



Institute for Child Health Policy at the University of Florida
Texas External Quality Review Organization

The Texas Children's Health Insurance Program

Survey Report

Fiscal Year 2011

The Institute for Child Health Policy
University of Florida

The External Quality Review Organization
for Texas Medicaid Managed Care and CHIP

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Executive Summary

Purpose

This report provides results from the state fiscal year (SFY) 2011 Children's Health Insurance Program (CHIP) Survey for the State of Texas, prepared by the Institute for Child Health Policy (IHP) at the University of Florida. As of September 2010, CHIP was administered through 15 managed care organizations (MCOs), providing services in nine urban geographic regions of Texas, as well as an exclusive provider organization (EPO) that administers care to CHIP members in rural areas of the state.¹ The Institute for Child Health Policy is contracted by the Texas Health and Human Services Commission (HHSC) to evaluate caregivers' experiences and satisfaction with their children's health care while enrolled in CHIP.

The purpose of the SFY 2011 CHIP Survey is to:

- Describe the demographic and household characteristics of child members and their families.
- Assess the health status of the population, including children with special health care needs (CSHCN).
- Document caregiver experiences and general satisfaction with the care their children receive through CHIP across four domains of care:
 - Utilization of health services, particularly emergency department (ED) use
 - Access to and timeliness of care
 - Patient-centered medical home
 - Health plan information and customer service
- Test the influence of domains of care on member ED use, controlling for demographic and health status variables.

Methodology

Survey participants were selected from a stratified random sample of children enrolled in CHIP for six months or longer between September 2010 and February 2011. The EQRO set a target sample of 4,800 completed telephone interviews with caregivers of sampled children, representing 300 respondents per CHIP MCO/EPO. The response rate for this survey was 49 percent and the cooperation rate was 72 percent.

The SFY 2011 CHIP Survey included:

- The Consumer Assessment of Healthcare Providers and Systems (CAHPS[®]) Health Plan Survey 4.0 for child members
- Items from the CAHPS[®] Clinician and Group Surveys
- The Children With Special Health Care Needs (CSHCN) Screener[®]
- Items developed by IHP pertaining to caregiver and member demographic and household characteristics.

Summary of Findings

Profile of CHIP survey child members:

- Fifty-two percent were male and 48 percent were female.
- The average age was 11 years old.
- The majority were Hispanic (68%), primarily of Mexican descent.
- Forty-one percent of girls and 49 percent of boys were overweight or obese.
- Twenty percent had at least one special health care need.

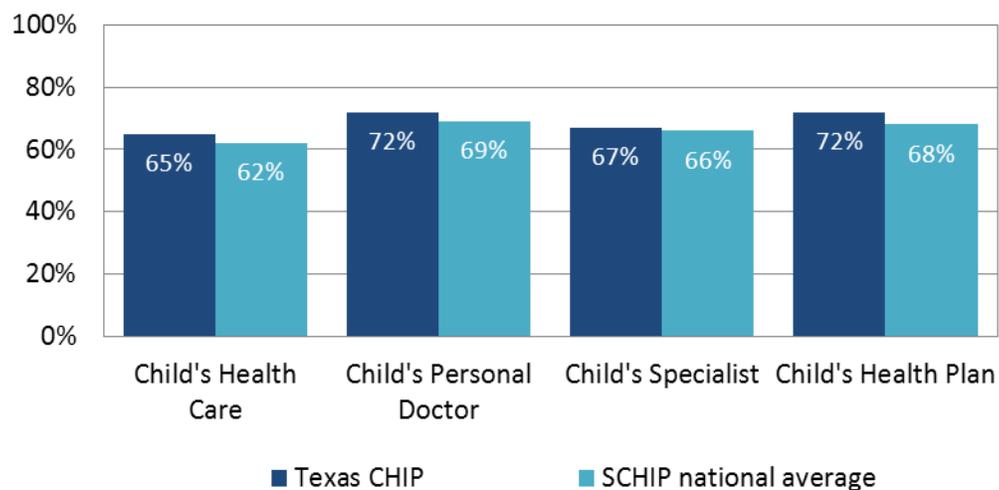
Profile of CHIP survey participants (caregivers):

- Ninety-seven percent were the biological parents of CHIP members, and the vast majority were female (89 percent).
- The average age was 39 years old.
- The majority were Hispanic (68%), primarily of Mexican descent.
- Thirty percent did not complete high school.
- Sixty-four percent were married, 14 percent were single, and 10 percent were divorced.

Positive findings

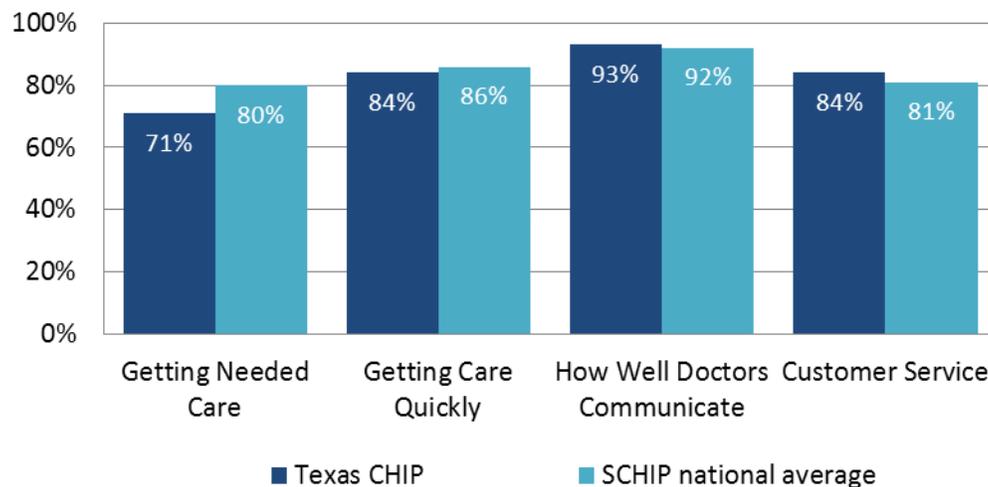
- *Caregiver Ratings.* The majority of caregivers provided high ratings of their child's health care, doctors, and health plan, indicated by a rating of 9 or 10 on a 10-point scale. These ratings were slightly greater than those published from State Children's Health Insurance Program (SCHIP) data nationally.

Percent of caregivers rating child's health services a "9" or "10"



- *Getting Care Quickly.* Most caregivers reported that they usually or always had positive experiences getting care quickly for their child (84 percent), which is comparable to the 86 percent reported for CHIP members nationally.
- *How Well Doctors Communicate.* The vast majority of caregivers reported usually or always having positive experiences communicating with their child's doctors (93 percent), which is comparable to the 92 percent reported for CHIP members nationally.
- *Health Plan Information and Customer Service.* Most caregivers reported that they usually or always had positive interactions with customer service at their child's health plan (84 percent), which is slightly higher than the 81 percent reported for CHIP members nationally.

Percent of caregivers "usually" or "always" having positive experiences (CAHPS®)



Improvement areas

- *Getting Needed Care.* Seventy-one percent of CHIP caregivers usually or always had positive experiences with *Getting Needed Care*, compared to the 80 percent reported for CHIP members nationally.
- *Getting Care and Services for CSHCN.* Caregivers of CSHCN were significantly less likely than caregivers of non-CSHCN to report positive experiences with *Getting Needed Care* and with *Health Plan Information and Customer Service*.
- *HHSC Performance Dashboard Indicators.* Results for most performance indicators indicate that few health plans are meeting HHSC Dashboard standards.
 - Only one MCO met the standard for *Good Access to Routine Care*.
 - Five MCOs met the standard for *Good Access to Specialist Referral*.
 - None of the CHIP MCOs met the standards for *No Delays for Health Plan Approval* or *No Exam Room Wait Greater than 15 Minutes*.

HHSC Performance Dashboard Indicators	CHIP	HHSC Standard
<i>Good access to routine care</i>	78%	86%
<i>Good access to urgent care</i>	89%	89%
<i>Good access to specialist referral</i>	73%	77%
<i>No delays in health care while waiting for health plan approval</i>	67%	91%
<i>No exam room wait greater than 15 minutes</i>	24%	68%
<i>Good access to behavioral health treatment or counseling</i>	62%	-

- Getting Specialized Services.* Among caregivers who reported that their child needed specialized services, the percentage who usually or always had positive experiences getting specialized services for their child was lower than reported for CHIP members nationally (67 percent vs. 74 percent).
- Potentially preventable ED visits.* Among caregivers who took their child to the ED, 46 percent said they visited the ED at least once because they could not get an appointment at a doctor's office or clinic as soon as they thought their child needed care. This type of potentially preventable ED visit was associated with lower personal doctor ratings, independent of other demographic, health status, and health plan factors.

Recommendations

The EQRO recommends the following strategies to Texas HHSC for improving the delivery and quality of health care for children in CHIP. These strategies are relevant to the reduction of potentially preventable ED visits (PPVs), which is one of HHSC’s over-arching goals for CHIP MCOs.

Domain	Recommendations	Rationale
Potentially preventable ED use among children in CHIP	<ul style="list-style-type: none"> • For members with high ED utilization, CHIP MCOs should ensure not only that those members have a personal doctor, but also that they have a positive relationship with their personal doctor. MCOs should focus quality improvement studies and provider education on PCPs who are assigned to members associated with or at risk for PPVs. • Research suggests that interventions for improving the relationship between caregivers and personal doctors should focus on communication, and take into consideration preferences associated with caregiver’s race, ethnicity, and language.² 	<p>Nearly half of caregivers who took their child to the ED in the past six months said they went because they could not get a routine appointment for their child.</p> <p>Caregivers who rated their child’s personal doctor highly were less likely to have this type of potentially preventable visit.</p>

Introduction and Purpose

Publicly insured children, such as those in state Medicaid programs or the Children’s Health Insurance Program (CHIP), experience disparities in health care in comparison to their privately insured counterparts. Specifically, publicly insured children are more likely than privately insured children to have problems with access to health care specialists.³ In addition, fewer than half of publicly insured children have a medical home, meaning that they do not have a personal doctor or nurse as a usual source of care. Given the issues with health care that these children experience, it is important to assess caregivers’ preferences, experiences, and satisfaction with their child’s health care.^{4,5} Caregivers are in a unique position to report on experiences with their child’s personal doctors, clinics, and managed care organizations (MCOs), and to identify the aspects of their child’s health care that need improvement.⁶ Health care that is patient-centered – that reflects caregivers’ preferences, wants, and needs – is associated with improved health status and fewer diagnostic tests and referrals.⁷

CHIP is a program designed for children ages 0 through 19 who live in families with incomes too high to qualify for Medicaid, yet who cannot afford to buy private insurance. In Texas, CHIP

members receive a basic set of health care benefits that is cost-effective and focuses on primary health care needs.⁸ In SFY 2011, the CHIP Program was administered through 15 managed care organizations (MCOs), providing services in nine urban geographic regions of Texas, and one exclusive provider organization (EPO), providing services to CHIP members in rural areas of the state. This report presents findings from the CHIP Survey conducted by the Institute for Child Health Policy – the External Quality Review Organization (EQRO) for Texas Medicaid Managed Care and CHIP – evaluating caregivers’ experiences and satisfaction with the care their children receive through CHIP MCOs.

The purpose of the SFY 2011 CHIP Survey is to:

- Describe the demographic and household characteristics of child members and their families.
- Assess the health status of the population, including children with special health care needs (CSHCN).
- Document caregiver experiences and general satisfaction with the care their children receive through CHIP MCOs across four domains of care:
 - Utilization of health care, particularly emergency department (ED) use
 - Access to and timeliness of care
 - Patient-centered medical home
 - Health plan information and customer service
- Test the influence of domains of care on member ED use, controlling for demographic and health status variables.

In addition, this report examines trends in caregiver experiences and satisfaction over time, comparing the results of the SFY 2010 and 2011 CHIP Surveys.

Methodology

This section provides a brief overview of the methodology used to generate this report. Detailed descriptions of sample selection procedures, survey instruments, data collection, and data analyses are provided in **Appendix A**.

Sample Selection Procedures

The EQRO selected a stratified random sample of children in CHIP, with a target of 4,800 completed telephone interviews (representing 300 respondents per MCO). CHIP members younger than 18 years old were considered for inclusion in the survey sample if they were continuously enrolled in a CHIP MCO for at least six months between September 2010 and February 2011 (allowing for one 30-day gap in enrollment). Members who participated in the prior year’s survey (SFY 2010) were excluded.

Survey Instruments

The SFY 2011 CHIP Survey included:

- The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 4.0 (Medicaid module) ⁹
- Items from the CAHPS® Clinician and Group Surveys ¹⁰
- The Children With Special Health Care Needs (CSHCN) Screener® ¹¹
- Items developed by the EQRO pertaining to caregiver and member demographic and household characteristics.

The CAHPS® Health Plan Survey (Version 4.0) is a widely used instrument for measuring and reporting consumer experiences with their or their child's health plan and providers. The survey includes six questions that function as indicators of health plan performance, as listed on HHSC's Performance Indicator Dashboard for SFY 2010. ¹² It also allows for the calculation and reporting of health care composites, which are scores that combine results for closely related survey items. The EQRO calculated CAHPS® composite scores in the following domains:

- *Getting Needed Care*
- *Getting Care Quickly*
- *How Well Doctors Communicate*
- *Health Plan Information and Customer Service*
- *Prescription Medicines*
- *Getting Specialized Services*
- *Personal Doctor*
- *Shared Decision-Making*
- *Getting Needed Information*
- *Care Coordination*

This is the first year that items from the CAHPS® Clinician and Groups Surveys were included in the CHIP Survey. The selected items assess the quality of pediatric care with regard to health literacy and physician-initiated discussions with caregivers about child development, safety, and prevention. It should be noted that these items were slightly modified to fit the format and six-month time frame of the CAHPS® Health Plan Survey.

Survey Data Collection Techniques

The EQRO sent letters written in English and Spanish to caregivers of 18,790 sampled CHIP members, requesting their participation in the survey. Of the advance letters sent, 27 were returned undeliverable.

The Survey Research Center (SRC) at the University of Florida conducted the survey using computer-assisted telephone interviewing (CATI) between June 2011 and December 2011. The SRC telephoned caregivers of CHIP members seven days a week between 10 a.m. and 9 p.m. Central Time. Up to 30 attempts were made to reach a family, and if the family was not reached

after that time, the software selected the next individual on the list. If a respondent was unable to complete the interview in English, SRC rescheduled the interview at a later date and time with a Spanish-speaking interviewer. Of 4,471 completed interviews, 565 (13 percent) were conducted in Spanish. On average, 10.6 calls per phone number were made in the CHIP member sample.

Thirty-one percent of families of members could not be located. Among those located, 17 percent indicated that their child was not enrolled in CHIP, and 14 percent refused to participate. The response rate was 49 percent and the cooperation rate was 72 percent.

Data Analysis

The EQRO conducted descriptive statistics and statistical tests using SPSS 17.0 (Chicago, IL: SPSS, Inc.). Frequency tables showing descriptive results for each survey question are provided in a separate Technical Appendix.¹³ Supplementary tables of results are provided in **Appendix B**. The statistics presented in this report exclude "do not know" and "refused" responses. Percentages shown in most figures and tables are rounded to the nearest whole number; therefore, percentages may not add up to 100 percent.

