



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

Texas Medicaid Managed Care STAR Health Caregiver Survey Report

Fiscal Year 2012

**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

Introduction

The Institute for Child Health Policy (IChP) serves as the External Quality Review Organization (EQRO) for Texas Medicaid managed care and biannually evaluates the health care experiences and satisfaction of caregivers of STAR Health members using a member telephone survey. This report provides results from the fiscal year 2012 STAR Health Caregiver Survey conducted with caregivers of children and adolescents in foster care who were enrolled STAR Health between December 2011 and May 2012. Although these children are under the state's conservatorship, in the report they are referred to as the children of caregivers for ease of reading.

The purpose of the fiscal year 2012 STAR Health Caregiver Survey is to:

- Describe the socio-demographic characteristics of children in foster care enrolled in STAR Health and their caregivers.
- Describe the health status of children in STAR Health.
- Document caregivers' experiences and satisfaction with the child's health care.
- Use Consumer Assessment of Healthcare Providers and Systems (CAHPS[®]) composites, caregiver ratings, and HHSC Performance Dashboard Indicators to evaluate the STAR Health program across the following domains:
 - Access to and timeliness of care;
 - Patient-centered medical home;
 - Service coordination; and
 - Health plan information and customer service.
- Identify disparities in caregiver experiences and satisfaction of care across member characteristics.

Methodology

Survey participants were selected from a simple random sample of members enrolled in STAR Health between December 2011 and May 2012. The EQRO set a target of 400 completed telephone interviews with caregivers of sampled members. The response rate for this survey was 73 percent and the cooperation rate was 91 percent.

The fiscal year 2012 STAR Health Caregiver Survey is comprised of:

- The CAHPS[®] Health Plan Survey 4.0 (Medicaid module)¹
- Items from the CAHPS[®] Clinician and Group Surveys²
- Items developed by the Texas Department of Family and Protective Services (DFPS) pertaining to service management
- The Children With Special Health Care Needs (CSHCN) Screener[®] ³
- Items from the National Survey of CSHCN (NS-CSHCN) addressing issues of transition to adult care

- Items developed by ICHP pertaining to member and caregiver demographics and household characteristics

Summary of Findings

Profile of STAR Health members:

- The average age was 7 years old.
- 49 percent were female, and 51 percent were male.
- Hispanic members were the most common racial/ethnic group (41 percent), followed by White, non-Hispanic members (28 percent), and Black, non-Hispanic members (27 percent).
- 36 percent lived in a single-parent household.
- 48 percent were classified as having special healthcare needs (CSHCN).

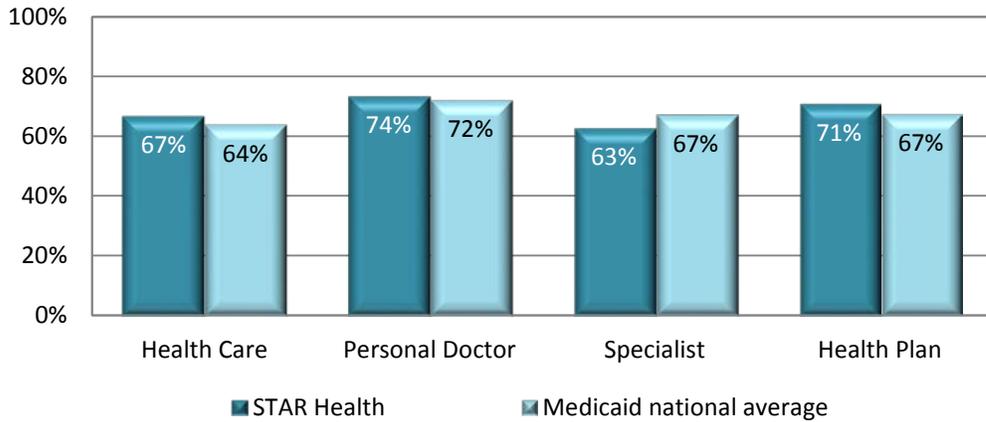
Profile of survey participants (caregivers):

- The average age was 48 years old.
- 87 percent were female, and 13 percent were male.
- White, non-Hispanic caregivers were the most common racial/ethnic group (41 percent), followed by Hispanic caregivers (29 percent), and Black, non-Hispanic caregivers (27 percent)
- 81 percent of caregivers had a high school diploma.
- 59 percent of caregivers were married.

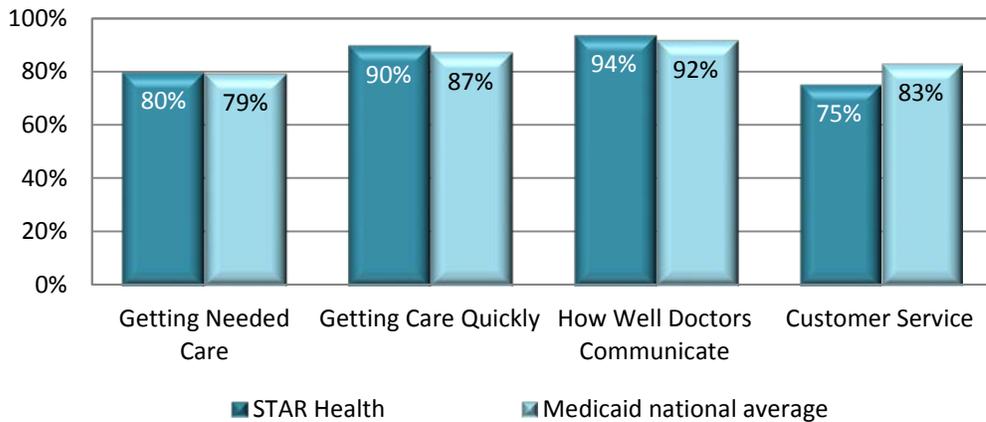
Positive findings

- *Member Ratings.* A 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 comparable to those published from Medicaid national data.
- *Getting Care Quickly.* Ninety percent of caregivers usually or always had positive experiences with *Getting Care Quickly*, which is higher than the Medicaid national average of 87 percent.
- *Good Access to Urgent Care.* A vast majority of caregivers reported that their child usually or always received care for an illness, injury, or condition as soon as they thought their child needed care (96 percent). This percentage exceeds the HHSC Dashboard standard of 88 percent.
- *Good Access to Routine Care.* Eighty-four percent of caregivers reported that they usually or always were able to make a routine appointment as soon as they thought their child needed care. This percentage is greater than the HHSC Dashboard standard of 76 percent.

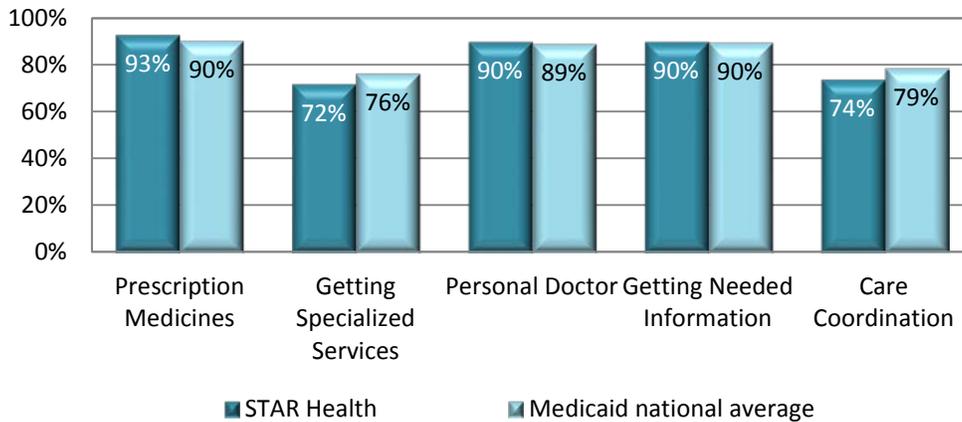
Percent of caregivers rating their child's health services a "9" or "10"



Percent of members "usually" or "always" having positive experiences (Core CAHPS® Composites)



Percent of members "usually" or "always" having positive experiences (CAHPS® Composites for Children with Chronic Conditions)



- *Good Access to Specialist Referral.* Eighty-four percent of caregivers reported it was usually or always easy to get a referral to a specialist for their child, which is higher than the HHSC Dashboard standard of 75 percent.

HHSC Performance Dashboard Indicators	STAR Health	HHSC Standard
<i>Good access to urgent care</i>	96%	88%
<i>Good access to specialist referral</i>	84%	75%
<i>Good access to routine care</i>	84%	76%
<i>No delays for an approval</i>	69%	69%
<i>No wait to be taken to the exam room greater than 15 minutes</i>	30%	50%
<i>Good access to behavioral health treatment/counseling</i>	78%	79%

Improvement areas

- *Body mass index (BMI).* Nearly one-third of children were classified as obese (30 percent). This rate is higher than the national and Texas averages for child/adolescent obesity (17 percent and 20 percent, respectively).
- *Preparing caregivers and CSHCN for transition to adulthood.* Among children 11 years of age and older, 13 percent of providers spoke with caregivers about their child having to eventually see providers who treat adults.
- *Service management.* Approximately one-third of caregivers said they received a call asking whether their child needed service management (38 percent). When service management was recommended by the service manager, nearly all caregivers agreed to participate in the program (96 percent).
- *Health plan information and customer service.* Seventy-five percent of caregivers usually or always had positive experiences on the CAHPS® composite *Health Plan Information and Customer Service* (75 percent), which is below the national average of 83 percent.

Recommendations

The EQRO recommends the following strategies to Texas HHSC and the STAR Health managed care organization (MCO) (Superior HealthPlan) for improving the delivery and quality of care for STAR Health enrollees:

Domain	Recommendations	Rationale
Obesity among STAR Health members	<ul style="list-style-type: none"> • Superior HealthPlan should implement or improve upon communication efforts and measurement of members' obesity. Potential strategies include: <ul style="list-style-type: none"> ○ Making discussion of both food intake and exercise during every well-child checkup mandatory. ○ Initiating unobtrusive interventions such as keeping food and exercise diaries to increase awareness and accountability.⁴ 	<p>Thirty percent of all STAR Health members were obese, a percentage higher than that of the national (17 percent) or Texas (20 percent) child/adolescent population. Sixty-two percent of caregivers said their child's doctor discussed how much their child exercises during visits.</p> <p>Members with special needs (CSHCN) were less likely than members with no special needs to have had their doctor discuss their dietary consumption (amount and kind of food).</p> <p>The stigma against obesity in children is increasing⁵ and can cause embarrassment, so interventions should aim to be relatively inconspicuous.</p>
Service Management Outreach	<ul style="list-style-type: none"> • Superior HealthPlan should investigate the need to improve service management outreach to STAR Health caregivers. Assessment of the following information could be useful in improving outreach: <ul style="list-style-type: none"> ○ The service management density—number of service managers per 1,000 STAR Health members. ○ Service manager caseloads and job responsibilities. ○ Barriers (for caregivers and service managers) to receiving calls about service 	<p>Thirty-eight percent of the caregivers of members who had medical, behavioral, or other health conditions that have lasted for more than three months (those members who would likely most benefit from service management) said they received a call from a service manager to assess their child's health care needs.</p>

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Introduction

Children in foster care are a vulnerable group with complex health needs. They typically enter foster care with chronic, developmental, and mental health conditions as a result of neglect or abuse, and often require comprehensive health services to address their needs.

