are presented with a list of gender identity categories and asked to indicate all categories that describe their gender identity.

The following chart compares the FFS membership profile to the State Oregon Health Plan benchmark distribution, if applicable, on the gender identity response categories. The left side displays the distribution of the FFS membership on a given gender identity response with the 2023 State Oregon Health Plan distribution, if applicable, on the same gender identity response. The right side shows how the overall rating of the plan varies by each gender identity response.

To prevent masking individual responses, the concept of gender "Alone or In Combination" (AOIC) was used for reporting purposes. This combines members who selected a single gender response alone and those who selected that gender response in combination with one or more of the other gender identity responses. The AOIC concept, therefore, represents the most inclusive grouping of members sharing a gender identity, either alone or in combination with one or more categories. The sum of the individual gender AOIC categories may add to more than the total population because members who selected more than one category were tallied in each gender response category.

55. What is your gender? Check all that apply. (% Yes)



Note: all percentages are rounded for display. *Rating of Health Plan* score should be interpreted with caution if the size of the group is small.

"NR" appears in place of the bar chart if the numerator for any displayed category is less than 3 or the number of attribute respondents is less than 30, indicating that the results are not reportable by OHA.

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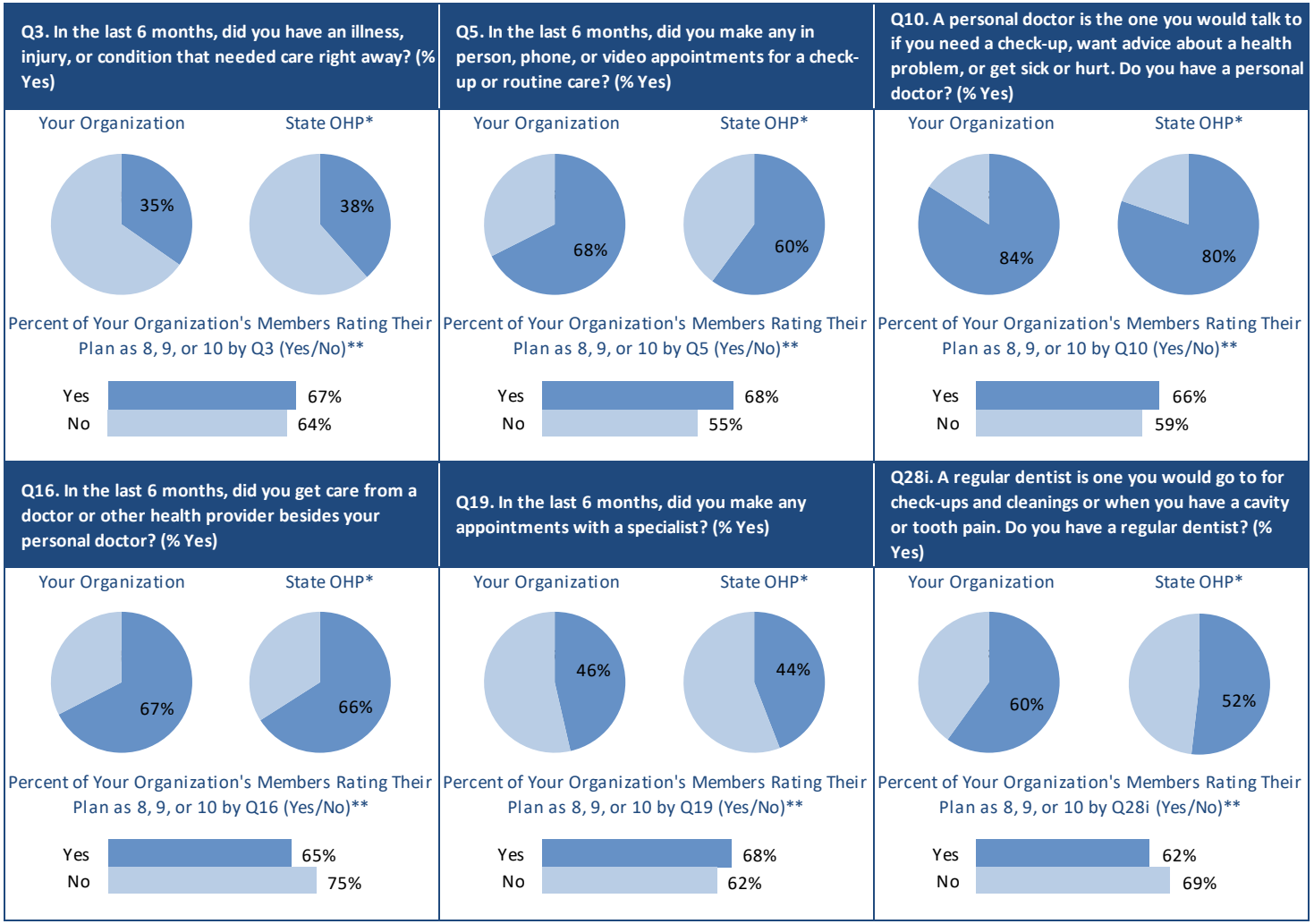
** Includes members who answered the question and provided a valid response to Q28 (Rating of Health Plan). "No data" appears in place of the score if none of the group respondents provided a valid response to Q28 or if no one rated the plan as 8, 9, or 10. "NR" appears in place of the score if the number of respondents within group rating plan as 8-10 is less than 3 or the number of respondents within group rating plan 0-10 is less than 30.

USE OF SERVICES

The following utilization measures are included in this section:

- Seeking urgent care
- Making appointments for routine care
- Having a personal doctor
- Receiving care from a provider other than personal doctor
- Making an appointment to see a specialist
- Having a regular dentist
- Number of visits to a doctor's office or clinic
- Number of specialists seen



Note: all percentages are rounded for display. *Rating of Health Plan* score should be interpreted with caution if the size of the group (pie slice) is small. 30730

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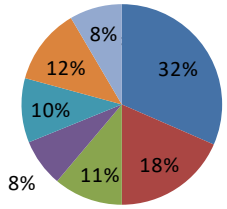
* Represents the combined distribution of responses to this question for all plans included in the 2023 State OHP Average.

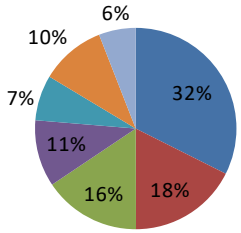
** Includes members who answered the question and provided a valid response to Q28 (Rating of Health Plan). "No data" appears in place of the score if none of the group respondents provided a valid response to Q28 or if no one rated the plan as 8, 9, or 10. "NR" appears in place of the score if the number of respondents within group rating plan as 8-10 is less than 3 or the number of respondents within group rating plan 0-10 is less than 30.

Q7. In the last 6 months, not counting the times you went to an emergency room, how many times did you get health care for yourself in person, by phone, or by video?

Your Organization

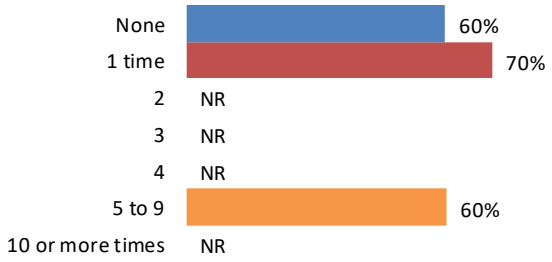


State OHP*



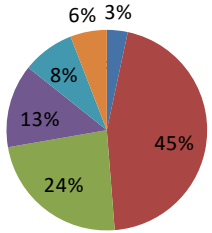
None | 1 time | 2 | 3 | 4 | 5 to 9 | 10 or more times

Percent of Your Organization's Members Rating Their Plan as 8, 9, or 10 by Response to Q7**

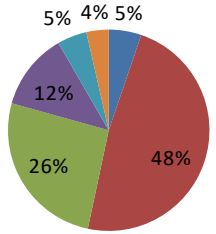


Q21. How many specialists have you talked to in the last 6 months? (Note: the question applies only to those respondents who had appointments with specialists.)