Analysis of differences in frequencies used the Pearson Chi-square test of independence, and analysis of differences in means used t-tests and analysis of variance (ANOVA). These tests allowed for comparison of frequencies and means between 2009 and 2011 results, among the different MCO groups, and among the demographic sub-groups within the sample.

In addition, researchers conducted a multivariate analysis to examine the effects of demographic, health status, and health delivery factors on parent-reported potentially avoidable ED visits. A more detailed description of this analysis is presented in **Appendix C**.

Survey Results

This section presents survey findings regarding: 1) The demographic characteristics of caregivers and children; 2) Children's health status; 3) Utilization of health care and services; 4) Access to and timeliness of care; 5) Presence of a usual source of care and patient-centered medical home; 6) Caregivers' experiences with their child's health plan and customer service; and 7) Comparison of CHIP survey results in SFY 2010 and 2011.

Description of Children and Their Caregivers

Table 1 presents the sociodemographic characteristics of child members and their caregivers participating in the SFY 2011 CHIP Survey.

Child Characteristics

- Fifty-two percent of children in the sample were male and 48 percent were female.
- The average age was 11.3 years old.

- Hispanics were the largest racial/ethnic group, comprising 68 percent of the sample.

Table 1. Sociodemographic Characteristics of Child Members and Their Caregivers

	CHIP Members	CHIP Caregivers
Mean Age	11.3 (SD = 4.4)	39.0 (SD = 8.9)
Sex		
Male	52%	11%
Female	48%	89%
Race/Ethnicity		
White, Non-Hispanic	16%	18%
Black, Non-Hispanic	9%	8%
Hispanic	68%	68%
Other	6%	6%

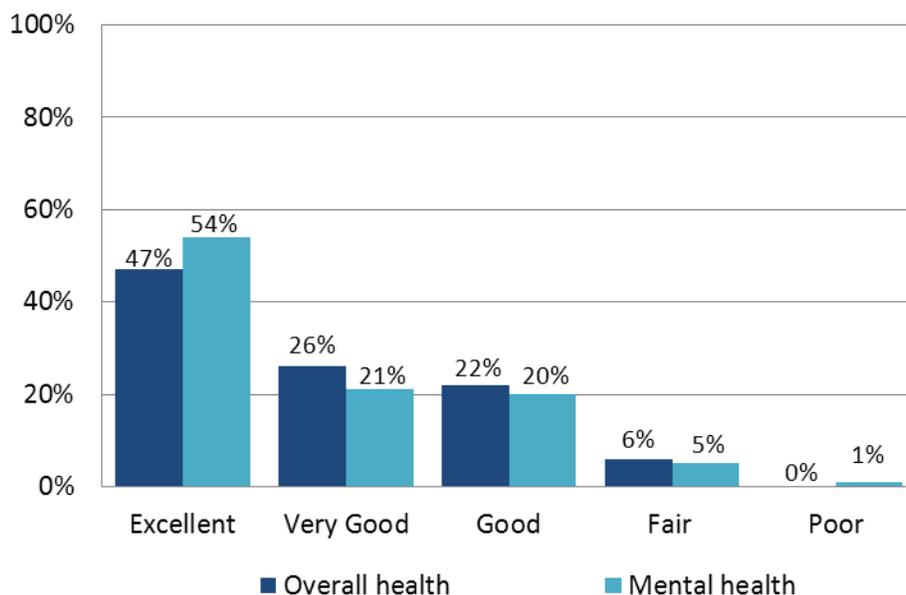
Respondent/Caregiver Characteristics

- Females comprised 89 percent of all caregivers participating in the survey.
- Ninety-seven percent of caregivers were the biological parent of a child member. Grandparents accounted for 1.3 percent of all caregivers, and other relatives, including aunts, uncles, and siblings, accounted for less than 1 percent of all caregivers.
- The age of caregivers ranged from 18 to 84 years old, with a mean age of 39 years.
- Thirty percent of caregivers had not completed high school. Thirty-five percent had completed high school, and 35 percent had completed some college, a college degree, or a graduate degree.
- Sixty-four percent of caregivers were married, five percent lived with an unmarried partner, and 31 percent were single, separated, divorced, or widowed.

Child's Health Status

Figure 1 presents caregivers' ratings of their child's overall health and mental health. The majority of caregivers provided positive ratings of their child's overall and mental health. Seventy-three percent of caregivers rated their child's overall health as very good or excellent, and 75 percent rated their child's mental health as very good or excellent. Six percent rated their child's overall health and mental health as fair or poor.

Figure 1. Caregivers' Ratings of Their Child's Overall Health and Mental Health



Body Mass Index

Figures 2 and 3 provide the Body Mass Index (BMI) results for boys and girls in the sample. Based on height and weight data, 49 percent of boys and 41 percent of girls in the sample were classified as overweight or obese. For state-level comparison, the prevalence of overweight and obesity in Texas (in 2003-2004) has been estimated at 42 percent for 4th-graders, 39 percent for 8th-graders, and 36 percent for 11th-graders.^{14,15} **Table B1** in Appendix B shows rates of obesity (\geq 95th percentile) by MCO. Obesity rates ranged from 19 percent in United Healthcare-Texas to 32 percent in Aetna.

Figure 2. Body Mass Index Classification for Boys

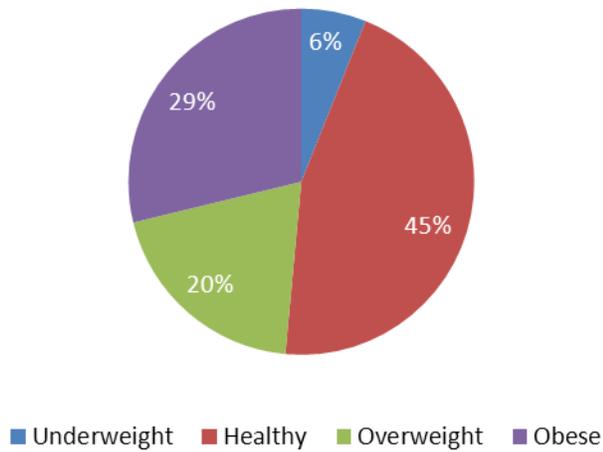
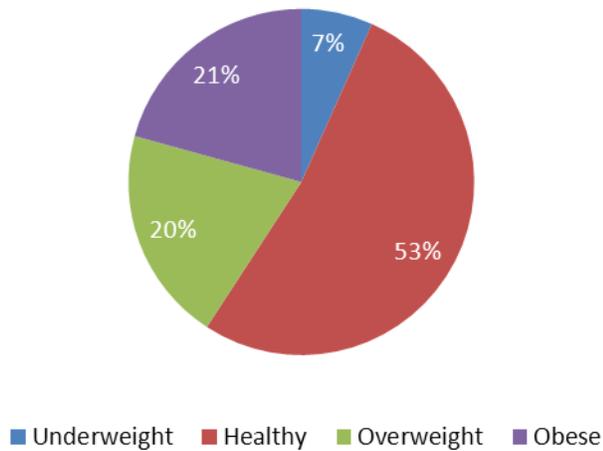


Figure 3. Body Mass Index Classification for Girls



Special Health Care Needs

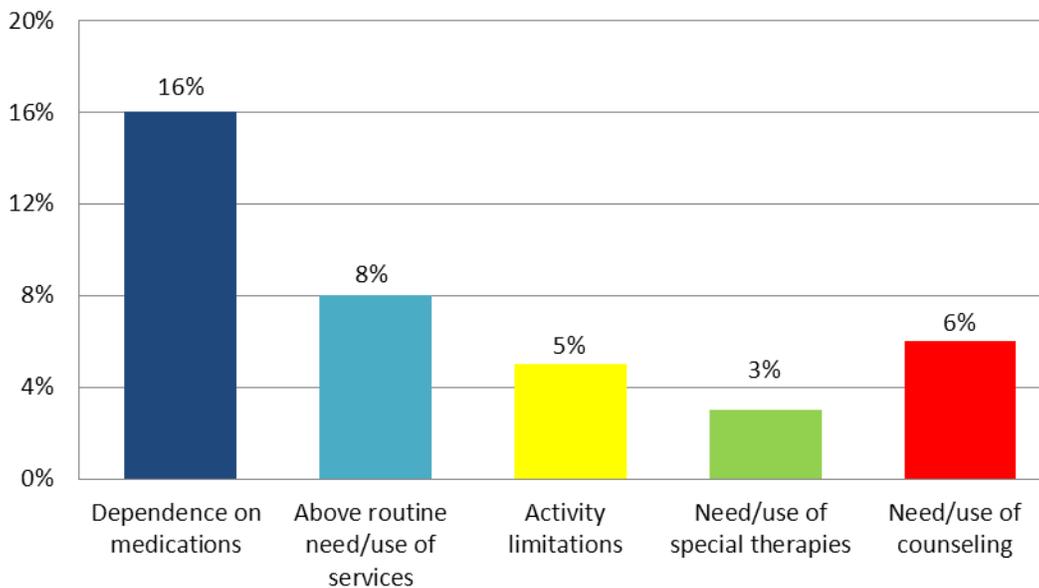
Using the CSHCN Screener[®], children were identified as having “special needs” if they met one or more of the following criteria:

- 1) Dependence on medications;
- 2) Greater than routine use of health or educational services;
- 3) Functional limitations (an inability to do things most children of the same age can do);

- 4) Need or use of specialized therapies; and
- 5) Need or use of treatment or counseling for emotional, developmental, or behavioral problems.

Based on the CSHCN Screener, 20 percent of children were identified as having special health care needs that have persisted for more than one year. **Figure 4** provides the percentage of children who met the criteria for each of the five CSHCN categories.

Figure 4. Children with Special Health Care Needs in CHIP



The most common special health care need among children in the sample was dependence on medications (16 percent), followed by above-routine need or use of services (8 percent). In addition, six percent of children had a problem for which they needed or used counseling. Five percent reported their child experienced activity limitations, and three percent reported their child needed or received special therapy, such as physical, occupational, or speech therapy.

Utilization of Health Care and Services

Seventy-three percent of caregivers participating in the CHIP survey reported their child went to a doctor's office or clinic to get health care in the past six months:

- 49 percent of children went to a doctor's office or clinic 1 or 2 times.
- 17 percent of children went to a doctor's office or clinic 3 or 4 times.
- 7 percent of children went to a doctor's office or clinic 5 or more times.
- 27 percent of children did not go to a doctor's office or clinic to get health care.

Sixteen percent of caregivers reported they took their child to the emergency department (ED) for care at least once in the past six months. Among these caregivers, 46 percent said they took their child to the ED because they could not get an appointment at a doctor's office or clinic as soon as they thought their child needed care. This follow-up question was used as the outcome of interest in the multivariate analysis discussed below.

On a scale of 0 to 10, caregivers rated the ED care their children received an average of 8.1 (SD = 2.4). Fifty-three percent rated the care their child received in the emergency department as 9 or 10.

Multivariate Analysis – Potentially Preventable ED Visits

Appendix C presents the methodology and findings of a multivariate analysis, testing the relative influence of various elements of the patient-centered medical home model on the likelihood of potentially preventable ED visits, controlling for demographic factors, health status, and MCO membership. This analysis found significant associations between the likelihood of potentially preventable ED visits and the following factors:

- *Child's age.* Compared with adolescents 12 to 18 years old, members 0 to 5 years old were about 1.5 times more likely to have had a potentially preventable ED visit. This association was stronger when controlling for caregivers' scores on the CAHPS® *Personal Doctor* or *How Well Doctors Communicate* composites (1.7 times more likely).
- *Child's MCO.* Compared with members of Texas Children's (who had the lowest rate overall of potentially preventable ED visits), members of Aetna, Community First, Community Health Choice, Driscoll, El Paso First, Molina, Superior, and UniCare were significantly more likely to have had a potentially preventable ED visit. The increase in likelihood was greatest for members of Community Health Choice (5 times more likely) and Community First (4 times more likely).
- *Personal doctor rating.* Caregivers who rated their child's personal doctor a 9 or 10 were 40 percent less likely than those who gave their child's personal doctor a lower rating to have taken their child to the ED because they could not get an appointment for ambulatory care as soon as they thought it was needed.

These findings suggest that high parental satisfaction with their child's personal doctor can help to reduce the occurrence of potentially preventable ED visits among children in CHIP.

Access to and Timeliness of Care

This section provides caregiver's reports of access to and timeliness of care for their child enrolled in CHIP, including urgent, routine, and specialist care, specialized services, and prescription medicines.

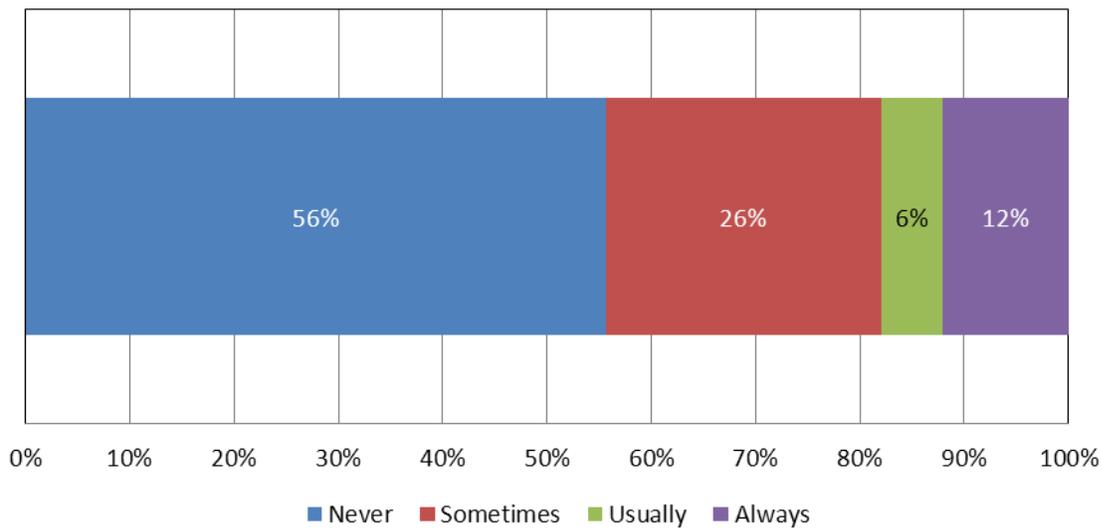
Timeliness of Getting Care

Caregivers were asked, "Not counting the times your child needed care right away, how many days did you usually have to wait between making an appointment and your child actually seeing a health provider?" The majority of caregivers said they were able to get an appointment

for their child with a health provider within three days (78 percent). Eleven percent of caregivers said they had to wait longer than one week to get an appointment for their child.

For some caregivers, access to providers was hampered by provider hours and availability (see **Figure 5**). When asked how often they had to wait for an appointment for their child because the provider worked limited hours or had few appointment slots available, 56 percent of caregivers said they never had to wait for an appointment, 26 percent said they sometimes had to wait for an appointment, and 18 percent said they usually or always had to wait.

Figure 5. How Often Child Waited for an Appointment Because Health Provider Worked Limited Hours or Had Few Available Appointments



Two CAHPS® survey questions comprise the composite *Getting Care Quickly*, assessing how often caregivers were able to get routine and urgent care for their child. Overall, 84 percent of caregivers “usually” or “always” had positive experiences with *Getting Care Quickly*. This is comparable to the 86 percent reported for this composite measure in CHIP nationally.