In order to improve the coordination of care for children and youth in foster care, the Texas Health and Human Services Commission (HHSC) launched STAR Health in 2008. Superior HealthPlan is a managed care organization (MCO) that contracts with HHSC to administer the STAR Health program to provide medical and behavioral health, dental, vision and pharmacy benefits to children and youth in foster care. Members receive services through a medical home (i.e., primary care doctor), expedited enrollment, and a 24-hour nurse hotline for caregivers and caseworkers, as well as service management provided by the MCO. STAR Health also utilizes an electronic health record system called the Health Passport, which allows providers to easily access patient information, including visit and claims history, immunizations, lab results, and demographic information.⁶

ICHP was contracted by HHSC to evaluate caregivers' experiences and satisfaction with their child's health care following enrollment in STAR Health.

This report presents results of the STAR Health Caregiver Survey, which is intended to:

- Describe the socio-demographic characteristics of children in foster care enrolled in STAR Health and their caregivers.
- Describe the health status of children in STAR Health.
- Document caregivers' experiences and satisfaction with the child's health care.
- Use CAHPS[®] composites, caregiver ratings, and HHSC Performance Dashboard Indicators to evaluate the STAR Health program across the following domains:
 - Access to and timeliness of care;
 - Patient-centered medical home;
 - Service coordination; and
 - Health plan information and customer service.
- Identify disparities in caregivers' experiences and satisfaction of care across member characteristics.

In addition, this report compares CAHPS[®] items, caregiver ratings, and HHSC Dashboard Indicator data to results from the fiscal year 2010 STAR Health Caregiver Survey Report to identify trends in health care quality.

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 survey participants from a simple random sample of children and adolescents 17 years of age and younger who were enrolled in STAR Health in Texas for six continuous months between December 2011 and May 2012. Members having no more than one 30-day break in enrollment during this period were included in the sample. The EQRO set a target of 400 completed telephone interviews with caregivers of sampled members.

Survey Instruments

The Fiscal Year 2012 STAR Health Caregiver Survey is comprised of:

- The CAHPS® Health Plan Survey 4.0 (Medicaid module)⁷
- Items from the CAHPS® Clinician and Group Surveys⁸
- Items developed by the Texas Department of Family and Protective Services (DFPS) pertaining to service management
- The CSHCN Screener®⁹
- Items from the NS-CSHCN addressing issues of transition to adult care¹⁰
- Items developed by ICHP pertaining to member and caregiver demographics and household characteristics

The CAHPS® Health Plan Survey is a widely used instrument for measuring and reporting consumers' experiences with their or their child's health plan and providers. The STAR Health Caregiver Survey uses the Medicaid module of the CAHPS® survey and includes both the core questionnaire and supplemental items. The CAHPS® survey allows for the calculation and reporting of health care composites, which are scores that combine results for closely related survey items. For children, CAHPS® composite scores are 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*

The first four composites – *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Health Plan Information and Customer Service* – are Core CAHPS® composites, which are also calculated for adults and are commonly used by health plans. The other six are CAHPS® composites for children with chronic conditions. Scores for composite measures were calculated using both Agency for Healthcare Research and Quality (AHRQ) and National Committee for Quality Assurance (NCQA) specifications.

Six survey questions function as indicators of health plan performance for children in STAR Health, as listed on HHSC’s Performance Indicator Dashboard for calendar year 2012.¹¹ These include: (1) Good access to urgent care; (2) Good access to specialist referral; (3) Good access to routine care; (4) No delays in health care while waiting for health plan approval; (5) No wait to be taken to the exam room greater than 15 minutes; and (6) Good access to behavioral health treatment and counseling.

Respondents were also asked to report their child’s height and weight. These questions allow calculation of the member’s BMI, a common population-level indicator of overweight and obesity.

Data Collection

The EQRO sent letters written in English and Spanish to 3,200 caregivers of sampled STAR Health members, requesting their participation in the survey.

The National Opinion Research Center (NORC) at the University of Chicago conducted the surveys using computer-assisted telephone interviewing (CATI) between June 2012 and August 2012. NORC telephoned caregivers of STAR Health members seven days a week between 9 a.m. and 9 p.m. Central Standard Time. If a respondent was unable to complete the interview in English, NORC referred the respondent to a Spanish-speaking interviewer.

Fifty percent of families could not be located. Among those located, 5 percent indicated that the child was not enrolled in STAR Health and 4 percent refused to participate. The response rate was 73 percent and the cooperation rate was 91 percent.

Data Analysis

Descriptive statistics and statistical tests were performed using SPSS 19.0 and focused on the CAHPS® composite measures and HHSC Performance Dashboard Indicators. Statistical tests of differences were conducted among relevant demographic sub-groups in the STAR Health sample. Multivariate analyses were also conducted to examine the influence of caregiver and member factors on scores in four CAHPS® composite domains – *Getting Needed Care*, *Getting Specialized Services*, *Prescription Medicines*, and *Care Coordination*. These four domains were selected for the more in-depth multivariate analysis because they have relevance for members who are hospitalized (or at risk of being hospitalized) for mental illness, which is the focus of one of the fiscal year 2011 HHSC Overarching Goals for STAR Health.¹²

Results

This section presents survey results for children in STAR Health regarding: 1) Demographic characteristics; 2) Health status; 3) Access to and timeliness of care; 4) Presence of a usual source of care and patient-centered medical home; 5) Care coordination; 6) Experiences and satisfaction with the STAR Health MCO (Superior HealthPlan); and 7) A comparison of experiences and satisfaction with the fiscal year 2010 STAR Health report, focusing on CAHPS® composites, HHSC Performance Dashboard Indicators, and global ratings. Frequency data for all survey items are available in a separate technical appendix.

Demographic Information

Caregiver and Household Characteristics

The age of caregivers of STAR Health members ranged from 19 to 84, with an average age of 48, and the majority of caregiver respondents were female (87 percent). The most common race of caregivers was White, non-Hispanic (41 percent), followed by Hispanic (29 percent), and Black, non-Hispanic (27 percent). Three percent of caregivers specified an 'Other' race.

More than three out of four caregivers had at least a high school diploma or GED (81 percent), and over half also had attended college and/or had a college degree (56 percent).

The vast majority of caregivers reported that they primarily spoke English at home (94 percent), with the other 6 percent reporting Spanish as the main language spoken at home. The most common marital status of caregivers was married (59 percent), followed by single (18 percent), and divorced or separated (13 percent). Most children were being cared for in a two-parent household (63 percent), whereas about a third of children were being raised by a single parent (36 percent).

Demographic Characteristics

Just over half of child members whose caregivers were surveyed were male (51 percent). Child members ranged in age from newborn to 18 years old, with a mean age of 7 years old. Hispanics represented the largest racial/ethnic group in the sample (41 percent), followed by White, Non-Hispanics (28 percent), and Black, non-Hispanics (27 percent). Four percent of survey respondents reported that they were of "Other" race/ethnicity. Just like the caregivers, 94 percent of children spoke English at home.

	STAR Health Members
Mean Age (years)	6.8 (SD = 5.13)
Sex	
Female	49%
Male	51%
Race/Ethnicity	
Hispanic	41%
White, Non-Hispanic	28%
Black, Non-Hispanic	27%
Other	4%

Health Status

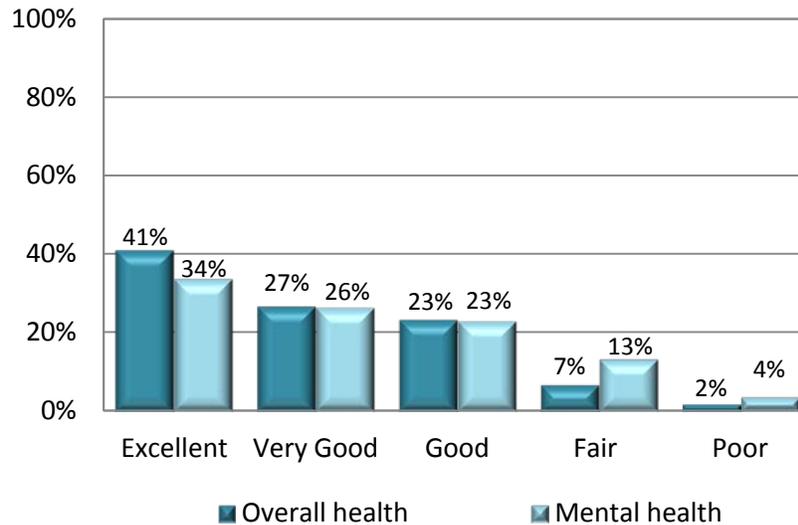
Overall and Mental Health

Caregivers were asked to rate their child's overall health and mental health. Overall, health ratings were good (**Figure 1**).

- Over two-thirds of children had excellent or very good overall health (68 percent), and only one in ten children had fair or poor overall health (9 percent).
- Nearly two-thirds of children also had excellent or very good mental health (60 percent), and about one in five children had fair or poor mental health (17 percent).

Children had slightly better overall health than mental health. However, this is somewhat expected, as children in foster care tend to face a high burden of mental health problems.¹³

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



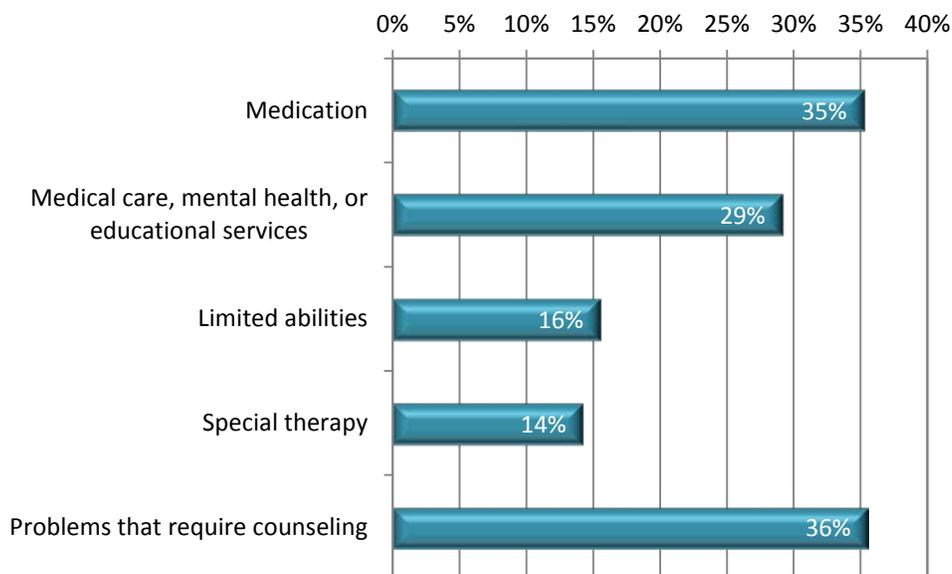
Special Health Care Needs of Members

Nearly half of children were identified as having “special needs” (48 percent) according to the CSHCN Screener[®] because they met one or more of the following criteria:

- 1) Dependence on medication
- 2) Greater than routine use of health and educational services
- 3) Functional/ability limitations (compared with others their age)
- 4) Required special therapy
- 5) Had problems that required counseling

Figure 2 shows the percentages of children that had special needs based on the five screener domains.

