

CAHPS Background Information for TAG

September 2013

The Consumer Assessment of Health Plans Survey (CAHPS) was initially developed as a way for people to make comparisons between commercial insurance carriers. Over time, AHRQ has recognized the needs of special populations were not captured in the one-size-fits-all approach. For example, those with language or literacy barriers were not adequately reflected in the survey. Consequently, AHRQ has developed different versions of the survey, including one for Medicaid managed care organizations, and added supplemental questions for children with chronic conditions.

To make the current suite of surveys more useful at several different levels, AHRQ recently added three important supplements to the Clinic and Groups survey: The Primary Care Medical Home items, and the Cultural Competency and the Health Literacy modules. These questions and resulting information have never been included in health plan or state level results. OHA is interested in adding these questions to the health plan survey to provide CCO-specific information based on their members' experience of care in order to help reduce disparities in health care that are linked to race, ethnicity, and socio-economic status.

Cultural Competency Module

In 2011, the CAHPS Consortium adopted a new set of supplemental items for the CAHPS Clinician and Group Surveys that focus on assessing the cultural competence of health care providers from the patient's perspective. The Joint Commission incorporated cultural competence in its 2009 requirement related to the provision of culturally and linguistically appropriate health care, which includes:

- Addressing communication needs across the care continuum
- Providing language access services and auxiliary aids
- Informing patients of their right to receive language access services

However, although there has been much discussion in the medical, research and public health communities about "culturally competent care", little is known about how to measure it accurately. Yet, one's beliefs about health and well-being play a critical role in self-management of disease, potential complementary and alternative medication interactions, lifestyle choices, and simply how well a person communicates about their care needs with a physician. One promising way to assess the cultural competency of care is to obtain the patient's perspective on the care that he or she receives.

Several national studies reveal racial and ethnic disparities in patients' assessment of care and studies using the CAHPS results have shown that racial and ethnic minorities have worse reports of care than Whites in commercial and Medicaid managed care. However, among Hispanics and Asians, language barriers have a larger negative impact on assessments of care than do race and ethnicity.

The Cultural Competency item set was developed to improve the ability of the CAHPS survey to assess the cultural competence of providers: the item set expands on existing survey domains and adds

questions in other domains of cultural competency that were not adequately addressed in the existing surveys.

The Cultural Competency items address the following five topics:

- Patient provider (or doctor) communication
- Complementary and alternative medicine
- Experiences of discrimination due to race/ethnicity, insurance, or language
- Experiences leading to trust or distrust, including level of trust, caring, and truth-telling
- Linguistic competency

https://cahps.ahrq.gov/clinician_group/cgsurvey/aboutculturalcompetenceitemset.pdf

This item set is intended to generate data that health care providers can use to improve their cultural competence by:

- Identifying specific topic areas for quality improvement
- Recognizing particular behaviors that inhibit effective communication
- Measuring the effect of behaviors that promote effective communication

Providers can identify their strengths and weaknesses by topic area as well as for individual items by conducting different kinds of analyses. These analyses can help them understand how their performance on the composite measures and individuals compare to that of other providers, assess the extent to which survey responses differ by race, ethnicity, or language of respondents and determine which topics are driving performance on the overall rating measure.

Example:

- Providers are polite and considerate (composite measure)
- Providers are caring and inspire trust (composite measure)
- Equitable treatment (individual items)

Having identified opportunities for improvement and embarked on quality improvement activities, the providers can then field the items again to evaluate the success of improvement activities.

Development process for the Cultural Competency item set

- Development of conceptual model
- Literature review and environmental scan
- Development of domains and an initial set of items
- Translation of item set into Spanish
- Cognitive testing of items in English and Spanish
- Field testing
- Construction of composite measures

Additional information about the cultural competency item set development and testing is available online at:

- <http://www.academyhealth.org/files/2010/saturday/weech-maldonado.pdf>
- <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3748811/>
- <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3466106/>
- <http://journals.lww.com/lww-medicalcare/toc/2012/09002>

Health Literacy Module

The primary goal of the CAHPS Health Literacy Item Set is to measure, from the patient's perspectives, how well health information is communicated to them by health care professionals. The item set is intended to serve as both a measure of whether health care professionals have succeeded in reducing the health literacy demands they place on patients, and as a tool for quality improvement. The items address the following five topic areas:

- Communication with providers
- Disease self-management
- Communication about medicines
- Communication about tests
- Communication about forms

https://cahps.ahrq.gov/clinician_group/cgsurvey/aboutitemsetaddressinghealthliteracy.pdf

The survey results can be used to:

- Identify specific topic areas for quality improvement (example: communication about test results, medication, and other forms)
- Recognize particular behaviors that inhibit effective communication (example: talking too fast, using medical jargon)
- Assist in designing a safer environment where patients feel comfortable discussing their health care concerns (Example: showing interest in questions, explaining forms)
- Measure the effect of behaviors that promote effective communication (Example: confirming understanding through teach-back).

To assist providers in determining how to address areas of improvement, the AHRQ has mapped each item in the Health Literacy Item Set to a health literacy practice recommended by the American Medical Association Foundation and the AMA in their 2007 monograph Health Literacy and Patient Safety: Help Patients Understand.¹

Development process for the CAHPS Health Literacy Item Set

¹ <http://www.ama-assn.org/ama1/pub/upload/mm/367/healthlitclinicians.pdf>

- Stakeholder interviews with health literacy experts.
- Literature review and environmental scan
- A call for Measure in the Federal Register
- The development of domains and an initial set of items
- Cognitive testing of items in English and Spanish
- A stakeholder meeting to obtain feedback
- A second cognitive testing
- Field testing at two sites
- The construction of composite measures

Additional information about the health literacy item set development and testing is available online at:

- <http://www.ncbi.nlm.nih.gov/pubmed/22895227>
- <http://www.iom.edu/~media/Files/Activity%20Files/PublicHealth/HealthLiteracy/WeidmerOcampo.pdf>
- <http://journals.lww.com/lww-medicalcare/toc/2012/09002>

Follow up from August TAG meeting

(1) Question wording should be consistent and be a clear reflection of experience with personal provider. A member could be fine with their PCP and have problems with their specialist. How to identify the issues in an actionable way if just asking “personal doctor” or “this provider” – too generic.

The survey has a clear definition of “personal doctor” and “provider” that respondents can read right before answering the specific question. The health plan survey uses the phrase “personal doctor” and describes the term as follows: A personal doctor is the one you would see if you need a check-up, want advice about a health problem, or get sick or hurt.

There is a separate set of survey items that ask questions about experience with a specialist, where the term “specialist” is defined for the respondent as: Specialists are doctors like surgeons, heart doctors, allergy doctors, skin doctors and other doctors who specialize in one area of health care.

(2) Are we trying to determine if providers are culturally competent? Or a snapshot of experience the last time a member saw a doctor?

The CAHPS cultural competency module for Clinician and Group is designed to assess the cultural competence of providers. It addresses the following five topic areas:

- Patient provider (or doctor) communication
- Complementary and alternative medicine
- Experiences of discrimination due to race/ethnicity, insurance, or language
- Experiences leading to trust or distrust, including level of trust, caring, and truth-telling

- Linguistic competency

(3) If a member answers never, does that mean it never happens? How accurate are people when responding to these questions. Can we find out anything else from validation / module development?

If a member answers never, then it did not happen to the member in the last 6 months. The survey modules are tested for validity and reliability by AHRQ and NCQA.

(4) Consider the length of the survey and how many questions are being added.

As per NCQA recommendation, only 20 additional questions will be added to the core questions in the CAHPS survey; this will eliminate the possibility of survey fatigue.