The mean score for the CAHPS® composite *Getting Care Quickly* was 2.58 out of 3.00, following NCQA specifications. Differences between health plans on this composite were not statistically or meaningfully significant (**Table B2** in Appendix B).

The two survey items that make up the CAHPS® composite *Getting Care Quickly* are also HHSC Performance Dashboard Indicators (**Table B3** in Appendix B).

- *Good access to urgent care.* Eighty-nine percent of caregivers whose child needed care right away for an illness, injury, or condition reported they usually or always received care as soon as needed. The percentage of CHIP members with good access to urgent care ranged from 81 percent in Community First to 97 percent in First Care. Nine MCOs performed at or above the Dashboard standard of 89 percent for this indicator.

- *Good access to routine care.* Seventy-eight percent of caregivers reported that they usually or always were able to make a routine appointment as soon as they thought their child needed. The percentage of members with good access to routine care ranged from 73 percent in UniCare to 87 percent in FirstCare. Only one MCO (FirstCare) met the Dashboard standard of 86 percent for this indicator.

Receiving care in a timely manner often depends on approval from the health plan. Sixty-seven percent of caregivers reported they never experienced delays in getting health care for their child due to waiting on health plan approval for that care. The percentage of CHIP members who had no delays in getting health plan approval for their child's care ranged from 56 percent in UniCare to 80 percent in El Paso First (**Table B3** in Appendix B). None of the CHIP MCOs met the Dashboard standard for this indicator.

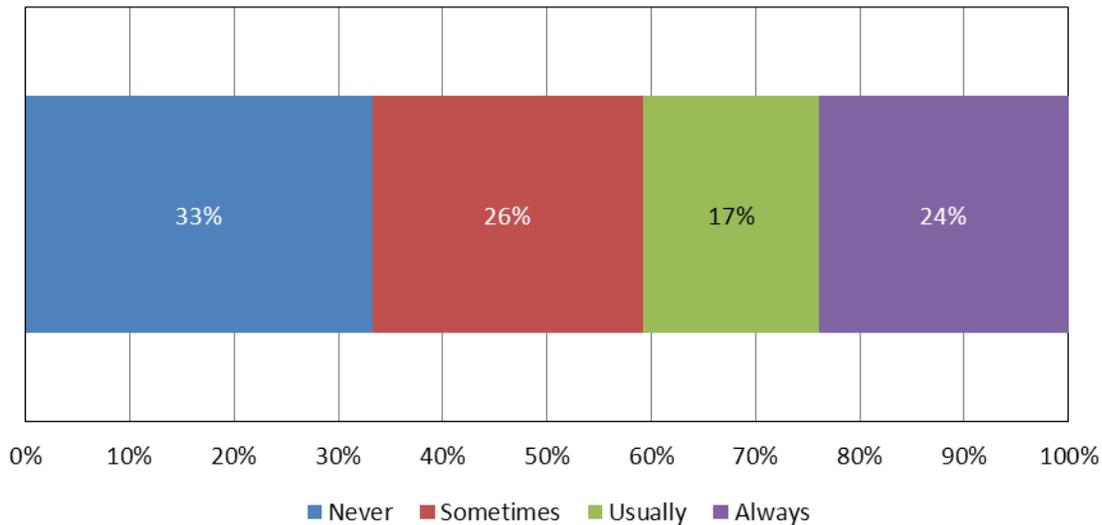
In addition, caregivers were asked about their experiences seeking after-hours care for their child. Seventeen percent of caregivers said their child needed to visit a doctor's office or clinic for after-hours care. Among these caregivers, 64 percent said it was usually or always easy to get after-hours care for their child. Eleven percent reported it was never easy and 26 percent reported it was only sometimes easy to get after hours care for their child.

Office Wait

Caregivers were asked how often their child was seen within 15 minutes of his or her appointment in the past 6 months. **Figure 6** provides the results for how often caregivers reported they waited less than 15 minutes before their child was seen for an appointment.

Office wait time in CHIP is below HHSC's Dashboard Standard (35 percent), with only 24 percent of caregivers reporting that their child was always seen within 15 minutes of his or her appointment. The percentage of caregivers who reported waiting no more than 15 minutes for their child to be taken to the exam room ranged from 18 percent in El Paso First to 38 percent in Seton (**Table B3** in Appendix B). None of the CHIP MCOs met the Dashboard standard of 68 percent for this indicator.

Figure 6. How Often Caregivers Waited Less Than 15 Minutes for Their Child's Appointment



Access to Specialist Care

Seventeen percent of caregivers reported that they tried to make an appointment for their child to see a specialist. Among these caregivers, 69 percent indicated that it was usually or always easy to get appointments for their child with specialists, and 31 percent indicated it was sometimes or never easy to get appointments for their child with specialists.

Having good access to specialist referrals is an HHSC Performance Dashboard Indicator. Seventy-three percent of caregivers reported it was usually or always easy to get a referral to a specialist their child needed to see. The percentage of CHIP members who had good access to specialist referrals ranged from 55 percent in Aetna to 81 percent in FirstCare and Parkland Community (**Table B3** in Appendix B). Five CHIP MCOs met the Dashboard standard of 77 percent for this indicator.

When asked to rate their child’s specialist on a scale of 0 to 10, 67 percent of caregivers gave a rating of 9 or 10. The mean specialist rating for CHIP was 8.7 (SD = 1.9).

The CAHPS® composite *Getting Needed Care* is based on two survey items that assess: (1) How often it was easy for caregivers to get appointments for their child with specialists, and (2) How often it was easy for caregivers to get care, tests, and treatment for their child through their child’s health plan. Seventy-one percent of caregivers “usually” or “always” had positive experiences with *Getting Needed Care*, compared to the 80 percent reporting for CHIP nationally. The mean score for the CAHPS® composite *Getting Needed Care* was 2.26 out of 3.00, following NCQA specifications. Differences among health plans on this composite were

statistically significant (**Table B2** in Appendix B). In addition, CSHCN were significantly less likely to get needed care than their non-CSHCN counterparts (**Table B4** in Appendix B).

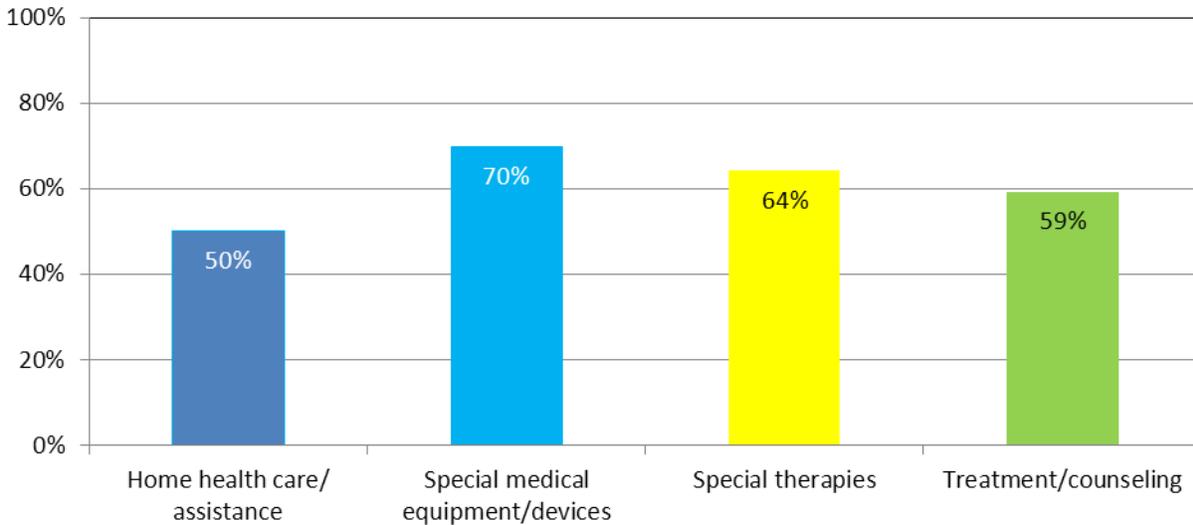
Access to specialized services

The percentage of CHIP Members needing specialized services in each of following four service categories was relatively low (as reported by caregivers):

- 1 percent needed home health care or assistance.
- 3 percent needed special medical equipment or devices.
- 4 percent needed special therapies, such as physical, occupation, or speech therapy.
- 7 percent needed treatment or counseling for an emotional, behavioral, or developmental problem.

Figure 7 provides the percentage of caregivers who said it was usually or always easy to get specialized services for their child. The service with the lowest access was home health care or assistance (50 percent). The service with the highest access was special medical equipment and devices (70 percent). Good access to the most commonly utilized special service – behavioral health treatment and counseling – was reported by 59 percent of caregivers. This measure is an HHSC Performance Dashboard Indicator, although there is no specified standard for performance.

Figure 7. The Percentage of CHIP Members with Good Access to Specialized Services



The CAHPS® composite, *Getting Specialized Services*, assesses how often it was easy for caregivers to get special medical equipment or devices, special therapies, and behavioral health treatment or counseling for their child. Sixty-seven percent of caregivers usually or always had positive experiences with *Getting Specialized Services* for their child, which is lower than the 74

percent reported for CHIP nationally. The mean score for *Getting Specialized Services* following NCQA specifications was 2.18 out of 3.00 for children in CHIP.

Prescription medicines

The CAHPS® composite *Prescription Medicines* consists of a single item assessing how often it was easy for parents to get prescription medicines for their child. Among the 43 percent of caregivers who reported getting or refilling a prescription medicine for their child in the past six months, the vast majority said it was usually or always easy to get prescription medicines for their child through his or her health plan (89 percent). This is comparable to the national CHIP mean of 91 percent. Slightly more than half of caregivers reported that someone at their child's health plan, doctor's office, or clinic helped them to get their child's prescription medicine (51 percent).

Caregiver Satisfaction with All Their Child's Health Care

When asked to rate all their child's health care in the past six months on a scale of 0 to 10, 65 percent of caregivers gave a rating of 9 or 10. This is slightly higher than the 62 percent reported for CHIP members nationally. The mean caregiver rating for all health care their child received in CHIP was 8.8 (SD = 1.6).

Patient-Centered Medical Home

This section examines caregiver experiences receiving care for their child from a patient-centered medical home model. The American Academy of Pediatrics (AAP) in its 2002 policy statement defined the medical home concept as a model for delivering primary care that is "accessible, continuous, family-centered, coordinated, compassionate, and culturally effective" for families and children.¹⁶ More recently, the AAP, the American Academy of Family Physicians, the American College of Physicians (ACP), and the American Osteopathic Association (AOA) issued a joint statement identifying seven principles of the medical home model:¹⁷

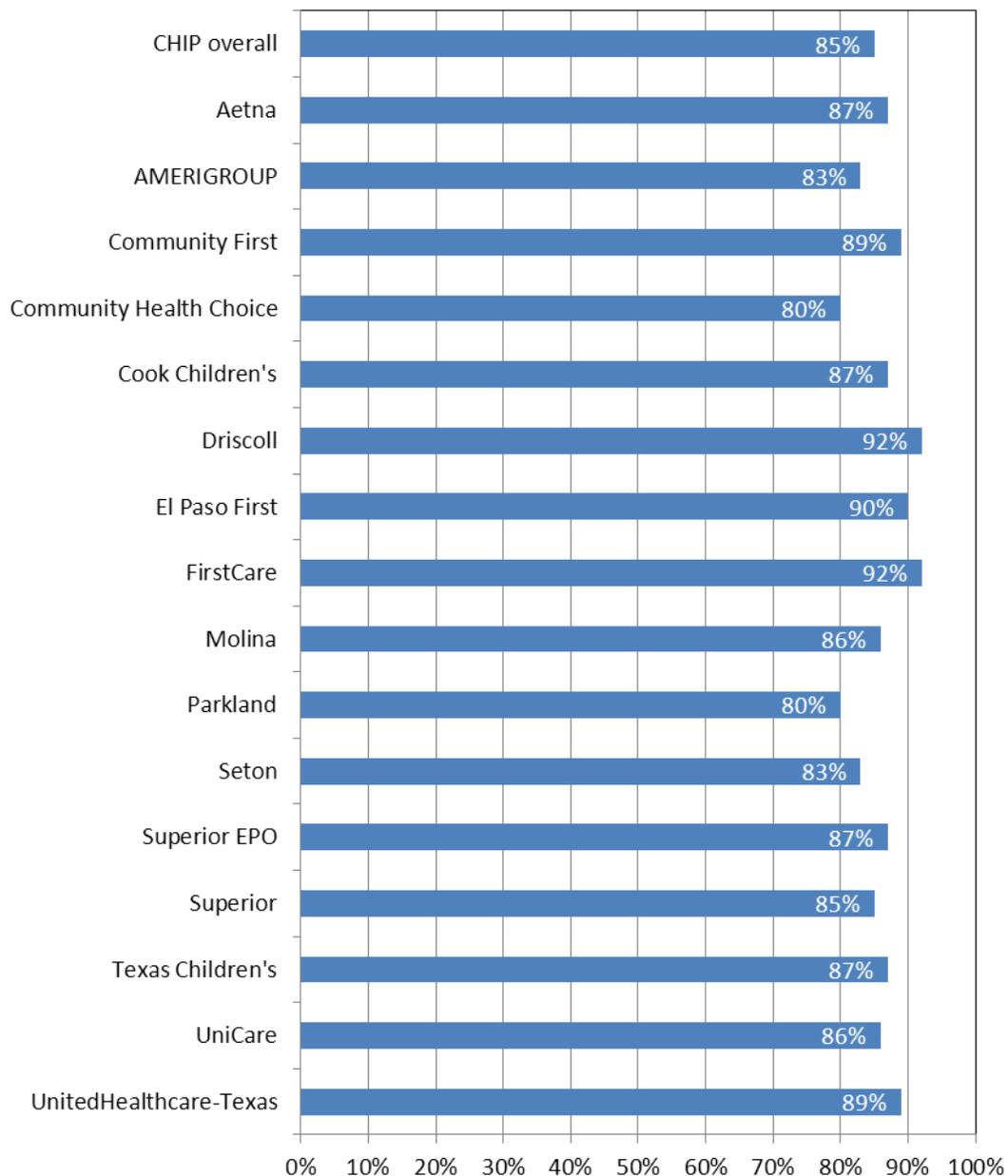
- Personal physician
- Physician-directed medical practice
- Whole person orientation
- Care that is coordinated and/or integrated across settings and providers
- Quality and safety
- Enhanced Access (e.g. open scheduling, extended hours)
- Payment

This survey addressed different components of the medical home model, specifically whether members have an ongoing relationship with a personal doctor, have access to advice and care during and after regular business hours, and receive high quality, patient-centered, and compassionate care from their personal doctor and office staff.

Presence of a Usual Source of Care

Figure 8 presents the percentage of CHIP members who had a personal doctor, by MCO. Overall, 85 percent of caregivers reported their child had a personal doctor. The percentage of members with a personal doctor ranged from 80 percent in Community Health Choice and Parkland to 92 percent in Driscoll and FirstCare.