Figure 2. Percent of Children with Special Needs Regarding:



About a third of children qualified as CSHCN because they:

- Had emotional, developmental, or behavioral problems that required counseling (36 percent)
- Were dependent on prescribed medicine (35 percent)
- Had higher medical care, mental health, or educational service needs than most children of the same age (29 percent)

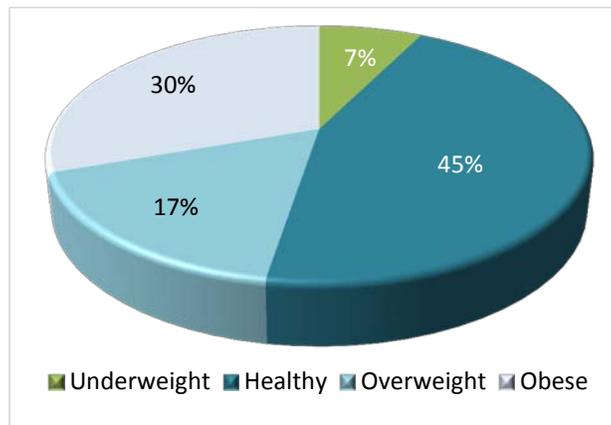
Less than twenty percent of children qualified as CSHCN because they:

- Were limited in their ability to do things compared with others their age (16 percent)
- Required special therapy, such as physical, occupational, or speech therapy (14 percent).

Body Mass Index

Figure 3 provides the BMI results for STAR Health members, which is based on their caregivers' reports of their weight and height. About a third of members were classified as obese (30 percent), and an additional 17 percent were classified as overweight. STAR Health members had a higher rate of obesity compared to the national rate for children and adolescents (17 percent),¹⁴ and the rate for the Texas population (20 percent), as reported by the Centers for Disease Control and Prevention in 2012.¹⁵

Figure 3. Body Mass Index Classification from Members' Heights and Weights as Reported by Their Caregivers



Girl and boy members had similar obesity rates (26 percent and 34 percent, respectively). The gender difference among STAR Health members was similar to that observed for the U.S. child and adolescent population, although the rates for STAR Health boys and girls were higher than their national counterparts. Hispanic and White, non-Hispanic members had higher rates of obesity (34 percent and 33 percent, respectively), than Black, non-Hispanic members (21 percent), although these differences were not overall significant.¹⁷

Obesity Prevalence in the U.S. by Sex and Race/Ethnicity^a		
	% obese in U.S. population (age 12-19)	% obese in STAR Health
Girls, overall	17%	26%
Hispanic (Girls)	17%	32%
Non-Hispanic White (Girls)	15%	26%
Non-Hispanic Black (Girls)	29%	15%
Boys, overall	19%	34%
Hispanic (Boys)	27%	37%
Non-Hispanic White (Boys)	17%	40%
Non-Hispanic Black (Boys)	20%	26%

^a Based on the NCHS Health E-Stat¹⁶

Access to and Timeliness of Care

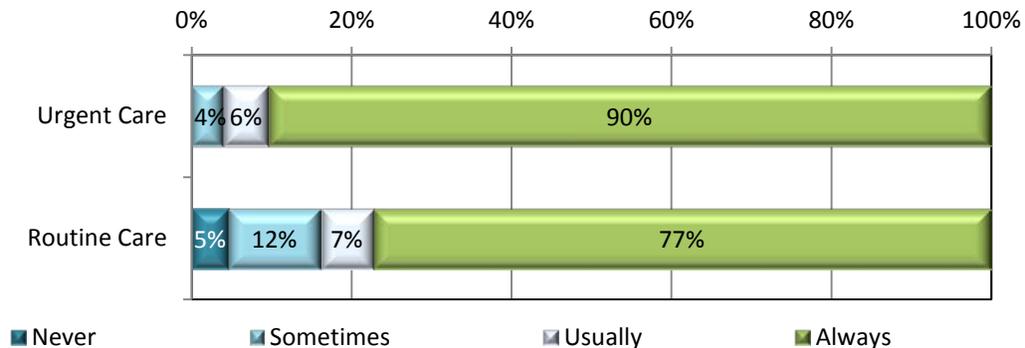
This section provides caregivers' reports of their child's access to and timeliness of health services delivered through their STAR Health providers, including those of urgent and routine care, emergency department use, specialist care, specialized services, prescription medicines, and dental care.

Urgent and Routine Care

Members utilized both urgent and routine care services in the last six months. One in three members had an illness, injury, or condition that required urgent medical care (30 percent), and the vast majority of caregivers said they made other appointments for their child's health care at a doctor's office or clinic (85 percent).

Figure 4 shows caregivers' satisfaction with two aspects of timeliness of their child's care: (1) how often members who needed care right away got care as soon as their caregiver thought they needed care; and (2) how often members who did not need care right away got an appointment for health care at their doctor's office or clinic as soon as their caregiver thought they needed care.

Figure 4. Percent of STAR Health Caregivers Who Said Their Child Got Care As Soon As They Thought They Needed Care Regarding...



These two survey items are HHSC Performance Dashboard Indicators:

- *Good Access to Urgent Care.* The vast majority of caregivers reported that their child usually or always received care for an illness, injury, or condition as soon as they thought their child needed care (96 percent). This percentage exceeds the HHSC Dashboard standard of 88 percent.
- *Good Access to Routine Care.* Eighty-four percent of caregivers reported that their child usually or always were able to make a routine appointment as soon as they thought their

child needed an appointment. This percentage surpasses the HHSC Dashboard standard of 76 percent.

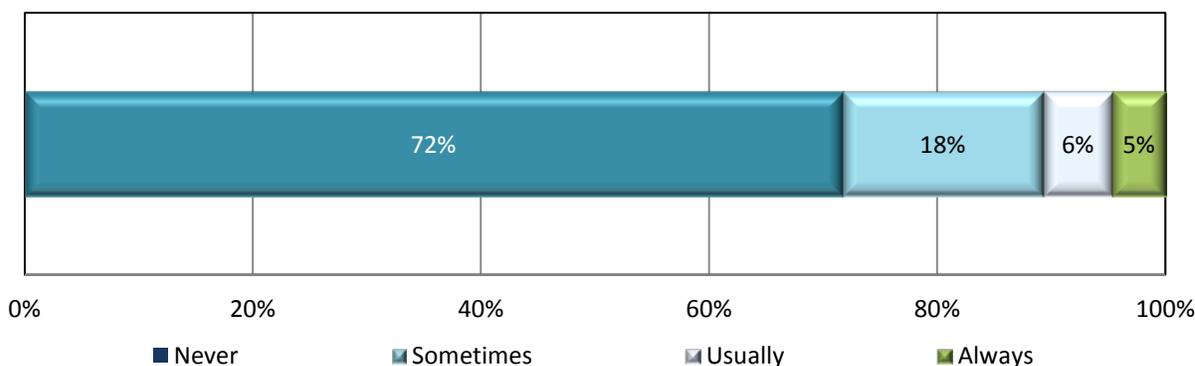
The above indicators also represent the individual items that comprise the CAHPS® composite *Getting Care Quickly*. The vast majority of caregivers reported usually or always having positive experiences with *Getting Care Quickly* for their child (90 percent), which exceeds the 87 percent reported for this composite measure in Medicaid plans nationally.

Getting Care Quickly was also calculated on a 3-point scale following NCQA specifications. The mean score for this CAHPS® composite was 2.62 (SD = 0.72).

Caregivers reported the number of days their child usually had to wait between them making an appointment for routine care and the child actually being seen by a health provider. Over three-fourths of members were able to be seen by a health provider within three days (77 percent); however, a small percentage of members had to wait longer than one week to be seen (13 percent).

Figure 5 shows how often members had to wait for a routine appointment because their provider worked limited hours or had few appointment slots available. Nearly three-fourths of caregivers said their child never had to wait for an appointment due to limited hours (72 percent), about one in five caregivers said their child sometimes had to wait for an appointment (18 percent), and the remaining 11 percent said their child usually or always had to wait.

Figure 5. How Often Members Waited for a Routine Appointment Because Provider Worked Limited Hours or Had Few Available Appointments

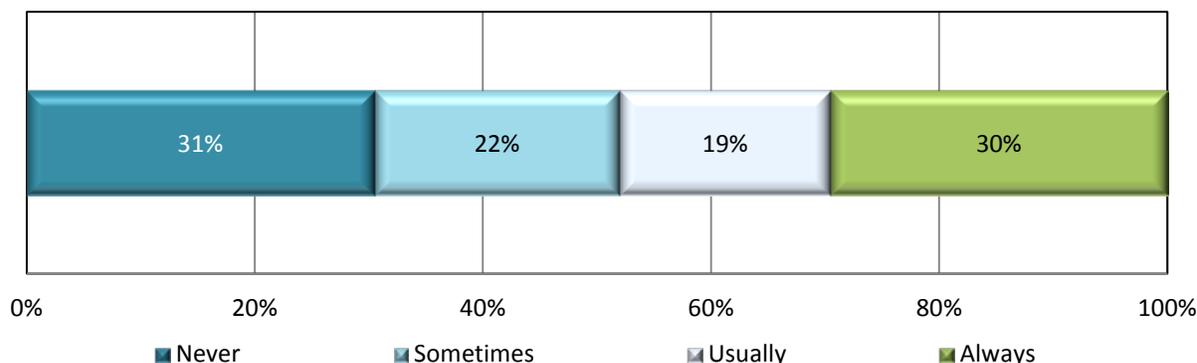


Caregivers were also asked about their experiences seeking after-hours care for their child. Twelve percent said their child needed to visit a doctor's office or clinic for after-hours care and, among these caregivers, a large majority said it was usually or always easy to get after-hours care (86 percent).

Caregivers also reported how often in the past six months their child was seen within 15 minutes of their appointment time (**Figure 6**). This question is an HHSC Dashboard Indicator for the STAR Health program, as shown in **Table B1** in **Appendix B**.

- *No Wait to be Taken to the Exam Room Greater than 15 Minutes.* Overall, 30 percent of members had a wait time of 15 minutes or less before being taken to the exam room, which falls short of the HHSC Dashboard standard of 50 percent.

Figure 6. How Often Members Waited 15 Minutes or Less to be Taken to the Exam Room



Caregivers of children age two or younger were asked about well-child access and timeliness of care. Nearly all children age 2 or younger had visited a doctor or other health provider at some point for a check-up, or for shots, or drops (96 percent), and the vast majority of caregivers said that their child got an appointment for a check-up, or shots or drops as soon as their child needed it.

Last, caregivers were asked about their child’s use of emergency room services. Caregivers reported that one in five members had visited the emergency room at least once in the last six months to get care (19 percent), and six percent of members had visited the emergency room on multiple occasions.