Your Organization

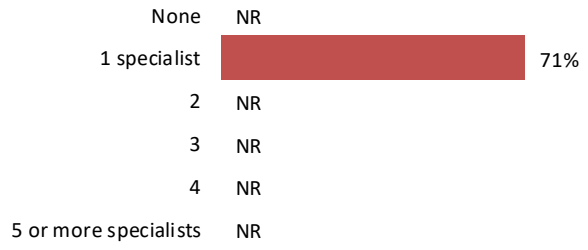


State OHP*



None | 1 specialist | 2 | 3 | 4 | 5 or more specialists

Percent of Your Organization's Members Rating Their Plan as 8, 9, or 10 by Response to Q21**



Note: all percentages are rounded for display. *Rating of Health Plan* score should be interpreted with caution if the size of the group (pie slice) is small. 30730

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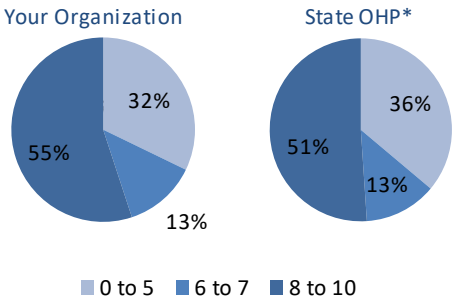
ACCESS TO DENTAL CARE

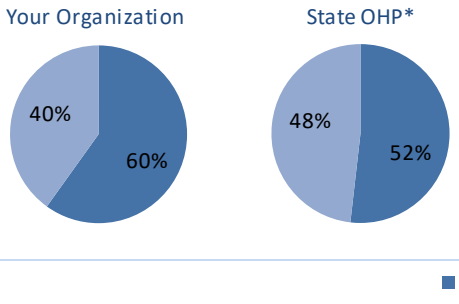
The following charts compare the FFS respondent profile to the State Oregon Health Plan benchmark distribution for the following access to dental care survey items:

- Ease of finding a dentist
- Having a regular dentist
- Receiving care from a dentist
- Explanation of dental treatment
- Making an appointment to see a dental specialist
- Making an appointment for a dental emergency

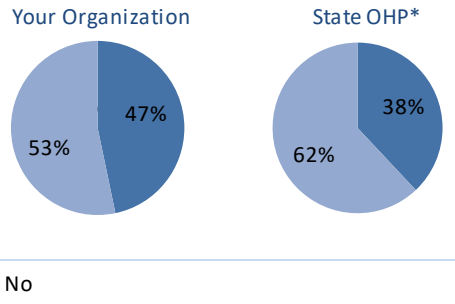
Q28n. Using any number from 0 to 10, where 0 is extremely difficult and 10 is extremely easy, what number would you use to rate how easy it was for you to find a dentist?



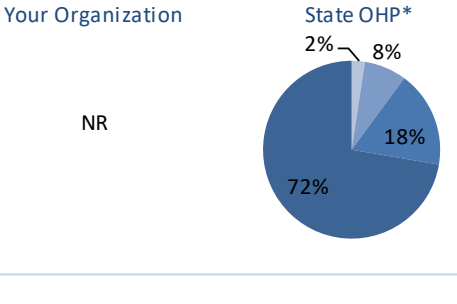
Q28i. A regular dentist is one you would go to for check-ups and cleanings or when you have a cavity or tooth pain. Do you have a regular dentist?



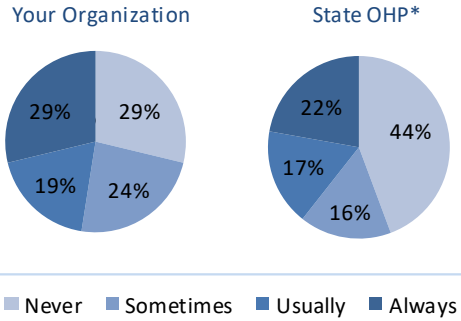
Q28j. In the last 6 months, did you go to a dentist's office or clinic for care?



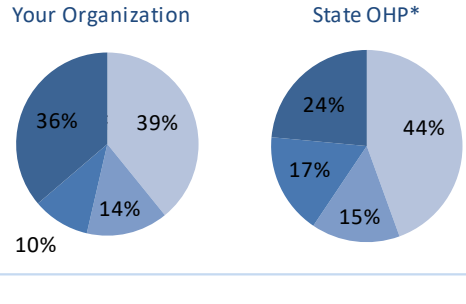
Q28k. In the last 6 months, how often did the dentists or dental staff explain what they were doing while treating you?



Q28l. If you tried to get an appointment for yourself with a dentist who specializes in a particular type of dental care (such as root canals or gum disease) in the last 6 months, how often did you get an appointment as soon as you wanted?



Q28m. In the last 6 months, if you needed to see a dentist right away because of a dental emergency, how often did you get to see a dentist as soon as you wanted?



Never Sometimes Usually Always

Note: all percentages are rounded for display.

30730

"NR" appears in place of the pie chart if the numerator for any displayed category is less than 3 or the number of attribute respondents is less than 30, indicating that the results are not reportable by OHA.

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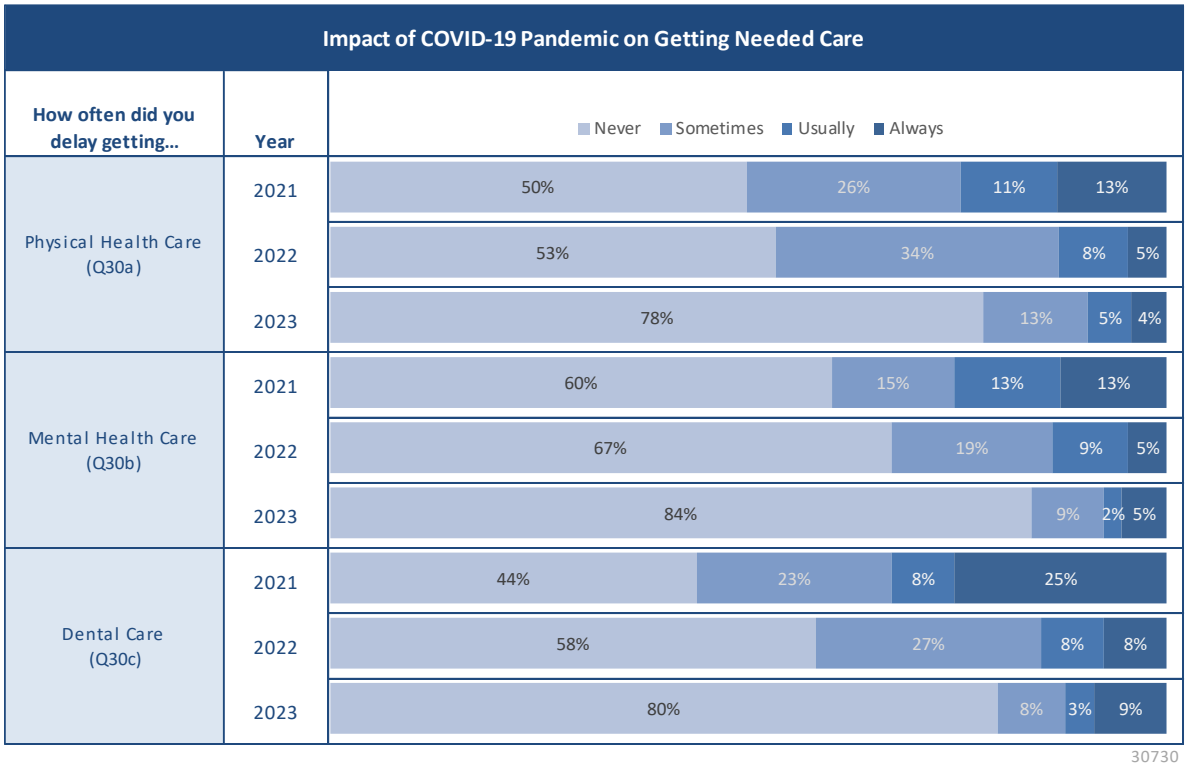
IMPACT OF COVID-19 PANDEMIC ON GETTING NEEDED CARE

Overall, a general reduction in the use of health services was seen due to the COVID-19 pandemic. Less urgent services were cancelled or postponed, while barriers imposed by curfews, transportation closures/slowdowns, and stay-at-home orders prevented some patients from attending appointments.

The following chart compares the FFS respondent profile of how often respondents delayed getting the following health services over time: physical health care, mental health care, and dental care. Responses are trended over three consecutive years of data collection, if available. A result may not be available if the survey was not administered in a given year and "no data" appears in place of the score.



Note: all percentages are rounded for display. "NR" appears in place of the bar chart if the numerator for any displayed category is less than 3 or the number of attribute respondents is less than 30, indicating that the results are not reportable by OHA.