Figure 8. The Percentage of CHIP Members with a Personal Doctor by MCO



Half of caregivers reported that their child had been going to his or her personal doctor for more than three years (49 percent). Approximately 11 percent of children had been going to their personal doctor for less than one year, suggesting the absence of a continuous, long-term relationship with their personal doctor. Sixty percent of caregivers said their child had the same personal doctor before joining their health plan. This suggests a need for improved continuity of care for the 40 percent of children who did not have the same personal doctor before joining their health plan.

When asked to rate their child's personal doctor on a scale of 0 to 10, 72 percent of caregivers gave a rating of 9 or 10, compared to 69 percent who gave their child's personal doctor a rating of 9 or 10 in CHIP nationally. The mean personal doctor rating for CHIP was 9.0 (SD = 1.5).

Several survey items assessed caregivers' experiences with their child's personal doctor in the clinical setting, for which the CAHPS[®] *Personal Doctor* composite provides an overall score. This composite uses three CAHPS[®] survey questions to assess whether personal doctors discussed developmental issues with caregivers and were able to understand how medical or behavioral health conditions affect the child's and family's day-to-day life. Eighty-seven percent of caregivers "usually" or "always" had positive experiences with their child's personal doctor, which is comparable to the CHIP national rate of 86 percent.

The NCQA mean for *Personal Doctor* was 0.87 on a scale from 0 to 1. Differences between health plans on the *Personal Doctor* composite were statistically significant, with performance ranging from 0.76 in UniCare to 0.89 in Seton (**Table B5** in Appendix B).

Courteous and Helpful Office Staff

Caregivers were asked about their experiences with clerks and receptionists at their child's doctor's office. Most provided positive evaluations of their experiences with office staff at their child's doctor's office:

- 79 percent reported that the office staff were usually or always helpful.
- 89 percent reported that the office staff usually or always treated them with courtesy and respect.

Seeking Help and Advice

Thirty-six percent of caregivers called their child's personal doctor's office during regular office hours to get help or advice for their child. Among these caregivers, 84 percent said they usually or always were able to get the help or advice for their child they needed.

Ten percent reported seeking after-hours help or advice from their child's personal doctor. Among these caregivers, three out of four said they usually or always were able to get help or advice from their child's personal doctor after regular business hours (74 percent). The remaining one out of four caregivers reported some difficulty seeking help or advice from their

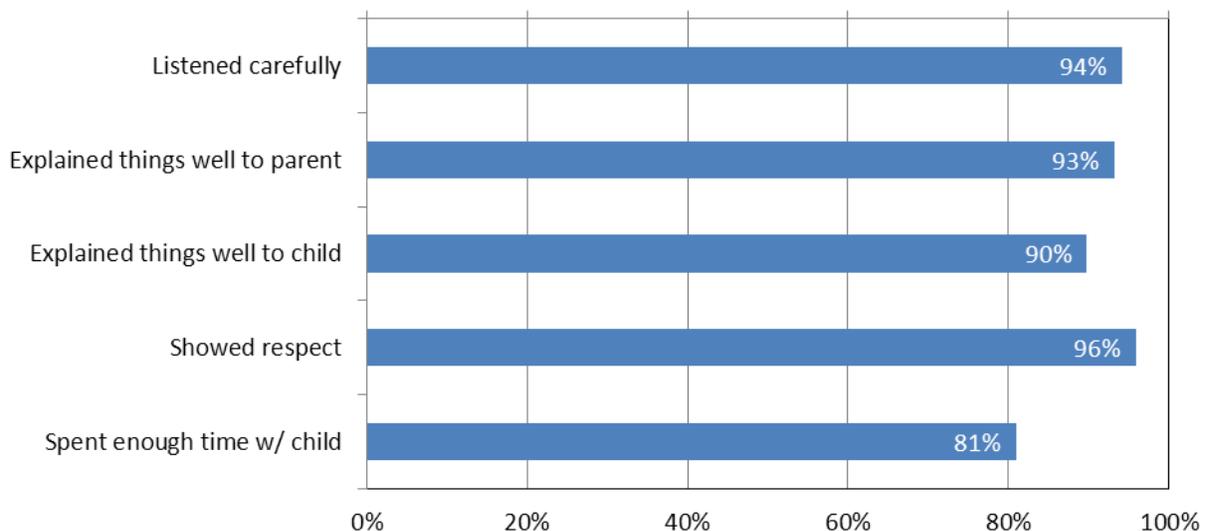
child's personal doctor after regular office hours, suggesting the need for many CHIP providers to improve access to their offices after hours and/or establish 24-hour medical advice lines.

The CAHPS® composite *Getting Needed Information* assesses how often caregivers had their questions answered by their child's doctors or other health care providers. Ninety-two percent of caregivers usually or always had positive experiences with *Getting Needed Information* from their child's doctors or other health care providers. This percentage is comparable to the 91 percent reported for CHIP nationally. The mean score for *Getting Needed Information* following NCQA specifications was 2.76 out of 3.00.

Caregiver Satisfaction with Doctors' Communication

Five CAHPS® survey questions comprise the composite *How Well Doctors Communicate*. This composite assesses how often a child's personal doctor explains things well, listens carefully, shows respect, and spends enough time with the family. Results are based on the percentage of caregivers who report they usually or always had positive communication experiences with their child's personal doctor (See **Figure 9**).

Figure 9. How Well Doctors Communicate - The Percentage of Caregivers Who Reported Their Child's Doctor Usually or Always...



The majority of caregivers were highly satisfied with the quality of communication they had with their child's personal doctor. Combining responses to all five questions, 93 percent of caregivers usually or always had positive experiences with *How Well Doctors Communicate*, which is comparable to the 92 percent reported for CHIP nationally. The mean score for *How Well Doctors Communicate* following NCQA specifications was 2.69 out of 3.00. Performance on this composite was significantly different across CHIP MCOs, ranging from 2.61 in AMERIGROUP to 2.83 in FirstCare (**Table B2** in Appendix B).

Among the items in this composite, the lowest caregiver satisfaction was for the amount of time the personal doctor spent with the child. Nineteen percent of caregivers indicated that their child's personal doctor never or only sometimes spent enough time with their child.

In addition to items that comprise the CAHPS® composite, caregivers were asked additional questions about their relationship with their child's personal doctor. The results of these items also indicate a high level of satisfaction with their child's personal doctor, and his or her communication skills and ability to provide patient-centered care:

- 93 percent reported that they felt their child's personal doctor usually or always cared about their child and family.
- 93 percent reported their child's personal doctor usually or always showed interest in their questions and concerns.
- 93 percent reported their child's personal doctor never interrupted them when they were talking.
- 96 percent reported their child's personal doctor never used a condescending, sarcastic, or rude tone or manner with them.

Shared Decision-making

Half of the caregivers (50 percent) said their child's provider informed them there was more than one choice for their child's treatment or health care. Among these caregivers:

- 94 percent said the provider informed them about the pros and cons of each choice for their child's treatment or health care.
- 87 percent said the provider asked them which choice they thought was best for their child.

Together, these CAHPS® survey items comprise the composite *Shared Decision-Making*, with which 91 percent of caregivers had positive experiences.¹⁸

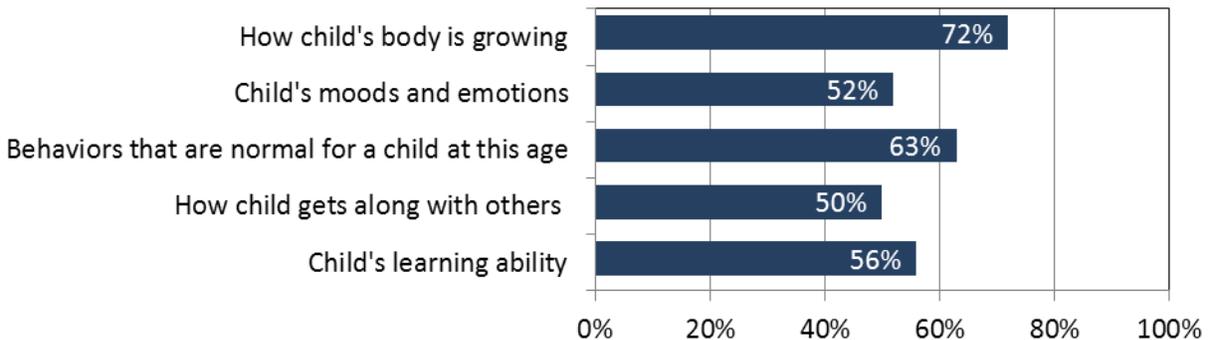
Well-child, Developmental, and Preventive Care

Caregivers of children younger than two years of age were asked if they received reminders to bring their child in for shots and other health care services. The vast majority said they had received reminders about their child's check-ups (90 percent), and 93 percent said they were able to schedule check-ups for their child as soon as they thought he or she needed.

A supplemental set of CAHPS® survey items from the Clinician and Group Surveys were included in the SFY 2011 CHIP Survey to assess caregiver experiences with their child's personal doctor in discussing developmental and preventive care issues. Although national CHIP comparative data is not available for these survey items, the results are useful in evaluating aspects of the medical home model, and the extent to which primary care providers (PCPs) take a "whole-person" approach to providing care. This approach includes discussing with caregivers the child's developmental milestones; emotional, psychological, and social functioning; and safety and prevention.

Figure 10 provides the percentage of caregivers whose child had a visit with their personal doctor in the past six months, and who reported their child's personal doctor had a discussion with them about their child's growth, moods and emotions, behavior, social functioning, and learning ability.

Figure 10. Developmental Care Issues - The Percentage of Caregivers Who Reported That Their Child's Personal Doctor Discussed...

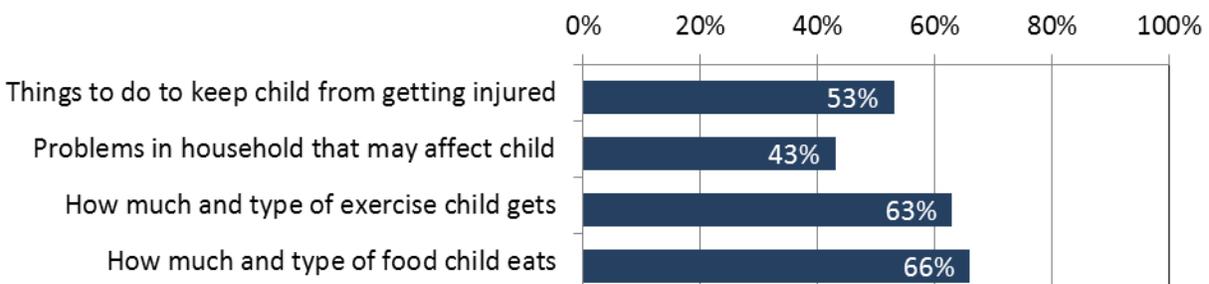


The majority of caregivers reported that they had a discussion about aspects of their child's development with their child's personal doctor. About three-quarters of caregivers reported that their child's personal doctor discussed their child's growth and physical development during an office visit (72 percent), and 63 percent reported their child's personal doctor had a discussion with them about age-appropriate, normative behavior among children.

A smaller percentage of caregivers said that their child's personal doctor talked with them about their child's learning ability (56 percent), moods and emotions (52 percent), and how well the child gets along with others (50 percent).

Figure 11 provides the percentage of caregivers whose child had a visit with their personal doctor in the past six months, and who reported their child's personal doctor had a discussion with them about their child's safety, their child's diet and exercise, and family problems that may affect their child's well-being.

Figure 11. Child Wellness and Safety Issues - The Percentage of Caregivers Who Reported That Their Child's Personal Doctor Discussed...



Health Literacy

For SFY 2011, the EQRO also added a series of supplemental CAHPS® items addressing health literacy and the efforts of providers in recognizing the health literacy of their patients. Among these items are five types of practices that personal doctors can do in the clinical setting to address health literacy. **Table 2** shows the percentage of caregivers who reported their child's personal doctor usually or always used these positive practices.

Table 2. Health Literacy Promotion by Personal Doctors

The child's personal doctor...	Percent of caregivers who answered "usually" or "always"
Used pictures, drawings, or models to explain things.	15%
Gave the caregiver easy-to-understand instructions about how the caregiver's child should take his/her medication.	95%
Explained the possible side effects of the child's medicines in a way that was easy to understand.	95%
Gave the caregiver written information about how the child should take medication that was easy to understand.	93%
Suggested ways to help the caregiver and child remember to take the child's medicine.	56%

Although most caregivers reported their child's personal doctor generally provided them with verbal and written instructions that were easy to understand, nearly one-third also reported that their child's personal doctor had used medical terms in the past six months that they did not understand (28 percent).

Care coordination

One-third of caregivers (31 percent) stated their child received care from another doctor or provider who was not their child's personal doctor. Among these caregivers:

- 74 percent said their child's personal doctor seemed informed and up-to-date about the care their child received through these other providers.
- 55 percent said that someone from their child's doctor's office or clinic helped them coordinate their child's care among these other health providers.

Two CAHPS® survey items comprise the composite *Care Coordination*, which assesses whether caregivers received help: (1) from their child's health plan, doctor's office, or clinic in coordinating care among different providers and services; and (2) from doctors or providers in contacting their child's school or daycare. Combining responses to both questions, 72 percent of

caregivers had positive experiences with *Care Coordination*. This percentage is slightly lower than the 74 percent reported for CHIP nationally. The NCQA mean for *Care Coordination* was 0.72 on a scale of 0 to 1.

Statistical comparison of racial/ethnic groups in CHIP revealed that White, non-Hispanic children were significantly less likely to receive care coordination than Hispanic or Black, non-Hispanic children (**Table B6** in Appendix B).

Thirteen percent of caregivers reported receiving help from a case manager or care coordinator who was not from their child's health plan, doctor's office, or clinic. The vast majority of respondents (95 percent) stated they were "satisfied" or "very satisfied" with the care coordination their children received.

Experiences with Child's Health Plan

Health Plan Information and Materials

Having control over which health plan a child can have and which providers a child can see is associated with caregiver satisfaction. Eighty percent of caregivers reported they chose their child's health plan, while 20 percent were told which plan their child was in.

Sixteen percent of caregivers said they looked for information in written materials or on the Internet about how their child's health plan works. Among those who looked for information, 67 percent said the materials usually or always provided the information they needed.

Before enrolling their child in the health plan, 65 percent of caregivers said they received information about the health plan in writing, by telephone, on the Internet, or in person. Among these caregivers, 66 percent said that all the information they were given about the health plan was correct, while 25 percent said that most of the information was correct.

The amount and complexity of paperwork required for enrollment, renewal, or other reasons may also be associated with caregiver satisfaction with their child's health plan. Thirty-seven percent of caregivers said their child's health plan had given them forms to fill out. Among these caregivers, 84 percent said that the forms were usually or always easy to fill out, compared with 82 percent nationally.

Customer Service

Eighteen percent of caregivers reported that they tried to get information or help from customer service at their child's health plan in the past six months. Among caregivers who contacted customer service in the past six months:

- 75 percent reported that they usually or always received the information or help they needed from customer service at their child's health plan.

- 89 percent reported that the customer service staff at their child’s health plan usually or always treated them with courtesy and respect.