Of caregivers who said their child visited the emergency room at least once, one-third said that they went to the emergency room because they could not get an appointment at a doctor’s office or clinic as soon as they needed one (31 percent).

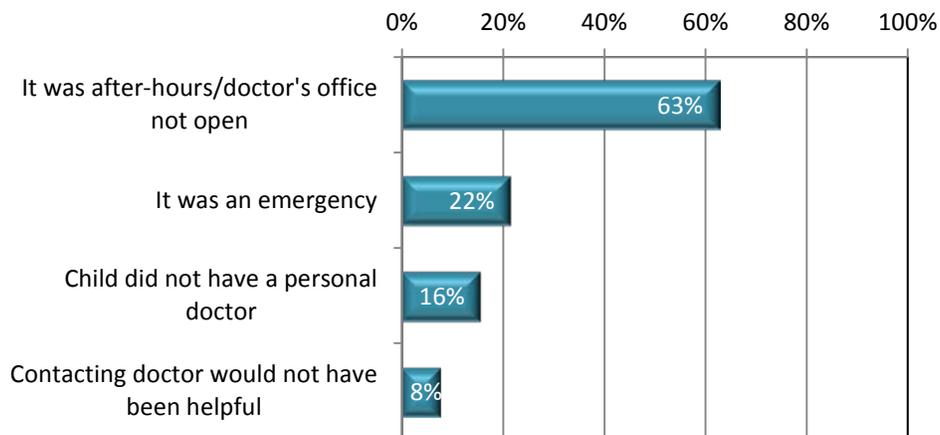
Qualitative analyses (n = 26) revealed that, of doctors who were contacted, 73 percent explicitly advised taking the child to the emergency room. Some caregivers provided the reasons their child’s doctor advised an emergency room visit, which included:

- The doctor’s office lacked the necessary facilities/equipment (16 percent).
- It was after hours and/or the doctor had limited appointments (11 percent).
- The child would need a specialist to look at him or her (11 percent).

Qualitative analyses (n = 51) also revealed reasons why caregivers did not contact the child’s personal doctor before taking their child to the emergency room. **Figure 7** presents the percentage of caregivers who gave each reason. Because some caregivers gave multiple reasons, the percentages add up to more than 100 percent. The most common reason caregivers did not contact their child’s personal doctor before taking their child to the emergency room was because it was after-hours (i.e. the office was closed) (63 percent). Twenty-two

percent of caregivers said that the child needed emergency care and went directly to the emergency room. About one in six caregivers said that their child did not have a personal doctor to contact (16 percent), and about one in ten stated that calling would not have yielded useful information (8 percent).

Figure 7. Percent of Caregivers Who Reported They Did Not Contact Their Child's Personal Doctor Because...



Note. The categories do not add up to 100 percent because some caregivers gave multiple reasons.

About a third of caregivers reported that they used emergency room services because they could not get an appointment with their child's doctor in a timely manner (31 percent).

Caregivers whose child had visited the emergency room in the last six months were asked to rate the care their child received on a scale of 0 to 10 (with 10 being the best possible care). Over half of those members gave a rating of 9 or 10 (55 percent), and the mean emergency room care rating was 8.0 (SD = 2.65).

Access to Specialist Care

Twenty-six percent of caregivers reported that they tried to make an appointment for their child to see a specialist in the last six months. Among these caregivers, three-quarters indicated that it was usually or always easy to get a specialist appointment for their child (75 percent).

Caregivers were also asked about access to specialist referrals for their child. This question is an HHSC Performance Dashboard Indicator.

- *Good Access to Specialist Referrals.* Eighty-four percent of caregivers reported it was usually or always easy to get a referral to a specialist their child needed to see. This percentage exceeds the HHSC Dashboard standard of 75 percent for this indicator.

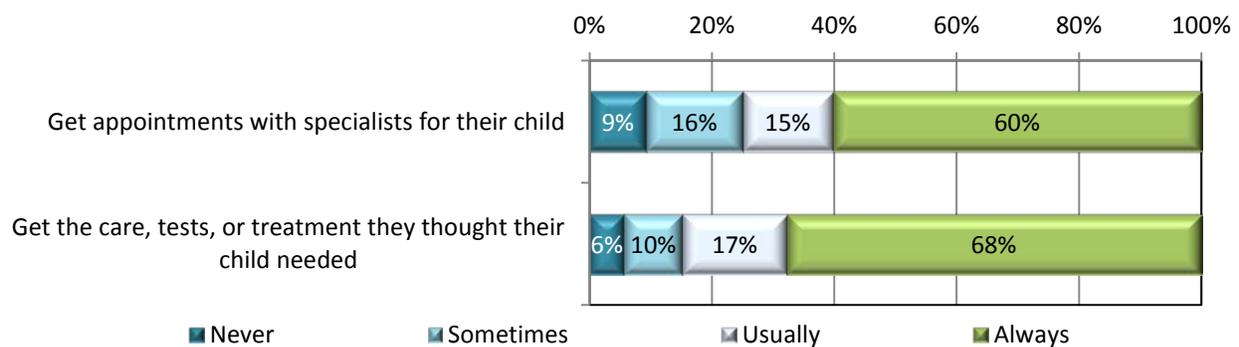
Caregivers were asked to rate their child's specialist on a scale of 0 to 10. Caregivers seemed generally satisfied with their child's specialist, with 63 percent giving a rating of 9 or 10, which is

lower than the national Medicaid average of 67 percent. However, caregivers gave a high mean specialist rating of 8.6 (SD = 2.17).

Figure 8 shows caregiver satisfaction with two aspects of access to needed care: (1) how often it was easy to get appointments with specialists; and (2) how often it was easy to get the care, tests, or treatment they thought they needed through their health plan. These items comprise the CAHPS® composite *Getting Needed Care*. Combining responses to both questions, 80 percent of members usually or always had positive experiences with *Getting Needed Care*, a percentage that is slightly greater than that of the national Medicaid population (79 percent).

Getting Needed Care was also calculated on a 3-point scale following NCQA specifications. The mean score for this CAHPS® composite was 2.49 (SD = 0.74).

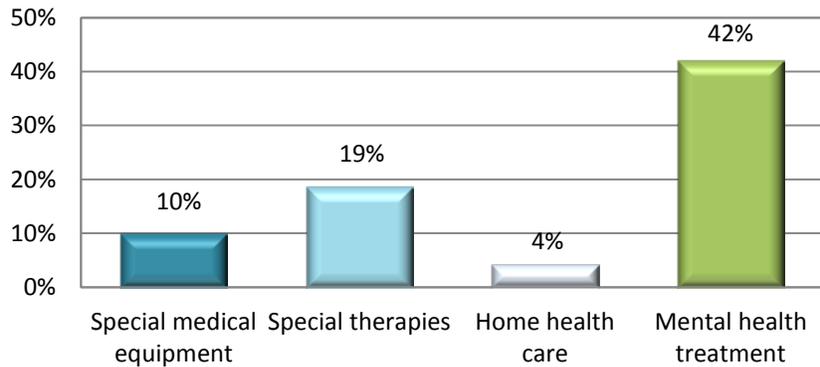
Figure 8. Percent of STAR Health Caregivers Reporting How Often It Was Easy To...



Access to Specialized Services

Over a third of caregivers reported that their child had medical, behavioral, or other health conditions that have lasted for more than three months (39 percent). **Figure 9** shows the percentage of STAR Health members who needed specialized services. The most-utilized specialized services were for mental health treatment (for an emotional, developmental, or behavioral problem) (42 percent), followed by special therapies (such as physical, occupational, or speech therapy) (19 percent). Few members required special medical equipment (such as a walker, nebulizer, or oxygen equipment) (10 percent) or home health care (4 percent).

Figure 9. The Percentage of STAR Health Members Needing Specialized Services

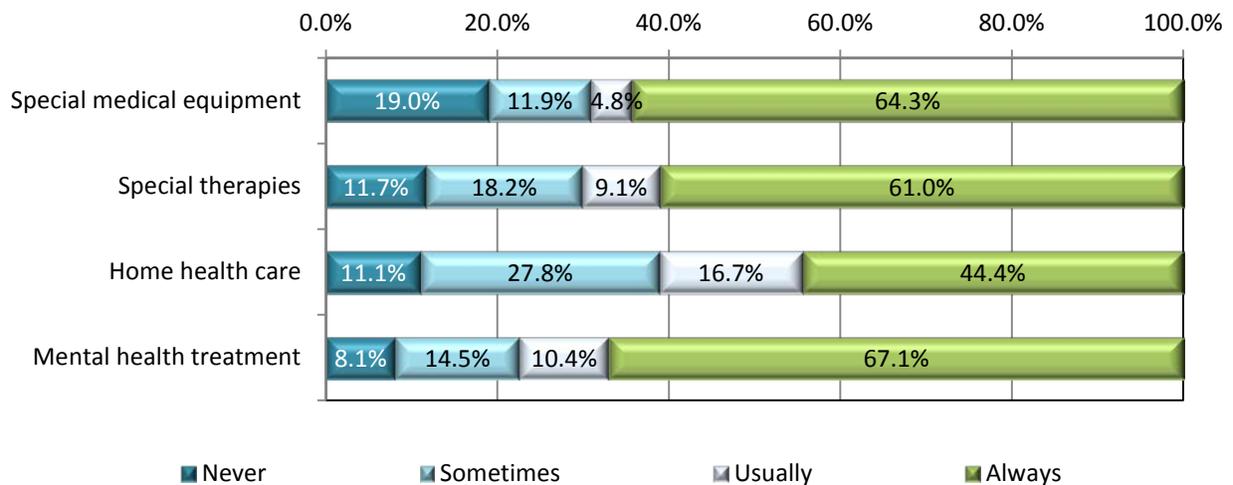


Caregivers who reported that their child used specialized services reported how easy it was to get the specialized services their child needed (**Figure 10**). Good access to specialized services was highest for mental health treatment, with 78 percent of caregivers saying that it was usually or always easy to get needed services, followed by specialized therapies (70 percent), special medical equipment (69 percent), and home health care (61 percent).

Having good access to behavioral health treatment or counseling is an HHSC Performance Dashboard Indicator for STAR Health.

- *Good Access to Behavioral Health Treatment or Counseling.* Seventy-eight percent of STAR Health caregivers whose children needed behavioral health treatment or counseling said it was “usually” or “always” easy to get this treatment. This percentage is similar to the HHSC Dashboard standard of 79 percent for this indicator.

Figure 10. STAR Health Caregiver Responses for How Easy It Was to Get Specialized Services For Their Child



Three of the four above indicators (ease of getting special medical equipment, special therapies, and mental health treatment) comprise the CAHPS® composite *Getting Specialized Services*. Combined, 72 percent of caregivers said they usually or always had positive experiences with *Getting Specialized Services for Their Child*, which is below the 76 percent reported for this composite measure in Medicaid plans nationally.

Getting Specialized Services was also calculated on a 3-point scale following NCQA specifications. The mean score for this CAHPS® composite was 2.41 (SD = 0.82).

Prescription Medicines

Two-thirds of STAR Health caregivers said their child got new prescription medicines or had a medication refilled during the past six months. Among these caregivers, 93 percent said it was usually or always easy to get their child's prescription medicine from their child's health plan, and over half said that someone from their child's health plan, doctor's office, or clinic helped them get their child's prescription medicine (58 percent).