KEY DRIVER ANALYSIS

OBJECTIVES

CSS's *Key Driver Analysis (KDA)* highlights some of the key differences between high- and low-rated health plans at the industry level. The principal objectives of the KDA are:

- To isolate a set of plan attributes, or key drivers, that distinguish high-rated plans from low-rated plans
- To highlight industry best practices on the key driver measures
- To compare the current performance of FFS to industry best practices in these areas
- To estimate the impact of improving performance on these measures on the *Rating of Health Plan* measure

TECHNICAL APPROACH

INDUSTRY VIEW

Industry-level analysis, which uses health plans as units of analysis, has several important advantages compared to the alternative approach, which focuses on member experiences *within* a single plan. Certain plan attributes are strongly related to member satisfaction *at the industry level*. However, these relationships may be missed if we focus on only one plan at a time. For example, it has been shown that plans that are rated highly on measures of access and availability of care tend to have high overall ratings. Conversely, poor access scores are associated with low overall plan scores. This relationship is clear when ratings are compared *across* plans. However, *within* a specific plan, member experiences may not be sufficiently varied to reveal the underlying relationship. That is, if all members are equally dissatisfied with access to care, this measure will show a misleadingly low correlation with the overall rating of the plan. As a result, the plan may underestimate the key role of access to care as a driver of member satisfaction and miss a critical opportunity for improvement.

In addition, expressing every CAHPS survey variable as a plan-level rate yields a complete and rich information set on each plan. This effectively eliminates any "gaps" in respondent-level data from a single plan caused by survey skip patterns and allows every response to be used in the analysis.

Finally, in addition to the standard CAHPS performance measures, other sources of differences between health plans can be explored, increasing the explanatory power of the model and allowing for more precise estimation of the individual key driver effects. These include experience rates, which are based on responses to the CAHPS screener questions. Screeners establish whether a member had a particular type of experience or interaction with the plan (e.g.,

contacted customer service, submitted a claim, etc.). CSS's analysis shows that these experience indicators explain a significant portion of the plan's overall satisfaction score. Additional components of the overall score include utilization rates and demographic characteristics of the plan's membership, addressed in more detail in the *Member Profile and Analysis of Plan Ratings by Member Segment* section of this report. Clearly, from the plan's perspective, some of these factors are more actionable than others. However, to yield an accurate model of key drivers of member satisfaction, the analysis must consider all measurable influences on the overall rating of the plan.

The 2023 CSS *Key Driver Model* was developed using our 2022–2023 Book-of-Business plan-level dataset of Medicaid CAHPS survey results. The dataset comprised all Medicaid plans surveyed by CSS in 2022 and 2023, for a total of 297 observations. CSS performed regression analysis of health plan ratings to identify sources of variation in overall scores across the industry spectrum, using individual health plans as units of analysis. Regression analysis expresses mathematically the relationship between plan attributes (predictors) and the global *Rating of Health Plan* score, controlling for interdependencies among the predictors and other factors that may influence ratings (e.g., member demographics, utilization patterns, etc.). Predictors were chosen carefully to yield a model that is both meaningful and actionable from the health plan's point of view.

All of the plan variables, including potential drivers of member experience (i.e., variables that the plan may consider actionable) and control variables (member demographics, health status, utilization rates, product type, and year of data collection) were entered into the regression model, and the independent contribution of each variable was estimated. As in the past, CSS excluded *Rating of All Health Care* from the list of predictors, both because of its high correlation with *Rating of Health Plan* and the presence of other survey items that measure more specific aspects of member experience. If included, *Rating of all Health Care* would account for a large portion of the variance and confound coefficient estimates for the remaining variables in the model.

INDUSTRY KEY DRIVER MODEL

The table below lists five key drivers of Medicaid member experience in order of importance, from highest to lowest, based on their relative contribution to the *Rating of Health Plan* score. These variables have statistically significant coefficients in the regression model (p-value < 0.05). Performance on these variables, together with the control variables, explains 75 percent of the industry variation in Medicaid health plan ratings. Note that this ordering reflects *only* the strength of the overall relationship between each key driver and the health plan score at the industry level. It does not consider how FFS is currently performing on these measures. Improvement targets identified specifically for FFS, which consider both the strength of the key driver and the current level of performance in the area, are presented graphically in the next section.

Medicaid member ratings of the plan are strongly related to having a personal doctor (Q10) and being able to get urgent care as soon as needed (Q4). Getting needed information from customer service (Q24) and access to highly rated providers (Q18 and Q22) are all significant drivers of member experience.

Key Driver	Interpretation
Q18. Rating of Personal Doctor (percent *9* or *10*)	The higher the proportion of members rating their personal doctor as *9* or *10*, the higher the overall plan score
Q10. Member has a personal doctor (percent *Yes*)	The higher the proportion of plan members reporting they have a personal doctor, the higher the overall plan score
Q4. Got an appointment for urgent care as soon as needed (percent *Usually or Always*)	The higher the proportion of plan members reporting they received urgently needed care as soon as needed, the higher the overall plan score
Q22. Rating of Specialist Seen Most Often (percent *9* or *10*)	The higher the proportion of members rating their specialist as *9* or *10*, the higher the overall plan score
Q24. Health plan customer service provided needed information or help (percent *Usually or Always*)	The higher the proportion of members who were able to get the information or help they needed from customer service, the higher the overall plan score

OPPORTUNITIES FOR PLAN QUALITY IMPROVEMENT

Specific improvement opportunities for FFS are presented in Exhibit 5. The ordering reflects both the strength of each key driver in the broad industry context and how FFS is currently performing on the measure.

The middle panel of the chart compares how FFS is performing compared to the *best practice* score on each key driver. CSS defined the best practice score as the highest score among all the Adult CCOs contributing to the 2023 State OHP Average. Room for improvement, represented by the green arrows on the chart, is the difference between the current level of FFS performance and the best practice score.

The bar chart on the right displays the expected improvement in the overall *Rating of Health Plan* score FFS could achieve if it performed on par with the best practice plan on each of the key driver measures. Each bar represents room for improvement on the key driver weighted by its contribution to the *Rating of Health Plan* score.

EXHIBIT 5. 2023 FFS ADULT MEDICAID OHA CAHPS SURVEY : KEY AREAS AND PRIORITIES FOR IMPROVEMENT

Current Key Driver Performance		Room for Improvement on Key Driver	Overall Improvement Opportunity
2023 Rate		Percentage Point Difference Between Current Key Driver Score and the **Best Practice Score***	Expected Percentage Point **Improvement** in **Rating of Health Plan** score (percent *9* or *10*) if Key Driver Performs at Best Practice Level
Q18. Rating of Personal Doctor (percent *9* or *10*)	**65.02%**	+6.84% → **71.87%**	**+3.07%**
Q24. Customer service provided information or help (percent *Usually* or *Always*)	**71.23%**	+24.86% → **96.09%**	**+2.47%**
Q4. Got an appointment for urgent care as soon as needed (percent *Usually* or *Always*)	**80.22%**	+4.33% → **84.55%**	**+0.47%**
Q22. Rating of Specialist Seen Most Often (percent *9* or *10*)	**64.35%**	+3.43% → **67.78%**	**+0.34%**
Q10. Member has a personal doctor (percent *Yes*)	**84.01%**	+0.73% → **84.74%**	**+0.17%**

*Highest score on the key driver measure among all the Adult CCOs included in the 2023 State OHP. 30730

If the numerator for any displayed category is less than 3 or the number of attribute respondents is less than 30, "NR" appears in place of the rate and point difference/improvement, indicating that the results are not reportable by OHA.

HEALTH PLAN QUALITY IMPROVEMENT RESOURCES FOR KEY DRIVERS

CSS's *Key Driver Analysis* identified improvement opportunities and priorities for FFS. This section, which lists some helpful publicly available quality improvement resources, is included as a guide to assist plan managers in their efforts. Inclusion of these sources should not be construed as an endorsement of any programs or activities. Some of these resources may be more applicable to your organization than others, especially because many of the cited interventions are intended to be implemented at the practice or provider level. For a useful introduction to quality improvement (QI), refer to the Agency for Healthcare Research and Quality's (AHRQ) reference guide that includes descriptions of QI strategies in health delivery systems (www.ahrq.gov/sites/default/files/wysiwyg/cahps/quality-improvement/improvement-guide/4-approach-qi-process/cahps-section-4-ways-to-approach-qi-process.pdf).

IMPROVING MEMBER ACCESS TO CARE

Removing barriers to care is central to improving the health care experience of plan members. The following resources suggest ways to improve patient access to care, tests, and treatment.