The above items comprise the CAHPS® composite *Health Plan Information and Customer Service*. Combining responses to both questions, 84 percent of CHIP caregivers “usually” or “always” had positive experiences with *Health Plan Information and Customer Service*, which is higher than the 81 percent reported for CHIP nationally. The mean score for this composite following NCQA specifications was 2.51 out of 3.00. Caregivers of CSHCN were significantly less likely to have positive experiences with their child’s health plan than caregivers of non-CSHCN (**Table B4** in Appendix B).

Caregivers also reported the number of calls it took to customer service at their child’s health plan to get the information or help they needed:

- 53 percent reported making 1 call
- 21 percent reported making 2 calls
- 18 percent reported making 3 or 4 calls
- 6 percent reported making 5 or more calls
- 3 percent reported they were still waiting for help.

Transportation

Two percent of caregivers reported phoning their child’s health plan to get help with transportation for their child’s appointments. Among those who needed help with transportation, 42 percent usually or always were able to get the transportation help they needed. When asked whether the transportation met their needs, 57 percent indicated these needs were usually or always met by the health plan.

Caregiver Satisfaction with Child’s CHIP Health Plan

When asked to rate their child’s CHIP health plan on a scale of 0 to 10, 72 percent of caregivers gave a rating of 9 or 10. The mean caregiver rating for their child’s health plan was 9.0 (SD = 1.5).

Prior-year Comparisons

Table 3 shows scaled results for the 10 CAHPS® Composite measures for CHIP in SFY 2010 and SFY 2011, using modified NCQA specifications.¹⁹ Since 2010, performance was significantly better for *Getting Care Quickly, How Well Doctors Communicate, Personal Doctor, Customer Service, and Getting Needed Information*.

Table 4 shows results for the six HHSC Performance Dashboard Indicators for CHIP in SFY 2010 and SFY 2011, as well as the HHSC performance standards (which remained the same for both years). Since 2010, significantly fewer caregivers reported that their child was usually or

always taken to the exam room within 15 minutes of their appointment and significantly more caregivers report good access to routine care.

Table 3. CAHPS® Composite Measures in 2010 and 2011

	2010 mean	2011 mean	F	p-value
Getting Needed Care	2.27	2.28	0.12	= 0.727
Getting Care Quickly	2.33	2.49	57.71	< 0.001
How Well Doctors Communicate	2.70	2.73	6.26	= 0.012
Customer Service	2.51	2.51	0.04	= 0.842
Prescription Medicines	2.70	2.65	4.97	= 0.026
Getting Specialized Services	2.15	2.22	0.41	= 0.520
Personal Doctor	0.83	0.89	4.09	= 0.043
Shared Decision-Making	0.90	0.91	1.45	= 0.229
Getting Needed Information	2.73	2.76	4.71	= 0.030
Care Coordination	0.65	0.66	0.18	= 0.674

Table 4. HHSC Performance Indicators in 2010 and 2011

	2010	2011	X ²	p-value	HHSC standard
Good access to routine care	73%	79%	30.21	< 0.001	86%
Good access to urgent care	87%	89%	3.68	= 0.055	89%
Good access to specialist referral	68%	72%	3.16	= 0.075	77%
No delays for an approval	68%	67%	0.23	= 0.632	91%
No exam room wait greater than 15 minutes	35%	32%	4.73	= 0.030	68%
Good access to BH treatment or counseling	64%	62%	0.33	= 0.566	-

Summary Points and Recommendations

This report provides results from the SFY 2011 CHIP Survey regarding: (1) demographic and household characteristics of CHIP members and their caregivers; (2) the health status of CHIP members, including body mass index and special health care needs; and (3) caregiver experiences and satisfaction with the access and timeliness of their child's routine, urgent, and specialized care; elements of the patient-centered medical home, such as doctor's communication, shared decision-making, and care coordination; and experiences with their child's health plan, including customer service and transportation.

Demographic and household characteristics

- **Member Characteristics.** Approximately half of CHIP members were male, and half were female. The average age of enrollees was 11 years old. Hispanic enrollees

represented the largest racial/ethnic group in CHIP (68 percent), followed by White, non-Hispanics (16 percent), and Black, non-Hispanics (9 percent).

- **Caregiver Characteristics.** Survey respondents were predominantly female and Hispanic, with an average age of 39 years old. Thirty percent of respondents had not completed high school. Two-thirds of respondents were married, and one-third were single, separated, divorced, or widowed.

Child's health status

- **Overall Health and Mental Health.** Three-quarters of caregivers reported that their child's overall health was "excellent" or "very good" and that their child's mental health was "excellent" or "very good." Forty-one percent of girls and 49 percent of boys were overweight or obese.
- **Special Health Care Needs.** One in five children in CHIP were identified as having at least one special health care need that persisted for more than one year. The most common type of special health care need was dependence on medications (16 percent), followed by above-routine need or use of services (8 percent) and need or use of behavioral health treatment or counseling (6 percent).

Utilization of Health Care and Services

- **Doctor's Office or Clinic Use.** About three-quarters of children in CHIP went to a doctor's office one or more times within the past six months to get health care.
- **Emergency Department Use.** Sixteen percent of caregivers took their child to the emergency department (ED) at least once in the past six months. Fifty-three percent of caregivers rated the care their child received at the ED as 9 or 10.
- **Preventable ED Visits.** Among caregivers who took their child to the ED, 46 percent said they visited the ED at least once because they could not get an appointment at a doctor's office or clinic as soon as they thought their child needed care. This type of potentially preventable ED visit was associated with lower personal doctor ratings, independent of other demographic, health status, and health plan factors.

Access to and timeliness of care

- **Timeliness of Getting Care.** Seventy-eight percent of caregivers were able to get an appointment for their child with a health care provider within three days. Over half of caregivers reported that they never had to wait for an appointment because the provider worked limited hours or had few appointment slots available.
- **Getting Care Quickly.** Eighty-four percent of caregivers usually or always had positive experiences with CAHPS® *Getting Care Quickly*, which is comparable to the national CHIP average of 86 percent.
- **Good Access to Urgent Care.** Eighty-nine percent of caregivers reported that they received care for an illness, injury, or condition as soon as they needed, which meets the HHSC Dashboard standard of 89 percent for CHIP.

- **Good Access to Routine Care.** Seventy-eight percent of caregivers were usually or always able to make a routine appointment as soon as they thought their child needed. Only one MCO met the HHSC Dashboard standard of 86 percent.
- **No Delays for Health Plan Approval.** Sixty-seven percent of caregivers reported they never had delays in health care for their child while waiting for approval from their health plan. None of the CHIP MCOs met the HHSC Dashboard Standard of 91 percent.
- **Office Wait.** Nearly one quarter of patients reported that their child was seen within 15 minutes of his or her appointment (24 percent). None of the CHIP MCOs met the HHSC Dashboard standard of 68 percent.
- **Access to Specialist Care.** Seventeen percent of caregivers tried to make a specialist appointment for their child. Among these caregivers, 69 percent reported that it was usually or always easy to see a specialist. Two-thirds of caregivers rated their child's specialist a 9 or 10 (67 percent), which is comparable to the CHIP national average of 66 percent. Seventy-one percent of caregivers usually or always had positive experiences with CAHPS® *Getting Needed Care*, which is below the national average of 80 percent.
- **Good Access to Specialist Referral.** Seventy-three percent of caregivers reported it was usually or always easy to get a referral for their child to see a specialist. Five MCOs met the HHSC Dashboard standard of 77 percent.
- **Access to Specialized Services.** The most needed specialized service reported by caregivers was treatment or counseling for an emotional, behavioral, or developmental problem (7 percent). Fifty-nine percent of caregivers reported that behavioral treatment was usually or always easy to get for their child. Specialized medical equipment and devices was the easiest type of specialized service to receive (70 percent). Two-thirds of caregivers reported usually or always having positive experiences with *Getting Specialized Services* (67 percent), which is below the national average of 74 percent.
- **Prescription Medicines.** Forty-three percent of caregivers reported having filled or refilled a prescription for their child during the six months prior to the survey. Among these caregivers, 89 percent said that it was usually or always easy to get prescription medicines through their health plan. The CAHPS® *Prescription Medicines* composite result was comparable to the CHIP national average of 91 percent.
- **Caregiver Satisfaction with All Their Child's Care.** Sixty-five percent of caregivers rated their child's health care in the past six months as 9 or 10, on a scale from 0 to 10. This is slightly higher than the national CHIP average of 62 percent.

Patient-Centered Medical Home

- **Presence of a Usual Source of Care.** Eighty-five percent of CHIP members had a personal doctor. Half of caregivers reported that their child had been going to his or her personal doctor for more than three years. Seventy-two percent of caregivers rated their child's personal doctor a 9 or 10, on a scale from 0 to 10, which is slightly higher than the CHIP national average of 69 percent. The CAHPS® *Personal Doctor* composite result was comparable to the CHIP national average (87 percent vs. 86 percent).

- **Courteous and Helpful Office Staff.** Seventy-nine percent of caregivers reported that the office staff was usually or always helpful, and 89 percent reported that the office staff usually or always treated them with courtesy and respect.
- **Seeking Help and Advice.** Caregivers of CHIP members reported good access to help or advice when calling their child's personal doctor during normal office hours (84 percent) and slightly lower access when calling after normal office hours (74 percent). The CAHPS® *Getting Needed Information* composite result was comparable to the CHIP national average (92 percent vs. 91 percent).
- **Satisfaction with Doctors' Communication.** Ninety-three percent of caregivers usually or always had positive experiences with CAHPS® *How Well Doctors Communicate*, which is comparable to the CHIP national average of 92 percent.
- **Shared decision-making.** The CAHPS® *Shared Decision-Making* composite result was 91 percent. Although no national comparisons were available, this high percentage is an indication of good performance for shared decision-making in CHIP.
- **Well-Child, Developmental, and Preventive Care.** Ninety-three percent of caregivers were able to schedule check-ups for their child as soon as they thought they needed to be seen by a provider. Caregivers reported that child's growth was the most common developmental issue that their doctors discussed with them (72 percent), and child's diet was the most common child safety issue that doctors discussed with them (66 percent). Most personal doctors practiced good promotion of health literacy, although few caregivers reported their child's personal doctor used pictures, drawings, and models to explain things (15 percent).
- **Care Coordination.** One-third of CHIP members received care from a health provider besides their personal doctor. Among caregivers of these children, approximately three-quarters said their child's personal doctor seemed informed and up-to-date about the care their child received from these other providers. The CAHPS® *Care Coordination* composite result was comparable to the CHIP national average (72 percent vs. 74 percent).

Experiences with Child's Health Plan

- **Health Plan Information, Materials, and Paperwork.** Eighty percent of caregivers reported that they chose their child's health plan. Among caregivers who looked for information about how their child's health plan works, two-thirds said that written materials or the Internet usually or always provided the information they needed. Among caregivers who received forms to fill out from their child's health plan, 84 percent said they were usually or always easy to fill out.
- **Customer Service.** The CAHPS® *Health Plan Information and Customer Service* composite result was 84 percent, which is slightly higher than the CHIP national average of 81 percent. Three-quarters of caregivers who called to get help or information from customer service at their child's health plan "usually" or "always" got the help or information they needed, and 53 percent got the help or information they needed in one call.

- **Caregiver Satisfaction with Child's CHIP Health Plan.** Seventy-two percent of caregivers rated their child's CHIP MCO a 9 or 10, on a scale from 0 to 10. This is slightly higher than the CHIP national average of 68 percent.

Recommendations

The EQRO recommends the following strategies to Texas HHSC for improving the delivery and quality of health care for children in CHIP. These strategies are relevant to the reduction of potentially preventable ED visits (PPVs), which is one of HHSC’s over-arching goals for CHIP MCOs.

Domain	Recommendations	Rationale
Potentially preventable ED use among children in CHIP	<ul style="list-style-type: none"> • For members with high ED utilization, CHIP MCOs should ensure not only that they have a personal doctor, but also that they have a positive relationship with their personal doctor. MCOs should focus future quality improvement studies and provider education programs on PCPs who are assigned to members associated with or at risk for PPVs. • Research suggests that interventions for improving the relationship between caregivers and personal doctors should focus on communication, and take into consideration preferences associated with the caregiver’s race, ethnicity, and language.²⁰ <ul style="list-style-type: none"> • Among white caregivers, poor satisfaction with personal doctors may be more associated with failure to provide explanations to children, as well as with the length of physician interaction. 	<p>Nearly half of caregivers who took their child to the ED in the past six months said they went because they could not get a routine appointment for their child.</p> <p>Caregivers who rated their child’s personal doctor highly were less likely to have this type of potentially preventable visit.</p> <p>Rates of parent-reported PPVs were significantly higher for younger members (0 to 5 years old).</p> <p>The likelihood of having a preventable ED visit was also significantly higher in a number of MCOs – particularly Community First (58 percent), Community Health Choice (66 percent), and Molina (59 percent).</p>

The EQRO also recommends that HHSC and CHIP MCOs monitor the following areas, based on findings of low caregiver satisfaction in domains that do not directly address the over-arching

goals. Continued issues with quality of care in these domains may warrant additional studies and their eventual inclusion in MCO performance improvement projects.

- *Getting Needed Care.* Results on the CAHPS® *Getting Needed Care* composite show that caregivers of children in Texas CHIP have more difficulty getting specialist care and health plan approval for their children than in CHIP nationally. Nearly one in three caregivers reported it was “never” or only “sometimes” easy to get an appointment for their child with a specialist. One in four reported it was “never” or only “sometimes” easy to get approval for tests and treatment for their child through his or her health plan. The CAHPS® Improvement Guide describes a number of strategies for increasing access to care at the provider level, including rapid referral programs and streamlined or improved patient flow.²¹

Appendix A. Detailed Survey Methodology

Sample Selection Procedures

Survey participants were selected from a stratified random sample of children who were enrolled in CHIP in Texas for six months or longer between September 2010 and February 2011. These criteria ensured that families would have sufficient experience with the program to respond to the survey questions. Members whose caregivers had participated in the prior year's survey (SFY 2010) were excluded from the sample. The sample was stratified to include representation from the 15 health plans and Superior EPO participating in CHIP during SFY 2011.

A target sample of 4,800 completed telephone interviews was set, representing 300 respondents per health plan. This sample size was selected to: (1) provide a reasonable confidence interval for the survey responses; and (2) ensure there was a sufficient sample size to allow for comparisons among health plans. **Table A1** presents the stratification strategy by health plan, showing both the number of targeted interviews (N = 4,800) and the number of completed interviews (N = 4,471).

Table A1. CHIP Survey Sampling Strategy

Health Plan	Targeted Interviews (N = 4,800)	Completed Interviews (N = 4,471)
Aetna	300	284
AMERIGROUP	300	268
Community First	300	289
Community Health Choice	300	273
Cook Children's	300	266
Driscoll	300	263
El Paso First	300	281
FirstCare	300	266
Molina	300	300
Parkland Community	300	295
Seton	300	299
Superior	300	278
Superior EPO	300	288
Texas Children's	300	270
UniCare	300	287
UnitedHealthcare-Texas	300	264

Using a 95 percent confidence interval, the responses provided in the tables and figures are within ± 1.5 percentage points of the “true” responses in the CHIP member population and ± 6.0 percentage points of “true” responses at the MCO level.