The item that assessed caregiver's ease of obtaining prescription medicines for their child comprises the CAHPS® composite *Prescription Medicines*. The 93 percent of caregivers who said it was usually or always easy to get their child's prescription medicine from their child's health plan exceeds the 90 percent reported for this composite measure in Medicaid plans nationally.

Prescription Medicines was also calculated on a 3-point scale following NCQA specifications. The mean score for this CAHPS® composite was very high at 2.76 (SD = 0.56).

Dental Care

Nine out of ten STAR Health members received dental care in the last six months (89 percent). Of members who received such care, a third went to the dentist on multiple occasions (33 percent). When asked to rate their child's dental care in the last six months on a scale of 0 to 10, 72 percent of caregivers gave a rating of 9 or 10. The mean dental rating was 8.8 (SD = 2.05).

Caregivers' Overall Satisfaction with Their Child's Health Care

When asked to rate their entire child's health care in the past six months on a scale of 0 to 10, 67 percent of members gave a rating of 9 or 10, which exceeds the 64 percent of national Medicaid average who gave a rating of 9 or 10. The mean rating for overall health care from all the STAR Health caregivers was 8.9 (SD = 1.62).

Patient-Centered Medical Home

This section examines caregiver experiences receiving care for their child from a patient-centered medical home model (PCMH). The American Academy of Family Physicians (AAFP) defines the PCMH as a “system of comprehensive coordinated primary care for children, youth and adults.”¹⁸

The PCMH model is built upon the idea that a personal physician coordinates care amongst a team of health care professionals, ensures that patients’ health care needs are being met, and delivers patient-centered care—care that respects the patient’s needs, values, and preferences. More specifically, the PCMH model is comprised of seven principles:¹⁹

- 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 several 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.

Having a Personal Doctor

A vast majority of caregivers reported that their child had a personal doctor (93 percent). Among these children, 53 percent had been going to their personal doctor for at least one year. Forty-seven percent of children had been going to their doctor for less than one year.²⁰

Caregivers were also asked how many times their child had a visit with their personal doctor in the past six months. Ninety-four percent of children had seen their personal doctor one time in the past six months, while 65 percent had visited their doctor on two or more occasions.

Twenty-five percent had visited their doctor on four or more occasions in the past six months.

Seeking Help and Advice

Caregivers were asked a series of questions concerning whether they received the help or advice they needed for their child when they called the doctor's office.

Nearly half of caregivers called their child's personal doctor's office during regular office hours to get help or advice for their child (46 percent). Among these caregivers, ninety percent reported that they usually or always received the help or advice they needed.

Approximately one in ten caregivers sought help or advice for their child after regular office hours (11 percent). Eighty-one percent of these caregivers reported that they received the after-hours help or advice they needed for their child.

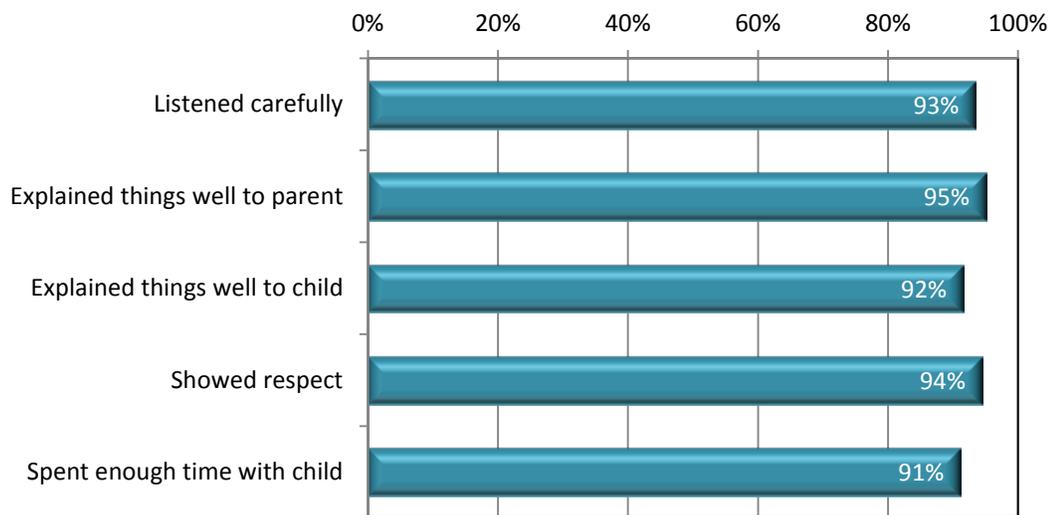
Satisfaction with Doctors' Communication

Several items assessed personal doctors' communication skills and ability to relate to the caregiver and child. Specifically, these items assessed a provider's ability to communicate effectively during visits and to respect caregivers' preferences and needs. These particular skills reflect essential components of patient-centered care.

Doctors' Communication Skills

Caregivers were asked five CAHPS[®] survey questions pertaining to the communication skills of their child's personal doctor. These five items form the composite *How Well Doctors Communicate*, which specifically addresses how often a child's personal doctor listens carefully, explains things well, 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 11**).

Figure 11. How Well Doctors Communicate - The Percentage of Caregivers Who Reported Their Child's Doctor Usually or Always...



A vast majority of caregivers reported that they were usually or always satisfied with the quality of communication they had with their child's personal doctor. Combining responses to all five questions, 94 percent of caregivers usually or always had positive experiences with *How Well Doctors Communicate*. This percentage is slightly higher than the 92 percent reported for Medicaid plans nationally. The mean score for *How Well Doctors Communicate*, following NCQA specifications, was 2.77 out of 3.00.

In addition to items that form the *How Well Doctors Communicate* CAHPS® composite, caregivers were asked additional questions about the communication skills of their child's personal doctor and his or her ability to show respect for their preferences and needs.

- Ninety-five percent reported their child's personal doctor usually or always showed interest in their questions and concerns.
- Ninety-four percent reported that they felt that their child's personal doctor usually or always cared about their child and family.

Doctors' ability to answer caregivers' questions

Caregivers were asked how often their child's personal doctor and other health care providers were able to answer their questions. This item forms the CAHPS® composite *Getting Needed Information*. Ninety percent of caregivers stated that they usually or always had positive experiences with *Getting Needed Information*. This percentage is the same as the Medicaid national average of 90 percent.

The *Getting Needed Information* composite was also calculated on a 3-point scale following NCQA specifications. The mean score for *Getting Needed Information* was 2.74 out of 3.00.

Doctors' ability to communicate about child's health and development

Three survey items assessed members' personal doctors' ability to communicate with caregivers about their child's health and development, for which the CAHPS® *Personal Doctor* composite provides an overall score. Specifically, this composite assesses: 1) whether members' personal doctors discussed developmental issues with caregivers; and 2) whether members' personal doctors were able to understand how medical and behavioral health conditions affect the child's and family's day-to-day life. Ninety percent of caregivers had positive experiences with their child's personal doctors, which is slightly higher than the national rate of 89 percent. Following NCQA specifications, the mean for *Personal Doctor* was also calculated on a scale from 0 to 1. The NCQA mean for *Personal Doctor* was 0.89 out of 1.00.

Overall, a majority of caregivers reported that they were satisfied with the communication skills of their child's personal doctor and his or her ability to be sensitive to their preferences and needs.

Shared Decision-Making

Caregivers were asked questions that assess whether providers involved them in decisions about their child's health care. Thirty-nine percent of caregivers reported that their child's provider informed them that there was more than one choice for their child's treatment or health care. Among these caregivers:

- Ninety-four reported that their provider informed them about the pros and cons of each choice for their child's treatment or health care.
- Eighty-five percent said the provider asked them which choice they thought was best for their child.

Together, these CAHPS® survey items form the composite *Shared Decision-Making*, for which 89 percent of caregivers had positive experiences. Following NCQA specifications, the mean for *Shared Decision-Making* was also calculated on a scale from 0 to 1. The NCQA mean was 0.89 out of 1.00.

Communication about Prescription Medicines

Caregivers were asked a series of questions regarding instructions provided by their child's personal doctor on how to use prescription medicines. Two-thirds of caregivers reported that their child uses prescription medicines (66 percent). Among these caregivers:

- Ninety-four percent said that their child's personal doctor usually or always gave them easy-to-understand instructions on how their child should take his or her medication.
- Nearly half of caregivers said that their child's doctor usually or always suggested ways to help the caregiver or their child remember to take his or her medicine (49 percent).
- Eighty-two percent of caregivers reported that their child's personal doctor explained the side effects of their child's medicines. A vast majority of these caregivers reported that their child's doctor usually or always explained possible side effects in a way that was easy to understand (98 percent).

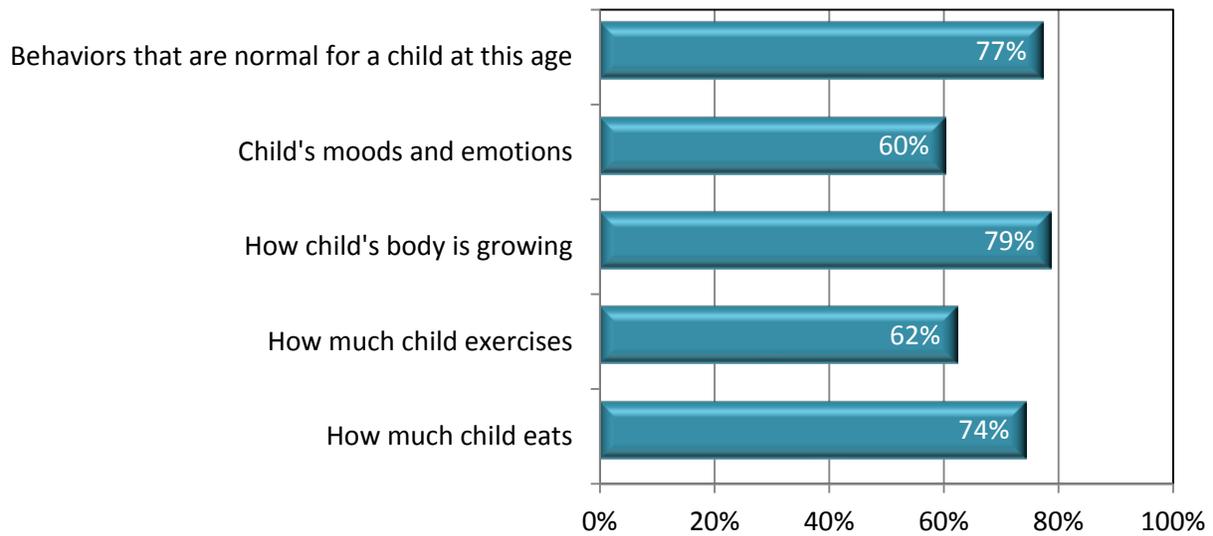
Preventive Care and Health Promotion

Caregivers of children younger than two years of age were asked questions about appointments for check-ups or other health care services. Approximately 4 in 5 caregivers reported that they received reminders from their doctor's office about their child's check-ups (81 percent). In addition, 95 percent of caregivers said they were able to schedule check-ups for their child as soon as they thought he or she needed to be seen by a provider.