Same-Day Appointment Scheduling

- The Agency for Healthcare Research and Quality (AHRQ) recommends a method of scheduling that leaves a part of each physician's day open for same-day appointments, rather than a traditional scheduling model that books appointments weeks or months in advance. Because the method does not differentiate between urgent and routine care, patients with non-urgent concerns are able to schedule appointments sooner than under traditional scheduling methods. For more information, see www.ahrq.gov/cahps/quality-improvement/improvement-guide/6-strategies-for-improving/access/strategy6a-openaccess.html.

- This article from *Healthcare Dive* describes the benefits and challenges of implementing same-day scheduling as well as some short case studies: https://www.healthcaredive.com/news/same-day-scheduling-can-improve-patient-satisfaction-and-your-bottom-line/506048/.

- An article in *Patient Engagement HIT* explains that the greatest challenge to implementing same-day appointments is clearing the backlog (see https://patientengagementhit.com/news/exploring-open-access-scheduling-in-patient-access-to-care).

Implement Process Improvements to Streamline Patient Flow

- Delays experienced by patients while waiting for care, tests, or treatment can be minimized through a variety of mechanisms. For example, reallocating tasks such as physical exams and ordering x-rays to physician assistants and nurse practitioners frees up physicians' time to attend to more pressing patient concerns. The exact form of these improvements will vary widely by practice. See https://www.ahrq.gov/research/findings/final-reports/ptflow/index.html for AHRQ's guide to plan and implement patient flow improvement strategies.

- ***VIDEO*** This webinar from the Virginia Mason Institute demonstrates how Virginia Mason Franciscan Health improved patient flow in the ambulatory setting (watch on YouTube at https://www.youtube.com/watch?v=0R6isKaZqVo).

Patient-Centered Medical Homes (PCMH)

- For AHRQ's resources detailing transitioning a practice to a patient-centered medical home model, see https://www.ahrq.gov/ncepcr/research/care-coordination/pcmh/index.html, with links to additional resources at https://www.ahrq.gov/ncepcr/research/care-coordination/pcmh/define.html.

- ***VIDEO*** This webinar from the National Association of Community Health Centers features presenters from The Joint Commission and the National Committee for Quality Assurance speaking about quality improvement as it relates to patient-centered medical homes (watch on YouTube at https://www.youtube.com/watch?v=gIpKgvtyifI).

- For more background on the patient-centered medical home model of care and health equity, see www.ncbi.nlm.nih.gov/pmc/articles/PMC2869425/ and nam.edu/wp-content/uploads/2015/06/PatientCenteredMedicalHome.pdf.

Alternative Access Centers

- This brief (https://www.rwjf.org/en/insights/our-research/2015/04/the-value-proposition-of-retail-clinics.html) from the Robert Wood Johnson Foundation highlights the growing capacity of retail clinics and telemedicine to meet patient medical needs, particularly in rural and underserved communities and for patients with acute but non-serious conditions who need care quickly.

- Providing patients with such alternative venues as telehealth to access health care, rather than the traditional doctor's office or hospital, lowers barriers to care (www.ncbi.nlm.nih.gov/pmc/articles/PMC4795318/).

- This article from *Patient Engagement HIT* concludes that retail health clinics and virtual care improve health equity by providing greater access to care (see https://patientengagementhit.com/features/retail-health-clinics-are-key-on-the-path-to-health-equity).

- The National Center for Health Statistics provides statistics on retail health and urgent care center utilization in 2019 by sex, race, age, and education level (see https://www.cdc.gov/nchs/products/databriefs/db409.htm).

Telehealth Solutions to Pandemic-Related Issues

- The COVID-19 pandemic has accelerated the usage and acceptance of telehealth by providers and patients alike. This article in *The Lancet* (www.thelancet.com/journals/langlo/article/PIIS2214-109X(20)30362-4/fulltext) details opportunities to expand telehealth beyond the pandemic.

- Telehealth also can be implemented to solve deferral of care issues brought about by the pandemic (see publichealth.jmir.org/2020/3/e21607?utm_source=TrendMD&utm_medium=cpc&utm_campaign=JMIR_TrendMD_1).

- Telemedicine was underutilized until the COVID-19 pandemic, when changes to regulations and payment policies permitted its rapid growth. Telemedicine improves access and equity, though barriers remain (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9035352/).

- ***VIDEO*** This webinar discusses "how people, processes, regulation and technology work together to support a successful telehealth transformation… potentially improving access, quality and costs" (https://www.aha.org/education-events/telehealth-and-its-emergence-during-pandemic-may-17).

- ***PODCAST*** Post-pandemic, telehealth is key to the future of digitally enabled care, which integrates in-person and virtual care in a clinically appropriate manner (https://www.ama-assn.org/practice-management/digital/2022-moving-beyond-telehealth-digitally-enabled-care).

IMPROVING HEALTH PLAN PROVIDER NETWORK

These resources concentrate on improving the physician-patient relationship, with a focus on communication. Implementing the solutions proposed here may result in improved patient ratings of doctors.

Improve Physician Communication

- Seminars and workshops for physicians serve as a resource for physicians to learn and practice patient-centered communication techniques. For general recommendations related to physician communication, see www.ahrq.gov/cahps/quality-improvement/improvement-guide/6-strategies-for-improving/communication/strategy6gtraining.html.

- This article in *Physicians Practice* shares nine ways to improve communication with patients (see https://www.physicianspractice.com/view/nine-ways-to-improve-your-patient-communications). Click through the slides at the top of the page to read information on each strategy.

- Similarly, this blog post shares 10 tips for communicating with patients using the RELATE (Reassure, Explain, Listen, Answer questions, Take action, and Express appreciation) model (see https://www.healthstream.com/resource/blog/10-ways-to-encourage-better-physician-communication).

- Much of patient dissatisfaction stems from a failure of effective physician communication. For a review of the literature on doctor-patient communication, see (www.ncbi.nlm.nih.gov/pmc/articles/PMC3096184/).

Help Patients Communicate

- Patients who can effectively communicate their needs tend to have higher satisfaction with their care. AHRQ recommends four interventions that prepare patients to better communicate with their providers, including record sharing, writing down talking points prior to visits, and "coached care" programs. See www.ahrq.gov/cahps/quality-improvement/improvement-guide/6-strategies-for-improving/communication/strategy6i-shared-decisionmaking.html and www.ahrq.gov/cahps/quality-improvement/improvement-guide/6- strategies-for-improving/communication/strategy6htools.html.

- ***TOOL*** For a sample discharge preparation/care transition document that providers can distribute to patients before or during visits, see www.rwjf.org/content/dam/farm/toolkits/toolkits/2013/rwjf404048.

- ***TOOL*** The National Institutes of Health provides five worksheets to help patients choose a new provider and to talk to their provider about family health history, medications, life changes, and health or other concerns (see https://www.nia.nih.gov/health/talking-with-doctor-worksheets)

- ***TOOL*** AHRQ provides tips for patients to become more engaged in their health care before, during, and after the appointment (see https://www.ahrq.gov/questions/be-engaged/index.html). A two-page PDF file can be downloaded from this page.

- ***TOOL*** AHRQ also provides a Question Builder tool that patients can use to customize a list of questions for their appointment. The tool is available for printing online at https://www.ahrq.gov/questions/question-builder/online.html and in a downloadable app in the Apple App Store and Google Play (see more information at https://www.ahrq.gov/questions/question-builder/index.html).

Build Physician-Patient Relationships

- A positive physician-patient relationship may correlate with better health care outcomes. This article describes three essential elements that contribute to a positive relationship between provider and patients: empathy, communication, and shared decision-making (see https://patientengagementhit.com/news/3-key-traits-of-a-positive-patient-provider-relationship).

- AHRQ discusses the SHARE Approach to shared decision-making and provides links to resources on their website at https://www.ahrq.gov/health-literacy/professional-training/shared-decision/tools/factsheet.html.

- Cultural competence is increasingly important to the physician-patient relationship. Tips and resources are available at https://www.ahrq.gov/health-literacy/professional-training/shared-decision/tool/resource-7.html.

Improve Referral Communication

- The coordination of care between primary and specialist providers can be a challenge and may affect patient perceptions of their specialist care. Improving the coordination of care and case management can increase patient satisfaction with their specialist. The Medical Group Management Association has tips for building relationships with specialists (see https://www.mgma.com/resources/operations-management/communication-lays-the-groundwork-for-successful-p).

- AHRQ's Health Literacy Universal Precautions Toolkit includes a section on making the referral process easier for patients (see https://www.ahrq.gov/health-literacy/improve/precautions/tool21.html).