Enrollment data were used to identify the members who met the sample selection criteria and to obtain their contact information. Member names, mailing addresses, and telephone contact information for 18,790 eligible CHIP members were collected and provided to interviewers. For households with multiple children enrolled in CHIP, one child from the household was randomly chosen as the member for whom the caregiver would respond to the survey. Member age, sex, and race/ethnicity were also collected for the enrollment data to allow for comparisons between respondents and non-respondents and identify any participation biases in the final sample.

Survey instruments

The SFY 2011 CHIP Survey is comprised of:

- The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 4.0 (Medicaid module).²²
- Items from the CAHPS® Clinician and Group Surveys.²³
- The Children With Special Health Care Needs (CSHCN) Screener®.²⁴
- Items developed by ICHP pertaining to caregiver and member demographic and household characteristics.

The CAHPS® Health Plan Survey is a widely used instrument for measuring and reporting consumer experiences with their or their child’s health plan and providers. The CHIP Survey uses the Medicaid module of the CAHPS® survey and includes both the core questionnaire and supplemental items. The survey instrument is divided into sections that assess health care experiences within the past six months specific to a child’s personal doctor, well-child care, specialist care and specialized services, care coordination, dental care, and communication with the health plan.

The CAHPS® Health Plan Survey allows for the calculation and reporting of health care composites, which are scores that combine results for closely related survey items. Composites provide a comprehensive yet concise summary of results for multiple survey questions. For the present survey, CAHPS® composite scores were calculated in the following ten domains:

- *Getting Needed Care*
- *Getting Care Quickly*
- *How Well Doctors Communicate*
- *Health Plan Information and Customer Service*
- *Prescription Medicines*
- *Getting Specialized Services*
- *Personal Doctor*

- *Shared Decision-Making*
- *Getting Needed Information*
- *Care Coordination*

Scores for the core composite measures were calculated using both AHRQ and NCQA specifications. Specifications by AHRQ produce scores that represent the percentage of caregivers who “usually” or “always” had positive experiences in the given domain. These percentage-based scores can be compared with Medicaid national data found in the CAHPS® Benchmarking Database.²⁵ Composite scores were calculated following AHRQ specifications for all domains except *Shared Decision-Making*. One item in the specifications for *Shared Decision-Making*, which assesses whether the child's doctor or provider told the caregiver there was more than one choice for their child's treatment, was dropped from composite calculations for this survey. In many health care decisions, there may only be one choice for treatment. In these situations, neglecting to tell caregivers of other choices does not reflect poor shared decision-making on the part of providers.

Specifications by NCQA produce scaled scores, rather than percentage-based scores. These scores range from 0 to 3 for most composites. For the *Personal Doctor* and *Care Coordination* composites, scores range from 0 to 1. For scoring *Shared Decision-Making*, NCQA specifications use a different response set than that used in the CAHPS® Health Plan Survey 4.0 for Medicaid. The response set for individual items in the Medicaid version is yes/no. The scaled scores for *Shared Decision-Making* presented in this report follow NCQA specifications for *Personal Doctor* and *Care Coordination* (0 to 1), which also have yes/no response sets.

It should be noted that analyses comparing CAHPS® composite scores across different demographic groups and MCOs used a modified version of NCQA specifications. In order to permit statistical comparisons, a separate score was calculated for each member, and then averaged. This differs from NCQA specifications, in which means are calculated by averaging the aggregate scores on a composite's individual items. As a result, individual item responses in the means calculated for statistical comparison are weighted according to their frequency, and overall scores may vary slightly from those presented on **Table B7** in Appendix B.

The EQRO also calculated CAHPS® composites on the 100-point scale used in prior years' survey reports. Results of CAHPS® composites on the 100-point scale are shown in **Table B7** in Appendix B, for the purpose of comparison with the other two scoring methods. The 100-point scale was also used for the *Personal Doctor* and *How Well Doctors Communicate* composites in the multivariate analysis presented in this report. Scores range from 0 to 100, with higher scores indicating more positive health care experiences. A score of 75 or higher generally indicates that caregiver experiences in a composite domain were usually or always positive.

In addition, items from the CAHPS® Clinician and Groups Surveys were included in the CHIP Survey. The selected items assess the quality of pediatric care with regard to health literacy and physician-initiated discussions with caregivers about child development, safety, and prevention.

It should be noted that these items were slightly modified to fit the format and six-month time frame of the CAHPS® Health Plan Survey 4.0.

The CSHCN Screener® consists of five sequences of questions for identifying children with special health care needs based upon the Federal Maternal and Child Health Bureau definition of CSHCN. The screener asks caregivers about five particular health consequences their child may experience:

- Needing or using medication prescribed by a doctor
- Having above-routine need for or use of medical, mental health, or educational services
- Having limitations that result in an inability to do things most children of the same age can do
- Needing or using specialized therapies such as physical, occupational, or speech therapy
- Needing or receiving treatment or counseling for emotional, behavioral, or developmental problems

To qualify as CSHCN, the child must have at least one of the five screening criteria as a result of a medical, behavioral, or health condition that has lasted or is expected to last for at least 12 months.

Six items from the National Survey of CSHCN (NS-CSHCN) are included in this survey to assess issues related to transition of care (e.g., finding a new doctor, insurance eligibility) that may arise when a child with special health care needs reaches adulthood. The NS-CSHCN is a national telephone survey of randomly selected households in the United States that examines children's health status, particularly as it relates to health care coverage, access to care, and other quality of care indicators for both CSHCN and children with no special health care needs.²⁶ The six questions pertaining to transitional issues are only answered by a caregiver if their child is 11 years of age or older and has met one or more of the CSHCN Screener® criteria.

The survey also includes questions regarding the demographic and household characteristics of caregivers and their children. These questions were developed by ICHP and have been used in surveys with more than 25,000 Medicaid and CHIP members in Texas and Florida. The items were adapted from questions used in the National Health Interview Survey, the Current Population Survey, and the National Survey of America's Families.^{27,28,29}

Respondents were also asked to report their child's height and weight. These questions allow calculation of the child's body mass index (BMI), a common population-level indicator of overweight and obesity.

Survey data collection

The EQRO sent letters written in English and Spanish to caregivers of 18,790 sampled CHIP members requesting their participation in the survey. Of the advance letters sent, 27 were returned undeliverable.

The Survey Research Center (SRC) at the University of Florida conducted the survey using computer-assisted telephone interviewing (CATI) between June 2011 and December 2011. The SRC telephoned parents and caregivers of CHIP members seven days a week, between 10 a.m. and 9 p.m. Central Time. The Sawtooth Software System was used to rotate calls in the morning, afternoon, and evening to maximize the likelihood of reaching potential survey respondents. If a respondent was unable to complete the interview in English, SRC rescheduled the interview at a later date and time with a Spanish-speaking interviewer. Of 4,471 completed interviews, 565 (13 percent) were conducted in Spanish.

Up to 30 attempts were made to reach a family, and if the family was not reached after that time, the software selected the next individual on the list. No financial incentives were offered to participate in the surveys. Thirty-one percent of families could not be located. Among those located, 17 percent indicated that their child was not enrolled in CHIP and 14 percent refused to participate. The response rate was 49 percent and the cooperation rate was 72 percent.

To test for participation bias, the distributions of child's age, sex, and race/ethnicity were collected from the enrollment data and compared between caregivers who responded to the survey and caregivers who did not participate. Caregivers of Hispanic children were significantly more likely to participate in the survey (26 percent), compared to caregivers of Black, non-Hispanic children (20 percent).³⁰ Differences in the distribution of child's race/ethnicity by participation and non-participation suggest that a participation bias may be present in the survey data. When interpreting results of this report, it should be taken into account that those who participated were more likely to have Hispanic children and less likely to have Black, non-Hispanic children.

The respondent was selected by asking to speak to the person in the household who was most knowledgeable about the child's health and health care. The respondent was also asked to confirm that the child was presently enrolled in CHIP in Texas.

For most survey items, caregivers had the option of stating they did not know the answer to a question. They also were given the choice to refuse to answer a particular question. If a respondent refused to answer an individual question or series of questions but completed the interview, their responses were used in the analyses. If the respondent ended the interview before all questions had been asked, her or his responses were not included in the analyses.

Data analysis

Descriptive statistics and statistical tests were performed using SPSS 17.0 (Chicago, IL: SPSS, Inc). Frequency tables showing descriptive results for each survey question are provided in a separate Technical Appendix. The statistics presented in this report exclude “do not know” and “refused” responses. Percentages shown in figures and tables are rounded to the nearest whole number; therefore, percentages may not add up to 100 percent.

To facilitate inferences from the survey results to the CHIP member population, results were weighted to the full set of eligible beneficiaries in the enrollment dataset. Because sampling for CHIP was stratified by MCO, a separate weight was calculated for each MCO, in which frequencies were multiplied by the inverse probability of inclusion in the sample (the total number of eligible MCO members in the dataset divided by the number of MCO members with completed surveys). **Table A2** provides the weights for each of the 16 sampling groups. The frequencies and means presented in this report and the technical appendix that accompanies this report incorporate survey weights.

Table A2. Health Plan Weighting Strategy

Health plan	Population of eligible members (N)	Number of completed surveys (n)	Weight
Aetna	4,309	284	15.17
AMERIGROUP	27,947	268	104.28
Community First	10,093	289	34.92
Community Health Choice	12,620	273	46.23
Cook Children's	12,360	266	46.47
Driscoll	4,573	263	17.39
El Paso First	6,093	281	21.68
FirstCare	2,015	266	7.58
Molina	21,427	300	71.42
Parkland Community	13,443	295	45.42
Seton	7,028	299	23.51
Superior	25,742	278	89.38
Superior EPO	14,811	288	53.28
Texas Children's	32,139	270	119.03
UniCare	1,590	287	5.54
UnitedHealthcare-Texas	6,783	264	25.69

Analysis of differences in frequencies used the Pearson Chi-square test of independence, and analysis of differences in means used t-tests and analysis of variance (ANOVA). To prevent overestimation of statistical significance resulting from sample size inflation, all tests were

performed without weighting. These tests allowed comparison of frequencies and means between 2010 and 2011 results, among the 16 CHIP MCO groups, and among different demographic sub-groups within the sample

Body mass index (BMI) was calculated by dividing the child's weight in kilograms by their height in meters squared. BMI could be calculated for 3,285 children in the sample (73 percent) for whom height and weight data were complete. Height data were missing for 1,051 children (24 percent), and weight data were missing for 418 children (9 percent).

For children, the clinical relevance of BMI values varies by sex and age. Using sex-specific BMI-for-age growth charts from the National Center for Health Statistics (NCHS), children with valid BMI data were classified into one of four categories:³¹

- 1) Underweight (less than 5th percentile)
- 2) Healthy (5th percentile to less than 85th percentile)
- 3) Overweight (85th to less than 95th percentile)
- 4) Obese (\geq 95th percentile)

These standardized BMI categories for children may be used for comparison with national and state averages. Analyses of child BMI excluded children younger than two years old, for whom data are not provided on NCHS BMI-for-age growth charts. Also excluded were 180 children whose BMI deviated considerably from age- and sex-specific child growth standards provided by the World Health Organization.^{32,33} By these standards, any BMI value that exceeded five standard deviations below or above the age- and sex-specific median BMI was considered biologically implausible and likely the result of errors in data collection.

Lastly, the EQRO conducted a multivariate analysis to examine the effects of demographic, health status, and health delivery factors on parent-reported potentially preventable ED visits (PPVs). Five models were tested – the first testing the influence of demographic variables, health status, and MCO membership, and the four remaining models each testing a different element of the patient-centered medical home model. Controlling for child's race/ethnicity, sex, age, health status, and MCO membership, these models assessed whether PPVs were associated with: (1) The presence of a usual source of care; (2) CAHPS[®] *Personal Doctor*; (3) CAHPS[®] *How Well Doctors Communicate*; and (4) Caregivers' ratings of their child's personal doctor. The detailed methodology and results for these analyses can be found in Appendix C of this report.

Appendix B. Supplementary Tables and Figures

Table B1. CHIP Member Obesity Rates by MCO

Health Plan	Obesity rate (% of members in survey sample) ^a
Aetna	31.7%
AMERIGROUP	21.5%
Community First	23.5%
Community Health Choice	29.0%
Cook Children's	24.2%
Driscoll	30.4%
El Paso First	24.0%
FirstCare	30.7%
Molina	27.4%
Parkland Community	28.3%
Seton	20.0%
Superior EPO	25.5%
Superior	27.5%
Texas Children's	21.7%
UniCare	23.2%
UnitedHealthcare-Texas	19.3%
X ² test for significant differences	24.08 (p = 0.064)

^a Obesity defined as BMI-for-age \geq the 95th percentile on WHO growth charts

Table B2. CAHPS® Health Plan Survey Core Composite Scores by CHIP MCO

Health Plan	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service
CHIP overall ^a	2.28	2.49	2.73	2.51
Aetna	2.05	2.51	2.73	2.49
AMERIGROUP	2.48	2.38	2.61	2.44
Community First	2.24	2.46	2.65	2.39
CHC	2.12	2.51	2.71	2.65
Cook Children's	2.36	2.48	2.77	2.37
Driscoll	2.48	2.59	2.80	2.69
El Paso First	2.28	2.41	2.74	2.46
FirstCare	2.55	2.66	2.83	2.52
Molina	2.20	2.51	2.75	2.55
Parkland Community	2.28	2.55	2.67	2.46
Seton	2.25	2.55	2.75	2.46
Superior EPO	2.46	2.44	2.78	2.74
Superior	2.27	2.45	2.72	2.47
Texas Children's	2.31	2.43	2.75	2.47
UniCare	2.06	2.38	2.65	2.49
UHC-Texas	2.26	2.44	2.76	2.59
F significance ^b	= 0.001	= 0.034	< 0.001	N.S.

^a The method of calculation follows NCQA specifications, with the exception that a separate score is calculated for each member and then averaged. As a result, individual item responses are weighted according to their frequency and overall scores may vary slightly from those presented in the narrative and on Table B7. This method of scoring permits statistical comparisons.

^b Analyses performed on unweighted data.

Table B3. HHSC Performance Indicator Results by CHIP MCO

Health Plan	HHSC Performance Dashboard Indicator ^{a, b}					
	1	2	3	4	5	# ≥ Std.
CHIP overall	78%	89%	73%	67%	24%	
Aetna	80%	87%	55%	61%	26%	0
AMERIGROUP	76%	88%	77%	65%	20%	1
Community First	80%	81%	70%	59%	21%	0
Community Health Choice	81%	84%	65%	65%	27%	0
Cook Children's	77%	92%	75%	76%	28%	1
Driscoll	82%	95%	72%	77%	22%	1
El Paso First	75%	89%	79%	80%	18%	2
FirstCare	87%	97%	81%	77%	32%	3
Molina	78%	90%	69%	61%	19%	1
Parkland Community	83%	89%	81%	58%	23%	2
Seton	84%	92%	78%	65%	38%	2
Superior EPO	77%	94%	72%	68%	26%	1
Superior	76%	91%	70%	73%	19%	1
Texas Children's	78%	88%	75%	68%	30%	0
UniCare	73%	86%	70%	56%	21%	0
UnitedHealthcare-Texas	77%	83%	67%	67%	23%	0
HHSC Standard	86%	89%	77%	91%	68%	
# MCOs ≥ Standard	1	9	5	0	0	
X ² significance ^c	N.S	N.S	N.S.	p = 0.057	p <0.001	

^a Percentage of members who...