Caregivers were asked a set of supplemental CAHPS[®] survey items from the Clinician and Group Surveys to assess caregiver experiences with their child's personal doctor in discussing developmental and preventive care issues. These items reflect important aspects of patient-centered care and the extent to which primary care providers (PCPs) take a "whole-person" approach to providing care. National Medicaid comparative data is not available for these survey items.

Figure 12 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, and behavior.

Figure 12. Developmental and Preventive Care - The Percentage of Caregivers Who Reported That Their Child's Personal Doctor Discussed...



A majority of caregivers reported that they had a discussion about aspects of their child's development with their child's personal doctor. Three in four caregivers reported that their child's personal doctor had a discussion with them regarding their child's growth and physical development during an office visit (79 percent), and 77 percent reported their child's personal doctor had a discussion with them about age-appropriate, normative behavior among children. Sixty percent of caregivers reported that their child's personal doctor had a discussion with them about their child's moods and emotions.

Regarding preventive care, 74 percent of caregivers reported that their personal doctor had a discussion with them about how much or what type of food their child eats. Sixty-two percent of caregivers reported that their doctor had a discussion with them about how much their child exercises.

Preparing Caregivers and CSHCN for Transition to Adulthood

Caregivers were asked several questions that assess whether their personal doctor or other personnel discussed care issues with them that arise as a child with "special needs" reaches adulthood. These questions were asked of a caregiver only if his or her child was 11 years of age or older and met the CSHCN criteria.

Two-thirds of caregivers reported that their child's doctor treats only children (67 percent). Among these caregivers:

- Thirteen percent said that their child's doctor spoke to them about their child eventually having to see providers who treat adults.

- Forty-five percent said that a discussion about doctors who treat adults would have been helpful to them.

Approximately one-third of caregivers reported that their child's doctor spoke with them about the health care needs of their child as he or she becomes an adult (34 percent). Sixty-five percent reported that a discussion of their child's health care needs would have been helpful.

Caregivers were also asked questions about health insurance coverage. One in five reported that someone spoke with them about how to keep or obtain health insurance coverage as their child becomes an adult (21 percent). Among these caregivers, 64 percent reported that a discussion about their child's insurance would have been helpful to them.

Caregivers of children five to ten years of age who met CSHCN criteria were asked two questions concerning how often their child's doctor or other personnel encouraged their child to take responsibility for his or her healthcare needs. Approximately half reported that their child was usually or always encouraged to take responsibility for following medical advice, taking medication, or understanding his or her health (56 percent). Forty-two percent reported that their child was usually or always encouraged to take responsibility for learning about his or her health, or for help with treatments and medications.

Caregiver Rating of Personal Doctor

Caregivers were asked to rate their child's personal doctor on a scale of 0 to 10. Seventy-four percent of caregivers gave a rating of 9 or 10, compared to 72 percent who gave their child's personal doctor a rating of 9 or 10 in Medicaid plans nationally. The mean personal doctor rating for STAR Health was 9.1 (SD = 1.5).

Care Coordination

General Care Coordination

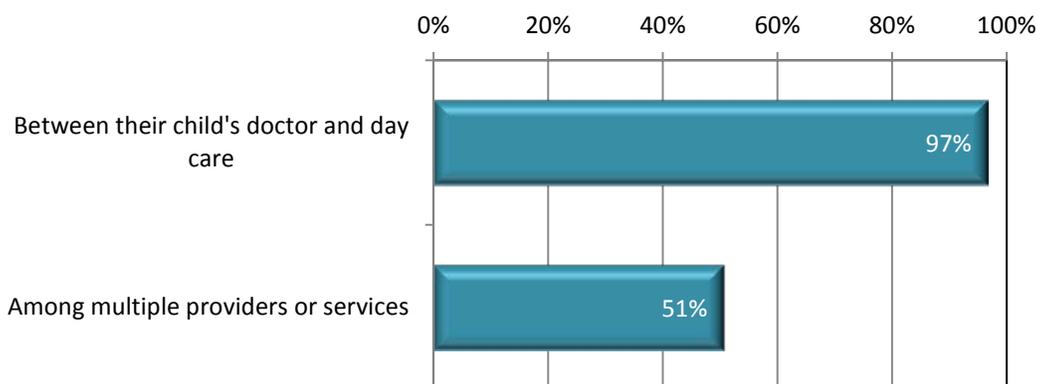
Caregivers were asked several questions that pertained to whether their child had utilized multiple health providers or services and how well these providers communicated with each other on their child's health care services. Forty-one percent of caregivers said that their child received care from a doctor or other health provider other than his or her personal doctor. Similarly, 39 percent of caregivers said that their child received care from more than one kind of health care provider, or used more than one kind of health care service. Among these caregivers, half reported that someone from their child's health plan, doctor's office, or clinic helped coordinate care among different providers and services (51 percent). Furthermore, most caregivers who said that their child received care from a doctor other than their child's personal doctor felt that the child's personal doctor was usually or always up-to-date about the care their child received from other providers (79 percent).

One in ten caregivers said that they needed some form of communication between their child's doctor and the child's school or daycare (10 percent). Of these caregivers, nearly all said that they got the help they needed from the doctor in these communications (97 percent).

Two of the CAHPS[®] survey items above 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. **Figure 13** shows caregivers' responses to the individual items that comprise *Care Coordination*. Combined, 74 percent of caregivers said that they got the care coordination they needed, which is below the 79 percent reported for this composite in the national Medicaid population.

Care Coordination was also calculated on a scale of 0 to 1 following NCQA specifications. The mean score for this CAHPS[®] composite was 0.55 (SD = 0.49).

Figure 13. Percent of Caregivers Who Reported That They Got the Coordination They Needed...



Service Management

One feature of the STAR Health program is service management, a more formal type of care coordination that involves a service manager who coordinates the health care services children receive if management is needed. Thirty-eight percent of caregivers said they received a call to assess the need for service management. Of caregivers who did receive a call, nearly half said that the service manager recommended service management for their child's health care needs (44 percent). Service managers who recommended service management communicated effectively, as 96 percent of caregivers said they understood how service management would facilitate coordination of their child's health care services. Nearly all caregivers for whose child service management was recommended agreed to participate in the program (96 percent).

Among caregivers who agreed to participate, more than half said they had received service management for their child in the last six months (59 percent). Of these caregivers, three out of four were either satisfied or very satisfied with the care coordination (77 percent).

Health Plan

The survey assessed caregivers' experiences and satisfaction with various aspects of their child's health plan, including health plan information and customer service; approval for care, tests, or treatment; and transportation services.

Health Plan Information and Customer Service

About one in six members said they tried to get help or information from their child's health plan's customer service in the past six months (17 percent).

Of caregivers who said they called customer service:

- Forty percent said it took them one call to get the help or information they wanted
- About half said it took them two or more calls to get the help or information they wanted (47 percent)
- One in eight said they were still waiting for help (13 percent)

Nearly two-thirds of caregivers said they usually or always got the help or information they needed from the customer service staff at their child's health plan (61 percent). Nearly one in four said that they never got the information they needed (23 percent). Ninety percent reported that customer service staff at their child's health plan usually or always treated them with courtesy and respect.

The above items pertaining to how often customer service gave members the help or information they needed, and how often customer service treated members with courtesy and respect, comprise the CAHPS[®] composite *Health Plan Information and Customer Service*. Combining responses to both questions, 75 percent of STAR Health caregivers usually or always had positive experiences with *Health Plan Information and Customer Service*, which is less than the 83 percent reported for Medicaid plans nationally. *Health Plan Information and Customer Service* was also calculated on a 3-point scale following NCQA specifications. The mean score for this CAHPS[®] composite was 2.35 (SD = 0.71).

Health Plan Approval

Over a third of caregivers said they tried to get care, tests, or treatment for their child through the STAR Health Superior HealthPlan in the past six months (38 percent). A vast majority said it was usually or always easy to get the care, tests, or treatment their child needed through their child's health plan (85 percent). The percentage of caregivers who experienced no delays for health plan approval is an HHSC Performance Dashboard Indicator for STAR Health:

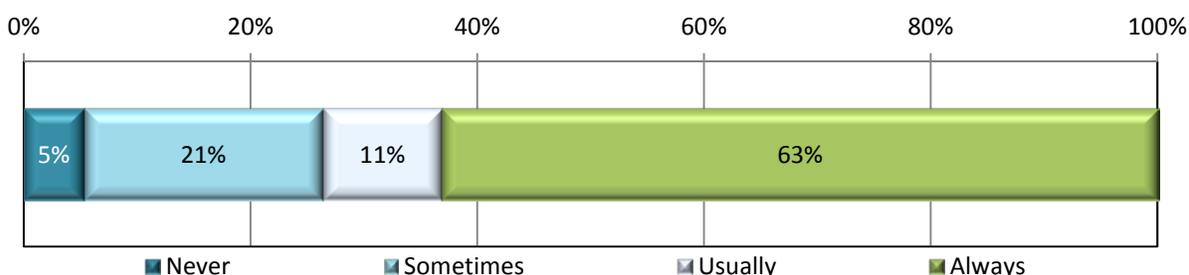
- *No Delays for an Approval*: Sixty-nine percent of STAR Health caregivers reported having no delays in their health care while waiting for approval from their health plan. This percentage meets the HHSC Dashboard standard of 69 percent for this indicator.

Transportation

About one in ten caregivers said that they phoned their STAR Health plan to facilitate transportation for their child in the last six months (12 percent). Among those who made calls for such assistance, about half said they usually or always received the transportation services they needed (63 percent), but one in five said they never got the help they needed for their child (21 percent). **Figure 14** shows how often members' health plans met caregivers' transportation needs:

- Three out of four said the transportation help they received for their child usually or always met their needs (74 percent).
- About one in five said the transportation help sometimes met their needs (21 percent).
- A very low percentage said the transportation help never met their needs (5 percent).

Figure 14. How Often Caregivers Said That Transportation Help for their Child Met Their Needs



Of caregivers who did not call their child's health plan for transportation assistance, 18 percent said that they did not know such assistance was available.

Caregivers' Satisfaction with Their Child's Health Plan

When asked to rate their child's STAR Health MCO (Superior HealthPlan) on a scale of 0 to 10, 71 percent of caregivers gave a rating of 9 or 10, which exceeds the percentage of the national Medicaid population who gave their health plan a rating of 9 or 10 (67 percent). The mean health plan rating was very high at 8.9 (SD = 1.7).

Prior-year Comparisons

Table 1 shows scaled averages of the 10 CAHPS® Composite measures for STAR Health in fiscal year 2010 and fiscal year 2012, using modified NCQA specifications.²¹ Compared to 2010, performance was significantly better for *Getting Needed Care* in 2012.