- High-functioning referral networks are critical for positive patient outcomes and require communication, measurement, and monitoring (see https://www.hfma.org/finance-and-business-strategy/population-health-management/61094/).

- A survey of Veterans Health Administration specialists found that use of referral templates was seen as helpful to improve the quality of referrals; service agreements and e-consults were less so (see https://www.ajmc.com/view/tools-to-improve-referrals-from-primary-care-to-specialty-care).

IMPROVING CUSTOMER SERVICE AND HEALTH PLAN-RELATED INFORMATION

It is important that health plan information is both easily available and useful to members. As representatives of the plan, customer service staff must ensure that members have confidence and trust in their ability to address their questions and concerns. The following resources contain recommendations for improving customer service.

Develop Customer Service Standards

- To improve customer service, the Agency for Healthcare Research and Quality suggests first articulating which aspects of customer service are most important to the plan. After developing these standards, monitor performance and promote accountability among staff. For more information, see www.ahrq.gov/cahps/quality-improvement/improvement-guide/6-strategies-for-improving/customer-service/strategy6q-custservice-standards.html.

Iterative Improvement for Member Services

- This RAND paper details a case study in which a health plan used additional surveys to supplement CAHPS results and thoroughly assess member dissatisfaction with customer service. Throughout the process, plan leadership continually examined and adjusted improvement goals. The intervention resulted in a reduction of wait time for customer service calls and increased member satisfaction with customer service, as measured on the CAHPS survey. See www.rand.org/pubs/working_papers/WR517.html.

Implement Service Recovery Procedures

- When members have a complaint, service recovery programs support customer service personnel in identifying and remedying the problem. While complaints may be inevitable, proper handling of complaints can reassure patients and restore loyalty to the health plan. For more information, see www.ahrq.gov/cahps/quality-improvement/improvement-guide/6-strategies-for-improving/customer-service/strategy6p-service-recovery.html.

- This article in *Forbes* defines service recovery and describes effective strategies to implement it in your practice (see https://www.forbes.com/sites/forbesagencycouncil/2022/12/15/service-recovery-in-healthcare-effective-strategies-to-retain-unsatisfied-patients/?sh=60c824e84cf7).

- ***VIDEO*** This four-part training series was developed as part of a grant from the Health Resources & Services Administration (HRSA). The videos total one hour and focus on why service recovery matters, eight steps for front-line staff, tips for de-escalation, and embedding service recovery into everyday practice (see https://stratishealth.org/service-recovery-in-health-care/).

Make Plan Information Accessible to All Members

- A Health Research and Educational Trust study found that demographic characteristics, including education, age, gender, and income, significantly impacted the use of an internet-based decision tool. The tool provided cost information as well as a health and wellness assessment. The study suggests that effort beyond internet-based tools is necessary to reach certain demographics. For further information, see www.ncbi.nlm.nih.gov/pmc/articles/PMC3447236/.

- This article addresses the importance of website accessibility for older adults and persons with disabilities to obtain, understand, and use health information (see https://ahimafoundation.org/research/the-critical-role-of-web-accessibility-in-health-information-access-understanding-and-use/).

- The Centers for Medicare & Medicaid Services (CMS) provides information on communication accessibility planning for people who are blind or have low vision (https://www.cms.gov/files/document/omh-visual-sensory-disabilities-brochure-508c.pdf), those who are deaf or hard-of-hearing (https://www.cms.gov/files/document/audio-sensory-disabilities-brochure-508c.pdf), and those with limited English proficiency (https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Language-Access-Plan.PDF).

Increase Access to Trusted Health Information

- Many people look to their health plan for information not only on how the health plan works, but also on resources to help them improve their health, particularly when dealing with chronic illnesses. Improved access to trusted health information has been shown to lead to improved outcomes (www.ncbi.nlm.nih.gov/pmc/articles/PMC5818676/).

- This James Madison University Library microsite includes sub-pages with links to reliable sources of health information, information for teens and young adults, and information about medications and supplements, among others (see https://guides.lib.jmu.edu/consumerhealth/health-websites).

Evaluate the Organization's Health Literacy Programs

- The CDC has developed guidance on evaluating an organization's health literacy program, including recommended sources of communication and health literacy measures. See www.cdc.gov/healthliteracy/researchevaluate/program-evaluation.html.

- The CDC's National Prevention Information Network also offers tools to create health materials in plain language to reduce health disparities (npin.cdc.gov/pages/health-communication-language-and-literacy).

- HHS has a strong focus on health literacy in its Healthy People 2030 initiative, with six objectives related to the topic. See information on these goals and the updated definitions of personal and organizational health literacy at https://health.gov/healthypeople/priority-areas/health-literacy-healthy-people-2030, and health literacy resources at https://health.gov/health-literacy.

Improve Patient Health Literacy

- This guide by the Office of Disease Prevention and Health Promotion outlines steps to improve health literacy, which may help patients to better absorb the information they obtain from written materials or the internet. For detailed steps, see health.gov/our-work/national-health-initiatives/health-literacy/resources.

- AHRQ also has developed its own health literacy toolkit to support physicians, the *Health Literacy Universal Precautions Toolkit, 2nd Edition*: www.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/literacy-toolkit/healthlittoolkit2.html.

- The companion guide, *Implementing the AHRQ Health Literacy Universal Precautions Toolkit: Practical Ideas for Primary Care Practices*, presents advice based on the experiences of 12 primary-care practices that implemented the Toolkit. It is available at https://www.ahrq.gov/health-literacy/improve/precautions/guide/index.html.

APPENDIX

CALCULATION GUIDELINES FOR RATING AND COMPOSITE GLOBAL PROPORTIONS

NCQA's *HEDIS Measurement Year 2022, Volume 3: Specifications for Survey Measures* contains detailed guidelines for calculating survey results. These guidelines include:

- Criteria for including a survey in the results calculation. A questionnaire must have the final disposition code of *Complete and Valid Survey* to be included in the calculation of plan-level scores.
- Rules for handling appropriately answered questions (i.e., questions that comply with survey skip-pattern instructions).
- Rules for handling inappropriately answered questions (e.g., unanswered questions, multiple-mark questions, questions that should have been skipped, and questions within a skip pattern of an inappropriately answered or skipped gate item).
- Denominator reporting thresholds. Health plans must achieve a denominator of at least 100 responses to obtain a reportable result. If the denominator for a particular survey result calculation is less than 100, NCQA assigns a measure result of "NA".
- Rules for calculating denominators for questions and composites. The denominator for a question is equal to the total number of responses to that question. The denominator for a composite is the average number of responses across all questions in the composite.
- Rules for handling changes in submission entity (i.e., if a health plan changes how it reports CAHPS results from one year to the next.)

COMPOSITE GLOBAL PROPORTIONS

Global Proportions are *average* proportions of respondents who gave the plan a favorable rating on each question in a composite. The steps involved in calculating the composite global proportion are:

Step 1

For each question in a composite, determine the proportion of respondents selecting the reported response option(s).

Step 2

Calculate the average proportion across all the questions in the composite. These are the composite global proportions. Note: all questions in a composite are weighted equally, regardless of how many members respond.

Example:

Response option	Q4	Q6	Global Proportion
Never or *Sometimes*	1 / 5 = 0.20	1 / 4 = 0.25	(0.20 + 0.25) / 2 = 0.2250
Usually	2 / 5 = 0.40	1 / 4 = 0.25	(0.40 + 0.25) / 2 = 0.3250
Always	2 / 5 = 0.40	2 / 4 = 0.50	(0.40 + 0.50) / 2 = 0.4500
Usually or Always	4 / 5 = 0.80	3 / 4 = 0.75	(0.80 + 0.75) / 2 = 0.7750

Therefore, 80.00 percent and 75.00 percent of members respectively provided favorable responses to the *Getting Care Quickly* questions Q4 and Q6. Averaging these two proportions yields the global proportion score of 77.50 percent for the *Getting Care Quickly* composite.