1. Had good access to routine care
2. Had good access to urgent care
3. Had good access to specialist referral
4. Had no delays for an approval
5. Had no exam room wait greater than 15 minutes

^b The indicator, *Good Access to Behavioral Health Treatment or Counseling*, is not shown due to low denominators.

^c Analyses performed on unweighted data.

Table B4. CAHPS[®] Health Plan Core Composite Scores for Gender, Race/Ethnicity, and Health Status

	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service
Child gender				
Female	2.30	2.50	2.75	2.54
Male	2.28	2.47	2.71	2.48
T-test significance ^a	N.S.	N.S.	= 0.017	N.S.
Child race/ ethnicity				
Hispanic	2.30	2.46	2.72	2.56
White, NH	2.33	2.63	2.78	2.40
Black, NH	2.27	2.51	2.68	2.36
Other, NH	2.09	2.26	2.64	2.52
F-test significance ^a	N.S.	< 0.001	= 0.002	= 0.002
Health status				
CSHCN	2.20	2.55	2.73	2.44
No special need	2.35	2.47	2.73	2.54
T-test significance ^a	< 0.001	= 0.014	N.S.	= 0.022

^a Analyses performed on unweighted data.

Table B5. CAHPS® Health Plan Survey Composite Scores by CHIP MCO – Chronic Conditions Set

Health Plan	Prescription Medicines	Getting Specialized Services	Personal Doctor	Shared Decision-making ^b	Getting Needed Information	Care Coordination
CHIP overall ^a	2.65	2.22	0.89	0.91	2.76	0.66
Aetna	2.54	1.87	0.85	0.92	2.77	0.76
AMERIGROUP	2.61	2.00	0.78	0.87	2.67	0.56
Community First	2.62	2.27	0.83	0.93	2.70	0.75
CHC ^c	2.59	2.09	0.87	0.92	2.69	0.68
Cook Children's	2.62	2.41	0.88	0.87	2.60	0.53
Driscoll	2.76	2.37	0.88	0.92	2.90	0.70
El Paso First	2.71	2.46	0.85	0.91	2.75	0.69
FirstCare	2.75	2.51	0.86	0.94	2.83	0.65
Molina	2.70	2.23	0.88	0.94	2.80	0.71
Parkland Community	2.61	2.30	0.86	0.89	2.80	0.68
Seton	2.70	2.09	0.89	0.86	2.77	0.67
Superior EPO	2.70	2.00	0.88	0.93	2.83	0.67
Superior	2.66	2.18	0.86	0.89	2.77	0.64
Texas Children's	2.64	1.85	0.87	0.90	2.78	0.65
UniCare	2.55	2.11	0.76	0.89	2.73	0.57
UHC-Texas ^c	2.63	2.17	0.82	0.89	2.81	0.60
F significance ^d	N.S.	0.046	= 0.015	N.S.	< 0.001	N.S.

^a The method of calculation follows NCQA specifications, with the exception that a separate score is calculated for each member and then averaged. As a result, individual item responses are weighted according to their frequency and overall scores may vary slightly from those presented in the narrative and on Table B7. This method of scoring permits statistical comparisons.

^b For scoring *Shared Decision-Making*, NCQA specifications use a different response set than that used in the CAHPS® Health Plan Survey 4.0 for Medicaid. The response set for individual items in the Medicaid version is yes/no. The scores for *Shared Decision-Making* shown here follow NCQA specifications for *Personal Doctor* and *Care Coordination*, which also have yes/no response sets.

^c Abbreviations: CHC = Community Health Choice; UHC-Texas = UnitedHealthcare-Texas.

^d Analyses performed on unweighted data.

Table B6. CAHPS® Health Plan Composite Scores by Gender, Race/Ethnicity, and Health Status – Chronic Conditions Set

	Prescription Medicines	Getting Specialized Services	Personal Doctor	Shared Decision-making ^a	Getting Needed Information	Care Coordination
Child gender						
Female	2.67	2.09	0.85	0.90	2.75	0.69
Male	2.62	2.31	0.85	0.91	2.77	0.62
F-test significance ^b	N.S.	= 0.007	N.S.	N.S.	N.S.	= 0.038
Child race/ethnicity						
Hispanic	2.65	2.18	0.89	0.91	2.78	0.69
White, NH	2.66	2.25	0.86	0.92	2.81	0.58
Black, NH	2.67	2.07	0.94	0.88	2.76	0.70
Other, NH	2.54	1.95	0.83	0.88	2.47	0.59
F-test significance ^b	N.S.	N. S.	N.S.	N.S.	< 0.001	= 0.008
Health status						
CSHCN	2.66	2.28	0.84	0.90	2.77	0.63
No special need	2.65	2.12	0.88	0.91	2.75	0.69
F-test significance ^b	N.S.	= 0.056	= 0.003	N.S.	N.S.	N.S.

^a For scoring *Shared Decision-Making*, NCQA specifications use a different response set than that used in the CAHPS® Health Plan Survey 4.0 for Medicaid. The response set for individual items in the Medicaid version is yes/no. The scores for *Shared Decision-Making* shown here follow NCQA specifications for *Personal Doctor* and *Care Coordination*, which also have yes/no response sets.

^b Analyses performed on unweighted data.

Table B7. Comparison of CAHPS® Composite Scoring Methods

CAHPS® Composite	Global proportion ^a	3-point mean ^b	100-point mean ^c
Getting Needed Care	71%	2.26	73.3
Getting Care Quickly	84%	2.58	86.4
How Well Doctors Communicate	93%	2.69	89.7
Health Plan Information and Customer Service	84%	2.51	78.7
Prescription Medicines	89%	2.65	87.6
Getting Specialized Services	67%	2.18	67.5
Personal Doctor	87%	N/A ^d	84.9
Shared Decision-Making	91%	N/A ^e	90.3
Getting Needed Information	92%	2.76	90.4
Care Coordination	72%	N/A ^d	67.0

^a The percentage of respondents who “usually” or “always” had positive health care experiences, following AHRQ specifications.

^b Mean ranging from 0 to 3, following NCQA specifications. Means differ slightly from those on Table B2 because they follow strict NCQA specifications, calculated by averaging the aggregate scores on a composite’s individual items.

^c Mean ranging from 0 to 100, developed and used by the EQRO in prior year survey reports.

^d NCQA specifications use a 0 to 1 scale for scoring *Personal Doctor* (CHIP mean = 0.87) and *Care Coordination* (CHIP mean = 0.72).

^e For scoring *Shared Decision-Making*, NCQA specifications use a different response set than that used in the CAHPS® Health Plan Survey 4.0 for Medicaid. Therefore, an NCQA mean could not be calculated for this composite.

Table B8. Survey Items Comprising the CAHPS® Composites

Core CAHPS® Composites

Getting Needed Care

CAHPS 20. How often was it easy to get appointments for your child with specialists?

CAHPS 24. How often was it easy to get the care, tests, or treatment you thought your child needed through his or her health plan?

Getting Care Quickly

CAHPS 4. When your child needed care right away for an illness, injury or condition, how often did you get care as soon as you needed?

CAHPS 6. Not counting the times your child needed care right away, how often did you get an appointment for health care as soon as you thought your child needed?

How Well Doctors Communicate

CAHPS 11. How often did your child's personal doctor explain things in a way that was easy to understand?

CAHPS 12. How often did your child's personal doctor listen carefully to you?

CAHPS 13. How often did your child's personal doctor show respect for you?

CAHPS 15. How often did your child's personal doctor explain things in a way that was easy for your child to understand?

CAHPS 16. How often did your child's personal doctor spend enough time with you?

Health Plan Information and Customer Service

CAHPS 26. How often did customer service at your child's health plan give you the information or help you needed?

CAHPS 27. How often did customer service staff at your child's health plan treat you with courtesy and respect?

CAHPS® Composites – Chronic Conditions Set

Parents' Experience with Child's Personal Doctor

Q17. Did your child's personal doctor talk to you about how your child is feeling, growing, or behaving?

CC20. Does your child's personal doctor understand how these medical, behavioral, or other health conditions affect your day-to-day life?

CC21. Does your child's personal doctor understand how your child's medical, behavioral, or other health conditions affect your family's day-to-day life?

Parents' Experience with Shared Decision Making

CC2. Did your child's doctor or other health provider tell you there was more than one choice for your child's treatment or health care?

CC3. Did your child's doctor or other health provider talk with you about the pros and cons of each choice for your child's treatment or health care?

CC4. When there was more than one choice for your child's treatment or health care, did your child's doctor or other health provider ask you which choice was best for your child?

Parents' Experience with Getting Needed Information about Their Child's Care

CC1. How often did you have your questions answered by your child's doctors or other health care providers?

Parents' Experience with Coordination of Their Child's Care

CC7. Did anyone from your child's health plan, doctor's office, or clinic help coordinate your child's care among these different providers or services?

CC18. Did you get the help you needed from your child's doctors or other health providers in contacting your child's school or daycare?

Parents' Experience Getting Specialized Services for Their Child

CC9. How often was it easy to get special medical equipment or devices for your child?

CC12. How often was it easy to get special therapy for your child?

CC15. How often was it easy to get behavioral health treatment or counseling for your child?

Parents' Experience with Prescription Medicine

CC23. How often was it easy to get prescription medicines for your child through his or her health plan?

Appendix C. Multivariate Analysis – Potentially Preventable ED Visits

Sixteen percent of caregivers responding to the SFY 2011 CHIP Survey (approximately 1,000 respondents) reported they had taken their child to the emergency department (ED) at least once in the past six months. Among these caregivers, 46 percent said they took their child to the ED at least once because they could not get an appointment at a doctor's office or clinic as soon as they thought it was needed. This follow-up question addresses the concept of *potentially preventable ED visits*, defined as emergency department visits that may result from lack of adequate access to primary care or ambulatory care coordination.³⁴ The EQRO used this question as an outcome in multivariate analyses, assessing the relative influence of various elements of the patient-centered medical home on reducing the likelihood of potentially preventable ED use among children in CHIP.

Methodology

The multivariate analysis was conducted using unconditional logistic regression, with the outcome dichotomized – coded as 1 for caregivers who took their child to the ED at least once because they could not get an ambulatory health care appointment, and 0 for caregivers who took their child to the ED, but not because of poor access to ambulatory care. The EQRO tested four models predicting the odds of a child having a potentially preventable ED visit, controlling for sociodemographic factors, health status, and MCO membership. The four models each tested the influence of a different element of the patient-centered medical home, grouped roughly into *presence of a usual source of care* and *parental satisfaction with their child's usual source of care*:

- 1) Presence of a usual source of care. The model testing the influence of having a usual source of care – the most basic element of the patient-centered medical home – compared caregivers whose children had a personal doctor whom they had been seeing for at least six months with caregivers whose children did not have a personal doctor whom they had been seeing for at least six months. Children in the latter category included both those who had a personal doctor they had been seeing for less than six months, and those who did not have a personal doctor at all.
- 2) CAHPS® *Personal Doctor*. This composite score combines responses to three questions about caregivers' experiences with their child's personal doctor in the clinical setting. Specifically, caregivers were asked whether their child's personal doctor talked with them about how their child is feeling, growing, or behaving; and whether their child's personal doctor understood how their child's medical, behavioral, and other health conditions affect the child's and the family's day-to-day life. When calculated on a 100-point scale, this composite can be dichotomized with a score of 75 as the threshold – with children having a *Personal Doctor* score of 75 or greater coded as 1 (indicating positive caregiver experiences), and children having a score less than 75 coded as 0.

- 3) CAHPS® *How Well Doctors Communicate*. This composite score combines responses to five questions about caregivers' experiences communicating with their child's personal doctor. Specifically, caregivers were asked how often their child's personal doctor listened carefully to them, showed respect for what they had to say, explained things in a way that was easy for them to understand, explained things in a way that was easy for their child to understand, and spent enough time with their child. When calculated on a 100-point scale, this composite can be dichotomized with a score of 75 as the threshold – with children having a *How Well Doctors Communicate* score of 75 or greater coded as 1 (indicating positive caregiver experiences), and children having a score less than 75 coded as 0.
- 4) Caregiver rating of their child's personal doctor. Overall satisfaction was assessed by asking caregivers to rate their child's personal doctor on a scale of 0 to 10. Following specifications for CAHPS® reporting by the Agency for Healthcare Research and Quality (AHRQ), children with personal doctor ratings of 9 or 10 were coded as 1 (indicating high satisfaction), and children with personal doctor ratings of 8 or less were coded as 0.

The EQRO used the following covariates in all logistic regression models:³⁵

- Child's race/ethnicity – categorized as White, non-Hispanic; Hispanic; Black, non-Hispanic; or Other, non-Hispanic. The reference group was White, non-Hispanic children.
- Child's age – categorized into three age cohorts: Birth to 5 years old, 6 to 11 years old, and 12 to 18 years old. The reference group was adolescents 12 to 18 years old.
- Child's MCO. Among the 16 CHIP sampling groups, the reference group was Texas Children's – chosen because it had the lowest rate of parent-reported potentially preventable ED visits (29 percent) and was therefore the best-performing MCO on the outcome measure. In two models (testing *How Well Doctors Communicate* and Personal Doctor rating), UnitedHealthcare-Texas had the lowest rate of parent-reported PPVs (28 to 29 percent), and was used as the reference group.

Results

Results of the multivariate analysis are presented in **Table C1** through **Table C5** as odds ratios. The odds ratios represent the likelihood of a caregiver reporting at least one potentially preventable ED visit for their child in the past six months, compared to caregivers who took their child to the ED, but not because of poor access. For any particular test variable or covariate, an odds ratio above 1.0 suggests that children in the specified category were more likely to have had a potentially preventable ED visit than children in the reference group. Conversely, an odds ratio below 1.0 suggests that children in the specified category were less likely to have had a potentially preventable ED visit than children in the reference group.

The tables also provide 95 percent confidence intervals for the odds ratios, which function as an indicator of statistical significance. An odds ratio with a confidence interval that includes 1.00 in its range is not considered statistically significant at $p < 0.05$.

Table C1 presents the simple model, which includes only the child's race, sex, age, and MCO. The only demographic covariate that was associated with the likelihood of potentially preventable ED visits was age. Fifty-five percent of caregivers of members 0 to 5 years old reported taking their child at least once to the ED because they could not get an appointment for ambulatory care, compared to 45 percent of caregivers of members 12 to 18 years old. Controlling for race/ethnicity, sex, and MCO membership, members 0 to 5 years old were approximately 1.5 times more likely than adolescent members to have had a potentially preventable ED visit.

- *Child's age.* Compared with adolescents 12 to 18 years old, members 0 to 5 years old were about 1.5 times more likely to have had a potentially preventable ED visit. This association was stronger when controlling for caregivers' scores on the CAHPS® *Personal Doctor* or *How Well Doctors Communicate* composites (1.7 times more likely).
- *Child's MCO.* Compared with members of Texas Children's (who had the lowest rate overall of potentially preventable ED visits), members of Aetna, Community First, Community Health Choice, Driscoll, El Paso First, Molina, Superior, and UniCare were significantly more likely to have had a potentially preventable ED visit. The increase in likelihood was greatest for members of Community Health Choice (5 times more likely) and Community First (4 times more likely).
- *Personal doctor rating.* Caregivers who rated their child's personal doctor a 9 or 10 were 40 percent less likely than those who gave their child's personal doctor a lower rating to have taken their child to the ED because they could not get an appointment for ambulatory care as soon as they thought it was needed.