Table 1. CAHPS® Composite Measures in 2010 and 2012

	2010 mean	2012 mean	<i>t</i>	<i>p</i> -value	<i>d</i>
Getting Needed Care	2.27	2.49	2.72	< 0.01	0.28
Getting Care Quickly	2.68	2.62	1.02	ns	-
How Well Doctors Communicate	2.76	2.77	0.40	ns	-
Customer Service	2.45	2.35	0.94	ns	-
Prescription Medicines	2.68	2.76	1.56	ns	-
Getting Specialized Services	2.42	2.41	0.20	ns	-
Personal Doctor	0.87	0.89	0.90	ns	-
Shared Decision-Making	0.93	0.89	1.68	ns	-
Getting Needed Information	2.72	2.74	0.42	ns	-
Care Coordination	0.48	0.55	1.31	ns	-

Table 2 shows results for the six HHSC Performance Dashboard Indicators for STAR Health in fiscal year 2010 and fiscal year 2012, as well as the HHSC performance standards for 2012 (there were no standards as of 2010). Since 2010, a lower proportion of caregivers reported that their child usually or always had good access to routine care. However, the percentage of members who had good access to routine care (84 percent) still exceeds the HHSC Dashboard Standard (76 percent). Also since 2010, a higher proportion of caregivers reported that their child usually or always had good access to urgent care; this increase brought good access to urgent care from just meeting the HHSC Dashboard standard to exceeding it. Lastly, since 2010, a higher proportion of caregivers reported that their child had no exam room wait great than 15 minutes; however, the percentage of members with a wait time of 15 minutes or less (30 percent) fell short of the HHSC Dashboard (50 percent).

Table 2. HHSC Performance Dashboard Indicators in 2010 and 2012

	2010	2012	Chi-square	p-value	ϕ	HHSC standard
Good access to routine care	96%	84%	11.88	= 0.001	0.16	76%
Good access to urgent care	88%	96%	6.49	= 0.01	0.12	88%
Good access to specialist referral	75%	84%	2.44	ns	-	75%
No delays for an approval	69%	69%	0.00	ns	-	69%
Wait to be taken to the exam room > 15 minutes	22%	30%	6.09	= 0.01	0.09	50%
Good access to behavioral health treatment or counseling	79%	78%	0.14	ns	-	79%

Table 3 shows results for the four global ratings for STAR Health in fiscal year 2010 and fiscal year 2012, as well as the national Medicaid averages for these ratings in 2010 and 2012. The percentages reflect the proportion of caregivers who gave a rating of 9 or 10 (out of 10) for each rating. Since 2010, a significant proportion of caregivers gave ratings of 9 or 10 for their child's overall health care and health plan.

Table 3. Global Ratings in 2010 and 2012

	2010	2012	Chi-square	p-value	ϕ	National Medicaid Average 2010	National Medicaid Average 2012
Health Care	57%	67%	8.70	< 0.01	0.11	60%	64%
Personal Doctor	69%	74%	1.59	ns	-	69%	72%
Specialist	66%	63%	0.25	ns	-	65%	67%
Health Plan	55%	71%	22.98	< 0.001	0.17	64%	67%

Summary Points and Recommendations

This report provides results from the fiscal year 2012 STAR Health Member Survey regarding the following domains:

- Demographic and household characteristics of STAR Health caregivers and members
- The health status of STAR Health members, including physical and mental health, BMI, and whether they qualify as having special needs (CSHCN)
- Caregivers' 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 a usual source of care, providers' communication, preventive care and health promotion, and shared decision-making
 - Aspects of care coordination, including utilization and satisfaction with service management
 - Experiences with their child's health plan, including health plan information, customer service, and transportation

Demographic Information

- **Caregiver and Household Characteristics.** The average age of STAR Health caregivers was 48, and the majority of caregivers sampled was female (87 percent). The most common race of caregivers was White, non-Hispanic (41 percent), followed by Hispanic (29 percent), and Black, non-Hispanic (27 percent).
- Most care caregivers held at least a high school degree (81 percent), and over half had some college education (56 percent).
- The majority of caregivers were married (59 percent), while 18 percent were single, and 13 percent were divorced or separated. Most members were being cared for in a two-parent household (63 percent).
- **Member demographics.** A small majority of the members were male (51 percent), and the mean age of members was 7 years old. The largest racial/ethnic group of members was Hispanic (41 percent), followed by White, non-Hispanic (28 percent), and Black, non-Hispanic (27 percent).
- The most commonly spoken language in households, both for members and their caregivers, was English (94 percent for each), followed by Spanish (6 percent for caregivers and 4 percent for members).

Health status

- **Overall health and mental health.** Over two-thirds of children had excellent or very good overall health (68 percent), and only one in ten children had fair or poor overall health (9 percent).
- Nearly two-thirds of children had excellent or very good mental health (60 percent), and about one in five children had fair or poor mental health (17 percent).
- **Special Health Care Needs.** Forty-eight percent of members were identified as having “special needs” according to the CSHCN Screener.[®] About a third of children had emotional, developmental, or behavioral problems that required counseling (36 percent); were dependent on prescribed medicine (35 percent); or had higher medical care, mental health, or educational service needs than most children of the same age (29 percent). Less than twenty percent of children were limited in their ability to do things compared with others their age (16 percent), or required special therapy, such as physical, occupational, or speech therapy (14 percent).
- **Body mass index.** About a third of members were classified as obese (30 percent), and an additional 17 percent were classified as overweight. Reported obesity rates were higher than national and Texas averages (17 percent and 20 percent, respectively). Obesity rates were similar for boys (34 percent) and girls (26 percent), and similar for Hispanic (34 percent); White, non-Hispanic (33 percent); and Black, non-Hispanic (21 percent) members.

Access to and timeliness of care

- **Getting care quickly.** The vast majority of caregivers reported usually or always having positive experiences with *Getting Care Quickly* for their child (90 percent), which exceeds the 87 percent reported for this composite measure in Medicaid plans nationally. The mean score for *Getting Care Quickly* was 2.62 (SD = 0.72).
- **Good access to urgent care.** Nearly all caregivers reported that their child usually or always received care for an illness, injury, or condition as soon as they thought their child needed (96 percent). This percentage surpasses the HHSC Dashboard standard of 88 percent.
- **Good access to routine care.** Eighty-four percent of caregivers reported that they usually or always were able to make a routine appointment as soon as they thought their child needed. This percentage is surpasses the HHSC Dashboard standard of 76 percent.
- **Appointment availability and provider hours.** Over three-fourths of members were able to be seen by a health provider within three days (77 percent), and a small percentage of members had to wait longer than one week to be seen (13 percent). Seventy-two percent of members reported never having appointment delays caused by limited hours or few appointments, 18 percent reported that they sometimes waited; however, 11 percent reported that they usually or always waited for an appointment.

- **Office wait** - Thirty percent of members did not have a wait greater than 15 minutes before being taken to the exam room, which falls short of the HHSC Dashboard standard of 50 percent.
- **Emergency room care.** One-fifth of members had visited the emergency room at least once in the last six months to get care (19 percent). About a third of caregivers reported that they used emergency room services because they could not get an appointment with their doctor in a timely manner (31 percent). On a scale from 0 to 10, over half of members gave their emergency room care a rating of 9 or 10 (55 percent), with an average of 8.0 (SD = 2.65).
- Caregivers who contacted their child's personal doctor before going to the emergency room (ER) (n = 26) typically said the doctor told them to bring their child to the ER (73 percent). Among caregivers who did not contact their child's personal doctor before going to the ER (n = 51), the most common reasons for not contacting the child's doctor were either that it was after-hours (63 percent) or that the child's care was an emergency (22 percent).
- **Access to specialist care.** About one in four caregivers of members reported that they tried to make an appointment for their child to see a specialist in the last six months (26 percent). Among these caregivers, three quarters indicated that it was usually or always easy to get a specialist appointment for their child (75 percent). Members rated their specialist on a scale from 0 to 10, with an average rating of 8.6 (SD = 2.17). About two-thirds of members gave their specialist a rating of 9 or 10 (63 percent), which is just short of the national Medicaid average of 67 percent.
- **Good access to specialist referral.** Eighty-four percent of caregivers reported it was usually or always easy to get a referral to a specialist their child needed to see. This percentage exceeds the HHSC Dashboard standard of 75 percent for this indicator.
- **Getting needed care.** Eighty percent of members usually or always had positive experiences with *Getting Needed Care*, a percentage that is just greater than that of the national Medicaid population (79 percent). The mean score for *Getting Needed Care* was 2.49 (SD = 0.74).
- **Access to specialized services.** The most-utilized specialized services were for mental health treatment (for an emotional, developmental, or behavioral problem) (42 percent), followed by special therapies (such as physical, occupational, or speech therapy) (19 percent). Few members required special medical equipment (such as a walker, nebulizer, or oxygen equipment) (10 percent) or health home care (4 percent). Good access to specialized services was highest for mental health treatment, with 78 percent of caregivers saying that it was usually or always easy to get needed services, followed by specialized therapies (70 percent), special medical equipment (69 percent), and home health care (61 percent).

- **Good access to behavioral health treatment and counseling.** Seventy-eight percent of STAR Health caregivers whose children needed behavioral health treatment and counseling said it was “usually” or “always” easy to get this care. This percentage is similar to the HHSC Dashboard standard of 79 percent for this indicator.
- **Getting specialized services.** Nearly three in four caregivers said they usually or always had positive experiences with *Getting Specialized Services* (72 percent), which is below the 76 percent reported for this composite measure in Medicaid plans nationally. The mean score for *Getting Specialized Services* was 2.41 (SD = 0.82).
- **Access to prescription medicines.** Two-thirds of STAR Health caregivers said their child got new prescription medicines or had a medication refilled during the past six months. Ninety-three percent of caregivers usually or always had positive experiences with *Prescription Medicines*, which exceeds the 90 percent reported for this composite measure in Medicaid plans nationally. The mean score *Prescription Medicines* was very high at 2.76 (SD = 0.56).
- **Dental care.** Nine out of ten STAR Health members received dental care in the last six months (89 percent). Of members who received such care, a third went to the dentist on multiple occasions (33 percent). When asked to rate their child’s dental care in the last six months on a scale of 0 to 10, 72 percent of caregivers gave a rating of 9 or 10. The mean dental rating was 8.8 (SD = 2.05).
- **Members’ rating of all their health care.** Members rated their child’s overall health care in the past six months on a scale from 0 to 10, with an average rating of 8.9 (SD = 1.62). Sixty-seven percent of members gave a rating of 9 or 10, which exceeds the 64 percent of national Medicaid average who gave a rating of 9 or 10.