GLOSSARY OF TERMS

Attributes	Areas of health plan performance and member experience assessed with the CAHPS survey
Benchmark	A reference score (e.g., the State Oregon Health Plan, the CSS Average, the highest or lowest performing CCO, or the CCO's own prior-year rate) against which performance on the measure is assessed. See *Comparisons to Benchmarks and Prior-Year Results*.
CAHPS Surveys	Consumer Assessment of Healthcare Providers and Systems (CAHPS) is a series of surveys designed to collect consumer feedback on their health care experiences. The CAHPS 5.1H Health Plan Survey asks members to report on their experiences with access to appointments and care through their health plan, communication with doctors available through the plan, and customer service. The Commercial plan version asks about member experiences in the previous twelve months, whereas the Medicaid version refers to the previous six months. The Medicaid version is available for adults and children; the Commercial version is for adults only. The Adult survey is intended for respondents who are 18 and older; the Child survey asks parents or guardians about the experiences of children 17 and younger. Health plans report survey results as part of HEDIS data collection. NCQA uses survey results to create national benchmarks for care and to report health plan performance to consumers. Health plans might also collect CAHPS survey data for internal quality improvement purposes.
Composite Measures	Composite measures combine results from related survey questions into a single score to summarize health plan performance in a specific area of care or service. The set of applicable composites varies slightly by survey version.
Confidence Level	A confidence level is associated with tests of statistical significance of observed differences in survey scores. It is expressed as a percentage and represents how often the observed difference (e.g., between the plan's current-year rate and the relevant benchmark rate) is real and not simply due to chance. A 95% confidence level associated with a statistical test means that if repeated samples were surveyed, in 95 out of 100 samples the observed measure score would be truly different from the comparison score.
Correlation	A degree of association between two variables, or attributes, typically measured by the *Pearson correlation coefficient*. The coefficient value of 1 indicates a strong positive relationship; -1 indicates a strong negative relationship; zero indicates no relationship at all.
Denominator (*n*, or Usable Responses)	Number of valid (appropriately answered) responses available to calculate a measure result. Examples of inappropriately answered questions include ambiguously marked answers, multiple marks when a single answer choice is expected, and responses that violate survey skip patterns. The denominator for an individual question is the total number of valid responses to that question. The denominator for a composite is the average number of responses across all questions in the composite. If the denominator is less than 30 responses, a measure result of "NR" was assigned.
Disposition	The final status given to a member record in the survey sample at the end of the study (e.g., completed survey, refusal, non-response, etc.)

Eligible Population	Members who are eligible to participate in the survey based on the following NCQA criteria: - Current enrollment (as of the date the sample frame is generated). Some members may no longer be enrolled by the time they complete the survey. They become ineligible and will be excluded from survey results based on their responses to the first two questions on the survey, which confirm membership. - Continuous enrollment (twelve months for Commercial and six months for Medicaid, with no more than one enrollment break of 45 days or less); - Member age (18 years old or older for the Adult survey and 17 years old or younger for the Child survey as of December 31 of the measurement year); - Primary coverage (through Medicaid or a commercial product line for Medicaid and Commercial surveys, respectively).
Global proportions	Applies to composite measures. The proportion of respondents selecting the favorable response(s) (e.g., *Usually or Always*) averaged across the questions that make up the composite.
HEDIS	The Healthcare Effectiveness Data and Information Set (HEDIS) is a set of performance measures in the managed care industry, developed and maintained by NCQA. HEDIS was designed to allow consumers to compare health plan performance to other plans and to national or regional benchmarks as well as to track year-to-year performance. HEDIS is one component of NCQA's accreditation process, although some plans submit HEDIS data without seeking accreditation. CAHPS measures are a subset of HEDIS.
Key Drivers	Key Drivers are plan attributes that have been shown to be closely related to members' overall assessment of the plan. Performance on these attributes predicts how the plan is rated overall and, viewed from the industry perspective, helps to distinguish high-rated plans from poorly performing plans.
NCQA	The National Committee for Quality Assurance (NCQA) is an independent non-profit organization that works to improve health care quality through the administration of evidence-based standards, measures, programs, and accreditation. NCQA manages voluntary accreditation programs for individual physicians, health plans, and medical groups. Health plans seek accreditation and measure performance through the administration and submission of the Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey.
Question Summary Rate	Question Summary Rates express the proportion of respondents selecting the response option(s) of interest (typically representing the most favorable outcome(s) from a given question on the survey). Many survey items use a *Never*, *Sometimes*, *Usually*, or *Always* response scale, with *Always* being the most favorable outcome. Results are typically reported as the proportion of members selecting *Usually* or *Always*.

Response Rate	Survey response rate is calculated by NCQA using the following formula: $\text{Response Rate} = \frac{\text{Complete and Eligible Surveys}}{\text{[Complete and Eligible + Incomplete (but Eligible) + Refusal + Nonresponse after maximum attempts + Added to Do Not Call (DNC) List]}}$
Sample size	OHA's methodology used a sample size of 2,250 for Adult Medicaid samples, 2,250 for Child Medicaid samples, and 700 for Child Medicaid with Chronic Conditions samples.
Statistically Significant Difference	When survey results are calculated based on sample data and compared to a benchmark score (e.g., the NCQA National Average rate, the CSS Book-of-Business average, or the plan's own prior-year rate), the question is whether the observed difference is real or due to chance. A difference is said to be statistically significant at a given confidence level (e.g., 95%) if it has a 95% chance of being true.
Trending	Comparison of survey results over time
Usable Responses (*n*)	See *Denominator*
Valid Response	Any acceptable response to a survey question (i.e., falling within a predefined set) that follows the NCQA skip pattern rules and data cleaning guidelines.

SURVEY INSTRUMENT

Oregon Health Authority

2023

OHP3E

Survey Instructions

Answer each question by marking the box to the left of your answer.

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

☑ 1 Yes → ***If Yes, Go to Question 1***
☐ 2 No

Personally identifiable information will not be made public and will only be released in accordance with federal laws and regulations.

You may choose to answer this survey or not. If you choose not to, this will not affect the benefits you get. You may notice a number on the cover of this survey. This number is ONLY used to let us know if you returned your survey so we don't have to send you reminders.

If you want to know more about this study, please call 1-833-257-1377. For the hearing or speech impaired, call 711 to use the Telecommunications Relay Service (TRS).

1. Our records show that you are now in Oregon Health Plan. Is that right?

☐ 1 Yes → ***If Yes, Go to Question 3***
☐ 2 No

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

_____

Your Health Care in the Last 6 Months

These questions ask about your own health care from a clinic, emergency room, or doctor's office. This includes care you got in person, by phone, or by video. Do <u>not</u> include care you got when you stayed overnight in a hospital. Do <u>not</u> include the times you went for dental care visits.

3. In the last 6 months, did you have an illness, injury, or condition that <u>needed care right away</u>?

☐ 1 Yes
☐ 2 No → ***If No, Go to Question 5***

4. In the last 6 months, when you needed care right away, how often did you get care as soon as you needed?

- ☐ 1 Never
- ☐ 2 Sometimes
- ☐ 3 Usually
- ☐ 4 Always

5. In the last 6 months, did you make any in person, phone, or video appointments for a check-up or routine care?

- ☐ 1 Yes
- ☐ 2 No → ***If No, Go to Question 7***

6. In the last 6 months, how often did you get an appointment for a check-up or routine care as soon as you needed?

- ☐ 1 Never
- ☐ 2 Sometimes
- ☐ 3 Usually
- ☐ 4 Always

7. In the last 6 months, not counting the times you went to an emergency room, how many times did you get health care for yourself in person, by phone, or by video?

- ☐ 0 None → ***If None, Go to Question 10***
- ☐ 1 1 time
- ☐ 2 2
- ☐ 3 3
- ☐ 4 4
- ☐ 5 5 to 9
- ☐ 6 10 or more times

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

0	1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Worst health care possible — Best health care possible

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

- ☐ 1 Never
- ☐ 2 Sometimes
- ☐ 3 Usually
- ☐ 4 Always

Your Personal Doctor

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

- ☐ 1 Yes
- ☐ 2 No → ***If No, Go to Question 19***

11. In the last 6 months, how many times did you have an in person, phone, or video visit with your personal doctor about your health?

- ☐ 0 None → ***If None, Go to Question 18***
- ☐ 1 1 time
- ☐ 2 2
- ☐ 3 3
- ☐ 4 4
- ☐ 5 5 to 9
- ☐ 6 10 or more times

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

- ☐ 1 Never
- ☐ 2 Sometimes
- ☐ 3 Usually
- ☐ 4 Always

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

- ☐ 1 Never
- ☐ 2 Sometimes
- ☐ 3 Usually
- ☐ 4 Always

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

- ☐ 1 Never
- ☐ 2 Sometimes
- ☐ 3 Usually
- ☐ 4 Always

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

- ☐ 1 Never
- ☐ 2 Sometimes
- ☐ 3 Usually
- ☐ 4 Always

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

- ☐ 1 Yes
- ☐ 2 No → ***If No, Go to Question 18***

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

- ☐ 1 Never
- ☐ 2 Sometimes
- ☐ 3 Usually
- ☐ 4 Always

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

0	1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Worst personal doctor possible — Best personal doctor possible

Getting Health Care from Specialists

When you answer the next questions, include the care you got in person, by phone, or by video. Do <u>not</u> include dental visits or care you got when you stayed overnight in a hospital.