Children in a number of MCOs had significantly increased odds of having a potentially preventable ED visit, compared to the Texas Children's reference group:

- *Aetna.* In the simple model, 50 percent of caregivers of children in Aetna reported taking their child at least once to the ED because they could not get an appointment for ambulatory care. Controlling for other covariates, children in Aetna were 2.6 times more likely than children in Texas Children's to have had a potentially preventable ED visit.
- *Community First.* In the simple model, 58 percent of caregivers of children in Community First reported taking their child at least once to the ED because they could not get an appointment for ambulatory care. Controlling for other covariates, children in Community First were 3.6 times more likely than children in Texas Children's to have had a potentially preventable ED visit.
- *Community Health Choice.* In the simple model, 66 percent of caregivers of children in Community Health Choice reported taking their child at least once to the ED because they could not get an appointment for ambulatory care. Controlling for other covariates,

children in Community Health Choice were 5.0 times more likely than children in Texas Children's to have had a potentially preventable ED visit.

- *Driscoll*. In the simple model, 55 percent of caregivers of children in Driscoll reported taking their child at least once to the ED because they could not get an appointment for ambulatory care. Controlling for other covariates, children in Driscoll were 3.2 times more likely than children in Texas Children's to have had a potentially preventable ED visit.
- *El Paso First*. In the simple model, 51 percent of caregivers of children in El Paso First reported taking their child at least once to the ED because they could not get an appointment for ambulatory care. Controlling for other covariates, children in El Paso First were 2.8 times more likely than children in Texas Children's to have had a potentially preventable ED visit.
- *Molina*. In the simple model, 59 percent of caregivers of children in Molina reported taking their child at least once to the ED because they could not get an appointment for ambulatory care. Controlling for other covariates, children in Molina were 3.5 times more likely than children in Texas Children's to have had a potentially preventable ED visit.
- *Superior*. In the simple model, 60 percent of caregivers of children in Superior reported taking their child at least once to the ED because they could not get an appointment for ambulatory care. Controlling for other covariates, children in Superior were 3.7 times more likely than children in Texas Children's to have had a potentially preventable ED visit.
- *UniCare*. In the simple model, 49 percent of caregivers of children in UniCare reported taking their child at least once to the ED because they could not get an appointment for ambulatory care. Controlling for other covariates, children in UniCare were 2.5 times more likely than children in Texas Children's to have had a potentially preventable ED visit.

Among the four test factors, only caregiver's rating of their child's personal doctor was significantly associated with the likelihood of having a potentially preventable ED visit. Caregivers who rated their child's personal doctor a 9 or 10 on a scale from 0 to 10 were significantly less likely to have taken their child to the ED because they could not get an appointment for ambulatory care.

- *Personal doctor rating*. In the overall sample, 44 percent of caregivers who rated their child's personal doctor a 9 or 10 reported taking their child at least once to the ED because they could not get an appointment for ambulatory care. Controlling for demographic factors and MCO membership, children with high personal doctor ratings were 40 percent less likely than those with lower personal doctor ratings to have had a potentially preventable ED visit.

The EQRO used the likelihood-ratio test to determine the relative fit of each of the four models, and identify which model had the greatest predictive value with regard to the outcome of potentially preventable ED visits. For each of the four models, model fit statistics were compared to model fit statistics of a simpler model, which contained only demographic factors, health status, and MCO membership. This test permits an assessment of the increase in predictive value due to the addition of a test factor. Results of the likelihood-ratio tests are shown in the table below.

Test factor	Model Type			p-value
	Full (χ^2 , df)	Simple (χ^2 , df)	Difference (χ^2 , df)	
Having a usual source of care	40.776, df = 22	37.915, df = 21	2.861, df = 1	= 0.090
CAHPS® <i>Personal Doctor</i>	36.025, df = 22	35.369, df = 21	0.656, df = 1	= 0.418
CAHPS® <i>How Well Doctors Communicate</i>	35.396, df = 22	32.470, df = 21	2.926, df = 1	= 0.087
Personal doctor rating	44.793, df = 22	37.532, df = 21	7.261, df = 1	= 0.007

Among the four models, the only model that predicted the likelihood of potentially preventable ED visits significantly better than the simple model was Model 4 – testing the association with high personal doctor ratings. Overall, the findings of this multivariate analysis suggest that parental satisfaction with their child’s usual source of care has a greater influence than the simple presence of a usual source of care on reducing the likelihood of potentially preventable ED visits in CHIP.

These findings are particularly useful for CHIP MCOs working to reduce rates of potentially preventable ED visits, which is one of the over-arching goals for CHIP MCOs in SFY 2012. All MCOs should work toward improving the relationships between caregivers and personal doctors in their networks.

Table C1. Multivariate Analysis Simple Model – Influence of Demographic Factors, Health Status, and MCO on Likelihood of Potentially Preventable ED Visits (PPV)

Factor	Percent with ≥ 1 PPV	Odds Ratio	95% CI
Child's Race/Ethnicity			
White, non-Hispanic	47%	REF	-
Black, non-Hispanic	40%	0.86	(0.46 - 1.62)
Hispanic	48%	0.98	(0.64 - 1.45)
Other, non-Hispanic	45%	0.87	(0.41 - 1.84)
Child's Sex			
Male	48%	REF	-
Female	46%	0.86	(0.63 - 1.17)
Child's Age			
0 to 5 years old	55%	1.51	(0.96 - 2.39)
6 to 11 years old	45%	0.97	(0.68 - 1.38)
12 to 18 years old	45%	REF	-
MCO			
Aetna	50%	2.58	(1.07 - 6.20)
AMERIGROUP	33%	1.34	(0.50 - 3.67)
Community First	58%	3.57	(1.45 - 8.79)
Community Health Choice	66%	4.98	(1.83 - 13.52)
Cook Children's	47%	2.29	(0.91 - 5.77)
Driscoll	55%	3.18	(1.27 - 7.98)
El Paso First	51%	2.75	(1.05 - 7.25)
FirstCare	32%	1.20	(0.47 - 3.07)
Molina	59%	3.46	(1.35 - 8.89)
Parkland Community	44%	1.96	(0.79 - 4.82)
Seton	33%	1.30	(0.47 - 3.61)
Superior	60%	3.74	(1.52 - 9.24)
Superior EPO	40%	1.60	(0.63 - 4.09)
Texas Children's	29%	REF	-
UniCare	49%	2.51	(1.01 - 6.24)
UnitedHealthCare-Texas	30%	1.07	(0.37 - 3.06)

Table C2. Multivariate Analysis Model 1 – Influence of Having a Usual Source of Care on the Likelihood of Potentially Preventable ED Visits (PPV)

Factor	Percent with ≥ 1 PPV	Odds Ratio	95% CI
Child's Race/Ethnicity			
White, non-Hispanic	47%	REF	-
Black, non-Hispanic	40%	0.89	(0.47 - 1.69)
Hispanic	48%	0.99	(0.65 - 1.51)
Other, non-Hispanic	46%	0.91	(0.42 - 1.95)
Child's Sex			
Male	48%	REF	-
Female	46%	0.84	(0.61 - 1.15)
Child's Age			
0 to 5 years old	55%	1.41	(0.88 - 2.25)
6 to 11 years old	45%	0.93	(0.64 - 1.33)
12 to 18 years old	46%	REF	-
MCO			
Aetna	51%	3.71	(1.43 - 9.62)
AMERIGROUP	33%	1.88	(0.65 - 5.44)
Community First	58%	4.91	(1.85 - 13.04)
Community Health Choice	68%	7.51	(2.56 - 22.05)
Cook Children's	45%	3.02	(1.11 - 8.21)
Driscoll	57%	4.44	(1.65 - 11.99)
El Paso First	55%	4.27	(1.48 - 12.35)
FirstCare	32%	1.66	(0.60 - 4.54)
Molina	58%	4.60	(1.65 - 12.85)
Parkland Community	46%	2.94	(1.10 - 7.83)
Seton	39%	2.27	(0.75 - 6.86)
Superior	58%	4.90	(1.84 - 13.06)
Superior EPO	41%	2.34	(0.85 - 6.43)
Texas Children's	23%	REF	-
UniCare	50%	3.72	(1.38 - 10.00)
UnitedHealthCare-Texas	30%	1.46	(0.48 - 4.46)
Child has personal doctor			
No	44%	REF	-
Yes	48%	1.20	(0.80 - 1.81)

Table C3. Multivariate Analysis Model 2 – Influence of CAHPS® Personal Doctor on Likelihood of Potentially Preventable ED Visits (PPV)

Factor	Percent with ≥ 1 PPV	Odds Ratio	95% CI
Child's Race/Ethnicity			
White, non-Hispanic	48%	REF	-
Black, non-Hispanic	39%	0.72	(0.35 - 1.49)
Hispanic	50%	0.92	(0.59 - 1.45)
Other, non-Hispanic	50%	1.09	(0.46 - 2.57)
Child's Sex			
Male	50%	REF	-
Female	47%	0.81	(0.57 - 1.16)
Child's Age			
0 to 5 years old	59%	1.74	(1.03 - 2.94)
6 to 11 years old	47%	1.04	(0.69 - 1.57)
12 to 18 years old	46%	REF	-
MCO			
Aetna	49%	2.72	(1.01 - 7.31)
AMERIGROUP	35%	1.55	(0.49 - 4.89)
Community First	63%	4.64	(1.66 - 12.97)
Community Health Choice	70%	6.61	(2.17 - 20.12)
Cook Children's	44%	2.13	(0.76 - 5.99)
Driscoll	58%	3.88	(1.43 - 10.54)
El Paso First	50%	2.82	(0.97 - 8.14)
FirstCare	31%	1.24	(0.42 - 3.67)
Molina	52%	2.77	(0.98 - 7.83)
Parkland Community	54%	3.27	(1.17 - 9.17)
Seton	40%	1.90	(0.61 - 5.84)
Superior	58%	3.81	(1.35 - 10.70)
Superior EPO	47%	2.32	(0.83 - 6.44)
Texas Children's	28%	REF	-
UniCare	47%	2.52	(0.90 - 7.02)
UnitedHealthCare-Texas	29%	1.07	(0.31 - 3.66)
CAHPS® Personal Doctor			
Score < 75	53%	REF	-
Score ≥ 75	47%	0.83	(0.52 - 1.31)

Table C4. Multivariate Analysis Model 3 – Influence of CAHPS® How Well Doctors Communicate on Likelihood of Potentially Preventable ED Visits (PPV)

Factor	Percent with ≥ 1 PPV	Odds Ratio	95% CI
Child's Race/Ethnicity			
White, non-Hispanic	47%	REF	-
Black, non-Hispanic	38%	0.75	(0.36 - 1.57)
Hispanic	50%	0.95	(0.59 - 1.51)
Other, non-Hispanic	54%	1.24	(0.50 - 3.07)
Child's Sex			
Male	50%	REF	-
Female	46%	0.81	(0.56 - 1.17)
Child's Age			
0 to 5 years old	59%	1.76	(1.03 - 3.01)
6 to 11 years old	48%	1.03	(0.68 - 1.57)
12 to 18 years old	46%	REF	-
MCO			
Aetna	45%	2.19	(0.70 - 6.91)
AMERIGROUP	35%	1.43	(0.40 - 5.13)
Community First	63%	4.25	(1.32 - 13.71)
Community Health Choice	69%	5.61	(1.60 - 19.63)
Cook Children's	46%	2.07	(0.63 - 6.74)
Driscoll	57%	3.52	(1.12 - 11.12)
El Paso First	52%	2.83	(0.85 - 9.46)
FirstCare	36%	1.43	(0.42 - 4.95)
Molina	50%	2.44	(0.75 - 8.01)
Parkland Community	55%	2.83	(0.86 - 9.31)
Seton	40%	1.80	(0.51 - 6.33)
Superior EPO	59%	2.15	(0.66 - 6.98)
Superior	47%	3.65	(1.11 - 11.97)
Texas Children's	29%	0.98	(0.28 - 3.37)
UniCare	47%	2.27	(0.70 - 7.38)
UnitedHealthCare-Texas	29%	REF	-
CAHPS® Doctors' Communication			
Score < 75	61%	REF	-
Score ≥ 75	46%	0.62	(0.36 - 1.07)

Table C5. Multivariate Analysis Model 4 – Influence of Caregivers’ Personal Doctor Rating on Likelihood of Potentially Preventable ED Visits (PPV)

Factor	Percent with ≥ 1 PPV	Odds Ratio	95% CI
Child's Race/Ethnicity			
White, non-Hispanic	46%	REF	-
Black, non-Hispanic	40%	0.90	(0.45 - 1.79)
Hispanic	50%	1.02	(0.66 - 1.57)
Other, non-Hispanic	48%	0.99	(0.44 - 2.25)
Child's Sex			
Male	49%	REF	-
Female	47%	0.82	(0.58 - 1.15)
Child's Age			
0 to 5 years old	58%	1.62	(0.98 - 2.66)
6 to 11 years old	45%	0.92	(0.62 - 1.35)
12 to 18 years old	47%	REF	-
MCO			
Aetna	50%	2.71	(0.94 - 7.78)
AMERIGROUP	33%	1.45	(0.45 - 4.70)
Community First	62%	4.52	(1.54 - 13.33)
Community Health Choice	66%	5.24	(1.65 - 16.67)
Cook Children's	47%	2.41	(0.80 - 7.26)
Driscoll	58%	3.77	(1.28 - 11.10)
El Paso First	50%	2.79	(0.89 - 8.75)
FirstCare	32%	1.29	(0.42 - 3.91)
Molina	56%	3.44	(1.13 - 10.46)
Parkland Community	49%	2.33	(0.78 - 6.96)
Seton	34%	1.54	(0.47 - 5.03)
Superior EPO	61%	2.11	(0.70 - 6.34)
Superior	45%	4.21	(1.41 - 12.64)
Texas Children's	31%	1.10	(0.35 - 3.44)
UniCare	51%	2.76	(0.94 - 8.16)
UnitedHealthCare-Texas	28%	REF	-
Personal Doctor Rating			
0 to 8	57%	REF	-
9 or 10	44%	0.60	(0.41 - 0.87)

Endnotes

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- ¹³ Frequencies are weighted to the probability of inclusion in the sample by MCO.
- ¹⁴ Ogden C.L., M. D. Carroll, L. R. Curtin, M. A. McDowell, C. J. Tabak, and K. M. Flegal. 2006. “Prevalence of Overweight and Obesity in the United States, 1999 – 2004.” *JAMA* 295(13): 1549-1555.

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¹⁶ AAP (American Academy of Pediatrics). 2011. "Medical Home: What is a family-centered medical home?" Available at: <http://www.aap.org/healthtopics/medicalhome.cfm>.

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¹⁸ The national CHIP average for *Shared Decision-Making* was not available for comparison.

¹⁹ The method of calculation follows NCQA specifications, with the exception that a separate score is calculated for each member and then averaged. As a result, individual item responses are weighted according to their frequency. This method of scoring permits statistical comparisons.

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²⁴ CAHMI. 2008.

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³⁵ The presence of a special health care need was not found to be associated with PPVs in bivariate analyses (CSHCN = 48%; Non-CSHCN = 46%), and was not included in the models.