19. Specialists are doctors like surgeons, heart doctors, allergy doctors, skin doctors, and other doctors who specialize in one area of health care. In the last 6 months, did you make any appointments with a specialist?

- ☐ 1 Yes
- ☐ 2 No → ***If No, Go to Question 23***

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

- ☐ 1 Never
- ☐ 2 Sometimes
- ☐ 3 Usually
- ☐ 4 Always

21. How many specialists have you talked to in the last 6 months?

- ☐ 0 None → ***If None, Go to Question 23***
- ☐ 1 1 specialist
- ☐ 2 2
- ☐ 3 3
- ☐ 4 4
- ☐ 5 5 or more specialists

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

0	1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Worst specialist possible								Best specialist possible		

Your Health Plan

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

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

- ☐ 1 Yes
- ☐ 2 No → ***If No, Go to Question 26***

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

- ☐ 1 Never
- ☐ 2 Sometimes
- ☐ 3 Usually
- ☐ 4 Always

25. In the last 6 months, how often did your health plan's customer service staff treat you with courtesy and respect?

- ☐ 1 Never
- ☐ 2 Sometimes
- ☐ 3 Usually
- ☐ 4 Always

26. In the last 6 months, did your health plan give you any forms to fill out?

- ☐ 1 Yes
- ☐ 2 No → ***If No, Go to Question 28***

27. In the last 6 months, how often were the forms from your health plan easy to fill out?

- ☐ 1 Never
- ☐ 2 Sometimes
- ☐ 3 Usually
- ☐ 4 Always

28. Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your health plan?

0	1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Worst health plan possible — Best health plan possible

28a. In the last 6 months, did you have a health problem for which you needed special medical equipment, such as a cane, a wheelchair, or oxygen equipment?

- ☐ 1 Yes
- ☐ 2 No → ***If No, Go to Question 28c***

28b. In the last 6 months, how often was it easy to get the medical equipment you needed through your health plan?

- ☐ 1 Never
- ☐ 2 Sometimes
- ☐ 3 Usually
- ☐ 4 Always

28c. In the last 6 months, did you have any health problems that needed special therapy, such as physical, occupational, or speech therapy?

- ☐ 1 Yes
- ☐ 2 No → ***If No, Go to Question 28e***

28d. In the last 6 months, how often was it easy to get the special therapy you needed through your health plan?

- ☐ 1 Never
- ☐ 2 Sometimes
- ☐ 3 Usually
- ☐ 4 Always

Additional Questions

The following questions ask about how much you think your doctor or other health provider respects your beliefs, attitudes, language and behavior.

28e. In the last 6 months, how often did a doctor or other health provider talk too fast when talking to you?

- ☐ 1 Never
- ☐ 2 Sometimes
- ☐ 3 Usually
- ☐ 4 Always

28f. In the last 6 months, how often did a doctor or other health provider interrupt you when you were talking?

- ☐ 1 Never
- ☐ 2 Sometimes
- ☐ 3 Usually
- ☐ 4 Always

28g. In the last 6 months, how often did a doctor or other health provider use a condescending, sarcastic or rude tone or manner with you?

- ☐ 1 Never
- ☐ 2 Sometimes
- ☐ 3 Usually
- ☐ 4 Always

28h. In the last 6 months, did you feel you could trust a doctor or other health provider with your medical care?

- ☐ 1 Yes, definitely
- ☐ 2 Yes, somewhat
- ☐ 3 No

Access to Dental Care

28i. A regular dentist is one you would go to for check-ups and cleanings or when you have a cavity or tooth pain. Do you have a regular dentist?

- ☐ 1 Yes
- ☐ 2 No

28j. In the last 6 months, did you go to a dentist's office or clinic for care?

- ☐ 1 Yes
- ☐ 2 No → ***If No, Go to Question 28l***

28k. In the last 6 months, how often did the dentists or dental staff explain what they were doing while treating you?

- ☐ 1 Never
- ☐ 2 Sometimes
- ☐ 3 Usually
- ☐ 4 Always

28l. If you tried to get an appointment for yourself with a dentist who specializes in a particular type of dental care (such as root canals or gum disease) in the last 6 months, how often did you get an appointment as soon as you wanted?

- ☐ 1 Never
- ☐ 2 Sometimes
- ☐ 3 Usually
- ☐ 4 Always
- ☐ 5 I did not try to get an appointment with a specialist dentist for myself in the last 6 months

28m. In the last 6 months, if you needed to see a dentist right away because of a dental emergency, how often did you get to see a dentist as soon as you wanted?

- ☐ 1 Never
- ☐ 2 Sometimes
- ☐ 3 Usually
- ☐ 4 Always
- ☐ 5 I did not have a dental emergency in the last 6 months

28n. Using any number from 0 to 10, where 0 is extremely difficult and 10 is extremely easy, what number would you use to rate how easy it was for you to find a dentist?

0	1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Extremely difficult										Extremely easy

28o. If you delayed going to the dentist, what was the primary reason? (Select only one.)

- ☐ 1 Do not feel it is safe under COVID to visit the dentist's office or get dental care
- ☐ 2 The cost of care
- ☐ 3 Inconvenient location
- ☐ 4 Inconvenient appointment times
- ☐ 5 Trouble finding a dentist or dental care
- ☐ 6 Fear or anxiety of seeing a dentist
- ☐ 7 Went to the emergency room instead for dental care
- ☐ 8 I needed an interpreter and wasn't able to get one
- ☐ 9 Other reason *(Please print)*

  _____

- ☐ 10 I did not delay going to the dentist

Healthcare Visits by Phone or Video

These questions ask about your own health care you got by phone or by video only.

29a. In the last 6 months, did you have a healthcare visit by phone or video?

- ☐ 1 Yes
- ☐ 2 No → ***If No, Go to Question 29e***

29b. What type of device did you use for a healthcare visit by phone or video? (Please check ALL that apply.)

- ☐ A Personal computer with video
- ☐ B Smartphone or tablet with video
- ☐ C Telephone without video
- ☐ D Telehealth kiosk
- ☐ E Other

29c. How easy or difficult has it been to use technology during a healthcare visit by phone or video?

- ☐ 1 Very easy
- ☐ 2 Easy
- ☐ 3 Difficult
- ☐ 4 Very difficult

29d. In the last 6 months, was the quality of care you received during phone or video visits better or worse than the care you receive during in-person visits?

- ☐ 1 Much worse
- ☐ 2 Slightly worse
- ☐ 3 About the same
- ☐ 4 Slightly better
- ☐ 5 Much better

→ ***Go to Question 30a on Page 8***

29e. In the last 6 months, what were the reasons you have not had a phone or video session? (Please check ALL that apply.)

- ☐ A I didn't seek medical care
- ☐ B I wasn't aware that phone or video visits were available
- ☐ C I preferred to see my provider in person
- ☐ D My provider did not offer phone or video visits
- ☐ E I didn't have the technology to access a phone or video visit
- ☐ F I had privacy concerns about having a phone or video visit
- ☐ G I needed an interpreter and wasn't able to get one
- ☐ H Other reason *(Please print)*

_____

COVID-19

The following questions ask about the impact of the COVID-19 pandemic on your care.

30a. In the last 6 months, how often did you delay getting physical health care because of COVID-19?

- ☐ 1 Never
- ☐ 2 Sometimes
- ☐ 3 Usually
- ☐ 4 Always
- ☐ 5 I did not need physical health care in the last 6 months

30b. In the last 6 months, how often did you delay getting mental health care because of COVID-19?

- ☐ 1 Never
- ☐ 2 Sometimes
- ☐ 3 Usually
- ☐ 4 Always
- ☐ 5 I did not need mental health care in the last 6 months

30c. In the last 6 months, how often did you delay getting dental care because of COVID-19?

- ☐ 1 Never
- ☐ 2 Sometimes
- ☐ 3 Usually
- ☐ 4 Always
- ☐ 5 I did not need dental care in the last 6 months

About You

31. In general, how would you rate your overall health?

- ☐ 1 Excellent
- ☐ 2 Very Good
- ☐ 3 Good
- ☐ 4 Fair
- ☐ 5 Poor

32. In general, how would you rate your overall mental or emotional health?

- ☐ 1 Excellent
- ☐ 2 Very Good
- ☐ 3 Good
- ☐ 4 Fair
- ☐ 5 Poor

33. Have you had either a flu shot or flu spray in the nose since July 1, 2022?

- ☐ 1 Yes
- ☐ 2 No
- ☐ 3 Don't know

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

- ☐ 1 Every day
- ☐ 2 Some days
- ☐ 3 Not at all → ***If Not at All, Go to Question 38***
- ☐ 4 Don't know → ***If Don't know, Go to Question 38***

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

- ☐ 1 Never
- ☐ 2 Sometimes
- ☐ 3 Usually
- ☐ 4 Always

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

- ☐ 1 Never
- ☐ 2 Sometimes
- ☐ 3 Usually
- ☐ 4 Always

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

- ☐ 1 Never
- ☐ 2 Sometimes
- ☐ 3 Usually
- ☐ 4 Always

38. What is your age?

- ☐ 1 18 to 24
- ☐ 2 25 to 34
- ☐ 3 35 to 44
- ☐ 4 45 to 54
- ☐ 5 55 to 64
- ☐ 6 65 to 74
- ☐ 7 75 or older

39. What is the highest grade or level of school that you have completed?

- ☐ 1 8th grade or less
- ☐ 2 Some high school, but did not graduate
- ☐ 3 High school graduate or GED
- ☐ 4 Some college or 2-year degree
- ☐ 5 4-year college graduate
- ☐ 6 More than 4-year college degree

40. What language(s) do you use at home? (*Check all that apply*)

- ☐ A English → ***If English, Go to Question 42***
- ☐ B Spanish
- ☐ C Other *(Please print)*

_____

41. How well do you speak English?

- ☐ 1 Very well
- ☐ 2 Well
- ☐ 3 Not well
- ☐ 4 Not at all
- ☐ 5 Don't know
- ☐ 6 Don't want to answer

42. Do you prefer to use an interpreter when talking about medical or health information?

- ☐ 1 Yes
- ☐ 2 No → ***If No, Go to Question 45***

43. If you needed an interpreter, how often did you get an interpreter as soon as you needed?

- ☐ 1 Never
- ☐ 2 Sometimes
- ☐ 3 Usually
- ☐ 4 Always

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

0	1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Worst interpreter possible — Best interpreter possible

45. Are you deaf or do you have serious difficulty hearing?
- ☐ 1 Yes → ***If Yes, at what age did this condition begin?*** _____
- ☐ 2 No
- ☐ 3 Don't know
- ☐ 4 Don't want to answer

46. Are you blind or do you have serious difficulty seeing, even when wearing glasses?
- ☐ 1 Yes → ***If Yes, at what age did this condition begin?*** _____
- ☐ 2 No
- ☐ 3 Don't know
- ☐ 4 Don't want to answer

47. Do you have serious difficulty walking or climbing stairs?
- ☐ 1 Yes → ***If Yes, at what age did this condition begin?*** _____
- ☐ 2 No
- ☐ 3 Don't know
- ☐ 4 Don't want to answer

48. Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering or making decisions?
- ☐ 1 Yes → ***If Yes, at what age did this condition begin?*** _____
- ☐ 2 No
- ☐ 3 Don't know
- ☐ 4 Don't want to answer

49. Do you have difficulty dressing or bathing?
- ☐ 1 Yes → ***If Yes, at what age did this condition begin?*** _____
- ☐ 2 No
- ☐ 3 Don't know
- ☐ 4 Don't want to answer

50. Do you have serious difficulty learning how to do things most people your age can learn?
- ☐ 1 Yes → ***If Yes, at what age did this condition begin?*** _____
- ☐ 2 No
- ☐ 3 Don't know
- ☐ 4 Don't want to answer

51. Using your usual (customary) language, do you have serious difficulty communicating (for example understanding or being understood by others)?
- ☐ 1 Yes → ***If Yes, at what age did this condition begin?*** _____
- ☐ 2 No
- ☐ 3 Don't know
- ☐ 4 Don't want to answer
- ☐ 5 Don't know what this question is asking

52. Because of a physical, mental, or emotional condition, do you have serious difficulty doing errands alone such as visiting a doctor's office or shopping?

- ☐ 1 Yes → ***If Yes, at what age did this condition begin?*** _____
- ☐ 2 No
- ☐ 3 Don't know
- ☐ 4 Don't want to answer

53. Do you have serious difficulty with the following: mood, intense feelings, controlling your behavior, or experiencing delusions or hallucinations?

- ☐ 1 Yes → ***If Yes, at what age did this condition begin?*** _____
- ☐ 2 No
- ☐ 3 Don't know
- ☐ 4 Don't want to answer
- ☐ 5 Don't know what this question is asking

54. Please describe your gender in any way you prefer: *(Please print)*

_____

55. What is your gender? (*Check all that apply*)

- ☐ A Woman/Girl
- ☐ B Man/Boy
- ☐ C Non-binary
- ☐ D Agender/No Gender
- ☐ E Questioning
- ☐ F Not listed *(Please print)*

_____

- ☐ G Don't know
- ☐ H Don't know what this question is asking
- ☐ I Don't want to answer

56. Are you transgender?

- ☐ 1 Yes
- ☐ 2 No
- ☐ 3 Don't know
- ☐ 4 Questioning
- ☐ 5 Don't know what this question is asking
- ☐ 6 Don't want to answer

57. Please describe your sexual orientation or sexual identity in any way you want: *(Please print)*

_____

58. How do you describe your sexual orientation or sexual identity? (*Check all that apply*)

- ☐ A Same-gender loving
- ☐ B Same-sex loving
- ☐ C Lesbian
- ☐ D Gay
- ☐ E Bisexual
- ☐ F Pansexual
- ☐ G Straight (attracted mainly to or only to other gender(s) or sex(es))
- ☐ H Asexual
- ☐ I Queer
- ☐ J Questioning
- ☐ K Don't know
- ☐ L Not listed *(Please print)*

_____

- ☐ M Don't know what this question is asking
- ☐ N Don't want to answer

59. How do you identify your race, ethnicity, tribal affiliation, country of origin, or ancestry?

(Please print) _____

60. Which of the following describes your racial or ethnic identity? Please check ALL that apply.

Hispanic and Latino/a/x
- ☐ A Central American
- ☐ B Mexican
- ☐ C South American
- ☐ D Other Hispanic or Latino/a/x

Native Hawaiian and Pacific Islander
- ☐ E CHamoru (Chamorro)
- ☐ F Marshallese
- ☐ G Communities of the Micronesian Region
- ☐ H Native Hawiian
- ☐ I Samoan
- ☐ J Other Pacific Islander

White
- ☐ K Eastern European
- ☐ L Slavic
- ☐ M Western European
- ☐ N Other White

American Indian and Alaska Native
- ☐ O American Indian
- ☐ P Alaska Native
- ☐ Q Canadian Inuit, Metis, or First Nation
- ☐ R Indigenous Mexican, Central American, or South American

Black and African American
- ☐ S African American
- ☐ T Afro-Caribbean
- ☐ U Ethiopian
- ☐ V Somali
- ☐ W Other African (Black)
- ☐ X Other Black

Middle Eastern/North African
- ☐ Y Middle Eastern
- ☐ Z North African

Asian
- ☐ AA Asian Indian
- ☐ AB Cambodian
- ☐ AC Chinese
- ☐ AD Communities of Myanmar
- ☐ AE Fillipino/a
- ☐ AF Hmong
- ☐ AG Japanese
- ☐ AH Korean
- ☐ AI Loatian
- ☐ AJ South Asian
- ☐ AK Vietnamese
- ☐ AL Other Asian

Other Categories
- ☐ AM Other *(Please list)*

_____

- ☐ AN Don't know
- ☐ AO Don't want to answer

61. If you checked more than one category above, is there one you think of as your primary racial or ethnic identity?
- ☐ 1 Yes. Please circle your primary racial or ethnic identity above.
- ☐ 2 I do not have just one primary racial or ethnic identity.
- ☐ 3 No. I identify as Biracial or Multiracial.
- ☐ 4 N/A. I only checked one category above.
- ☐ 5 Don't know
- ☐ 6 Don't want to answer

Thank You

Please return the completed survey in the postage-paid envelope to:

Center for the Study of Services
PO Box 3416
Hopkins, MN 55343

Please do not include any other correspondence.