Patient-Centered Medical Home

- **Having a personal doctor.** A vast majority of caregivers reported that their child has a personal doctor (93 percent). Among these caregivers, 53 percent reported that their child had been going to their personal doctor for at least one year. Ninety-four percent of children had seen their personal doctor in the past 6 months.
- **Seeking help and advice.** Approximately half of caregivers called their child's personal doctor's office during regular office hours (46 percent). Among these caregivers, 90 percent reported that they usually or always receive the help or advice they needed. Eleven percent of caregivers sought after-hours help for their child. Among these caregivers, 81 percent said they received the after-hours help or advice they needed.
- **How Well Doctors Communicate.** Ninety-four percent of caregivers reported that they usually or always had positive experiences with *How Well Doctors Communicate*. This is slightly higher than the national Medicaid average of 92 percent. The mean score for *How Well Doctors Communicate* was 2.77 out of 3.00.
- **Getting Needed Information.** A vast majority of caregivers had positive experiences with *Getting Needed Information* (90 percent), which is equal to the national average of 90 percent. The mean score for *Getting Needed Information* was 2.74 out of 3.00.
- **Personal Doctor.** Ninety percent of caregivers said that they usually or always had positive experiences with their child's doctor, as assessed by the CAHPS® composite *Personal Doctor*. This is slightly higher than the Medicaid national average of 89 percent. The mean rating for *Personal Doctor* was 0.89 out of 1.00.
- **Shared Decision-Making.** Approximately 9 in 10 caregivers had positive experiences with *Shared Decision-Making* (89 percent). On a scale from 0 to 1, the mean score for *Shared-Decision Making* was 0.89.
- **Communication about Prescription Medicines.** Ninety-four percent of caregivers reported that their child's doctor usually or always gave them easy-to-understand instructions on how their child should take his or her medicine, and 98 percent of caregivers reported that their child's personal doctor usually or always explained side effects in a way that was easy to understand. Forty-nine percent of caregivers said that their child's doctor usually or always suggested ways to help the caregiver or their child remember to take his or her medicine.
- **Preventive care and health promotion.** Approximately four in five caregivers reported that they received reminders about check-up appointments for their child (81 percent). Furthermore, 95 percent of caregivers said that they were able to schedule check-ups for their child as soon as they thought they needed one.
- Caregivers reported that 60 percent of doctors discussed their child's moods and emotions. In addition, 62 percent of caregivers discussed how much their child exercises.

- **Preparing caregivers and CSHCN for transition to adulthood.** Thirteen percent of caregivers said their child's doctor spoke to them about their child eventually having to see providers who treat adults, and 34 percent of caregivers said that their child's personal doctor spoke to them about the health care needs of their child as he or she becomes an adult. Approximately 1 in 5 caregivers reported that their child's doctor spoke to them about how to keep or obtain health insurance coverage as their child becomes an adult (21 percent).
- Approximately half of caregivers reported that their child's personal doctor encouraged their child to take responsibility for following medical advice, taking medication, or understanding his or her health (56 percent). Furthermore, 42 percent of caregivers reported their child was encouraged to take responsibility for learning about his or her health, or for help with treatments and medications.
- **Caregiver rating of personal doctor.** On a scale from 1 to 10, 74 percent of caregivers gave their child's personal doctor a rating of 9 or 10. The mean personal doctor rating for STAR Health was 9.1 (SD=1.5).

Care coordination

- **General care coordination.** Forty-one percent of caregivers said that their child received care from a doctor or other health provider other than his or her personal doctor, and 39 percent of caregivers said that their child received care from more than one kind of health care provider, or use more than one kind of health care service.
- Half of caregivers reported that someone from their child's health plan, doctor's office, or clinic helped coordinate care among different providers and services (51 percent), and most caregivers said their child's personal doctor was up-to-date when their child received care elsewhere (79 percent).
- **Care coordination.** Three in four caregivers said that they got the care coordination they needed (74 percent), which is lower than the 79 percent reported for this composite in the national Medicaid population. The mean score for *Care Coordination* was 0.55 on a scale from 0 to 1 (SD = 0.49).
- **Service management.** Thirty-eight percent of caregivers said they received a call asking whether their child needed service management. When service management was recommended by the service manager, nearly all caregivers agreed to participate in the program (96 percent).
- Among caregivers who agreed to participate, about half said they had received any service management for their child in the last six months (59 percent). Of these caregivers, three out of four were either satisfied or very satisfied with the care coordination (77 percent).

Health plan

- **Health plan information and customer service.** Three out of four caregivers usually or always had positive experiences on the CAHPS® composite *Health Plan Information and Customer Service* (75 percent), which is below the national average of 83 percent. The mean score for *Health Plan Information and Customer Service* was 2.35 (SD = 0.71). Seventeen percent of caregivers said they called their child's health plan's customer service for help or information, and nearly half of these caregivers said they received all the information they needed in one call (40 percent). A large majority of members said that customer service treated them with courtesy and respect (90 percent).
- **Health plan approval.** Thirty-eight percent of caregivers said they tried to get care, tests, or treatment for their child through their child's health plan in the last six months, and most caregivers said that it was usually or always easy to get the care their child needed (85 percent). Over two-thirds of caregivers reported having no delays in health care while waiting for health plan approval (69 percent), which meets the HHSC Dashboard standard of 69 percent.

- **Transportation.** One in ten caregivers requested transportation assistance for their child (12 percent); of these members, half said they usually or always got the services they needed (52 percent), and three out of four said that the transportation assistance their child received met their needs (74 percent). One out of five caregivers who did not call for transportation assistance for their child said they did not do so because they were unaware of the service (18 percent).
- **Caregivers' rating of their health plan.** On a scale from 0 to 10, 71 percent of caregivers gave their child's health plan a rating of 9 or 10, which exceeds the 67 percent of the national Medicaid population who gave their health plan a rating of 9 or 10. Caregivers' gave their child's health plan an average rating of 8.9 (SD = 1.73).

Recommendations

The EQRO recommends the following strategies to Texas HHSC and the STAR Health MCO for improving the delivery and quality of care for STAR Health members:

Obesity among STAR Health members. Thirty percent of all STAR Health members were obese, a percentage higher than that among children and adolescents nationally (17 percent) or in Texas (20 percent). Furthermore, 62 percent of caregivers said their child's doctor discussed how much their child exercises during visits. Members with special needs (CSHCN) were significantly less likely than members with no special needs to have had their doctor discuss their dietary consumption (amount and kind of food). These findings suggest a need to address the rate of obesity among STAR Health members.

The EQRO recommends that Superior HealthPlan implement or improve upon communication efforts and measurement of members' obesity. Potential strategies include: making discussion of both food intake and exercise during every well-child checkup mandatory, and initiating unobtrusive interventions such as keeping food and exercise diaries to increase awareness and accountability.²² Because the stigma against obesity in children is increasing²³ and can cause embarrassment, interventions should aim to be relatively inconspicuous.

Service management outreach. Slightly more than one-third of caregivers of members who had medical, behavioral, or other health conditions that have lasted for more than three months (38 percent) said they received a call from a service manager to assess their child's health care needs. The EQRO recommends that Superior HealthPlan investigate the need to improve service management outreach to STAR Health caregivers. Assessment of the following information could be useful in improving outreach: (1) The service management density—number of service managers per 1,000 STAR Health members; (2) Service manager caseloads in each region of the state; (3) The job responsibilities of service managers; and (4) Barriers (for caregivers and service managers) to receiving calls about service management.

The EQRO also recommends that HHSC and Superior HealthPlan monitor the following areas, based on findings of low member satisfaction in domains that do not directly address the overarching goals. Continued issues with quality of care in these domains may warrant additional studies and their eventual inclusion in MCO performance improvement projects.

- *Continuity of personal doctor.* Nearly half of children in STAR Health had been going to their personal doctor for less than one year (47 percent). STAR Health should determine the factors that contribute to the absence of long-term relationships between personal doctors and members. Possible factors include: a large percentage of new enrollees in STAR Health who have recently started going to their personal doctor, and an issue with health care satisfaction—caregivers could be switching personal doctors because they are not satisfied with the quality of care their child is receiving from his or her doctor. Furthermore, these results could reflect a systematic issue among most foster children regarding continuity of coverage, as foster care children often experience disruptions in their Medicaid coverage.²⁴
- *Transition to adult care.* Among children 11 years of age or older who met the criteria for CSHCN, 13 percent of providers spoke with caregivers about their child having to eventually see providers who treat adults. STAR Health needs to determine the reasons for the low rate of discussion about transition to adult care.

Appendix A. Detailed Methodology

Sample Selection Procedures

The EQRO selected survey participants from a random sample of children and adolescents 17 years of age and younger who were enrolled in STAR Health in Texas for six continuous months or longer between December 2011 and May 2012. Following CAHPS[®] specifications, members having no more than one 30-day break in enrollment during this period were included in the sample. This criterion was chosen to ensure that the caregiver had sufficient history with their child's health care to respond to the survey questions.

It is important to note that the minimum enrollment criterion of six months excludes caregivers of children in less stable foster care placements. Children in foster care who move from one placement to another may have different health status, health care needs, and health care experiences than those in more established placements. This potential selection bias should be taken into consideration when interpreting the survey results.

The EQRO set a target of 400 completed telephone interviews with caregivers of sampled members. This sample size was selected to provide a reasonable confidence interval for the survey responses. Using a 95 percent confidence interval, the responses provided in the tables and figures are within ± 4.8 percentage points of the "true" responses in the STAR Health member population.

Enrollment data from the Superior HealthPlan Network, which administers the STAR Health Program in Texas, were used to identify the children who met the sample selection criteria and to obtain their contact information. Member names, mailing addresses, and telephone contact information for 3,200 eligible STAR members were collected and provided to interviewers. For households with multiple children enrolled in STAR Health, one member from the household was randomly chosen to be included in the sample. Member age, sex, and race/ethnicity were also collected from the enrollment data to allow for comparisons between respondents and non-respondents and identify any participation biases in the final sample.

Survey instruments

The fiscal year 2012 STAR Health Survey is comprised of:

- The CAHPS[®] Health Plan Survey 4.0 (Medicaid module)²⁵
- The CSHCN Screener[®] ²⁶
- Items from the NS-CSHCN, addressing transition to adult care for CSHCN ²⁷
- Items from the CAHPS[®] Clinician and Group Surveys²⁸
- Items developed by ICHP pertaining to caregiver and member demographic and household characteristics
- Items developed by the Texas Department of Family and Protective Services (DFPS) pertaining to service management

The CAHPS® Health Plan Survey is a widely used instrument for measuring and reporting consumers' experiences with their child's health plan and providers. The STAR Health Member Survey uses the Medicaid module of the CAHPS® survey and includes both the core questionnaire and supplemental items. The survey instrument is divided into six primary 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 domains:

- *Getting Needed Care*
- *Getting Care Quickly*
- *How Well Doctors Communicate*
- *Health Plan Information and Customer Service*
- *Personal Doctor*
- *Prescription Medicines*
- *Getting Specialized Services*
- *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.²⁹ 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 those 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 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 **Tables B1-B4** in Appendix B.

In addition, items from the CAHPS[®] Clinician and Groups Surveys were included in the STAR Health Survey. The selected items assess the quality of pediatric care with regard to health literacy and physician-initiated discussions with caregivers about child development 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 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.³⁰ 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.

Six survey questions function as indicators of health plan performance for STAR Health members, as listed on HHSC's Performance Indicator Dashboard for calendar year 2012.³¹ These include: (1) Good access to urgent care; (2) Good access to specialist referral; (3) Good

access to routine care; (4) No delays in health care while waiting for health plan approval; (5) No exam room wait greater than 15 minutes; (6) Good access to behavioral health treatment or counseling.

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.^{32,33,34}

Respondents were also asked to report their child's height and weight. These questions allow calculation of the child's 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 3,200 sampled STAR Health members, requesting their participation in the survey. Of the advance letters sent, 5 were returned undeliverable.

The EQRO contracted with the National Opinion Research Center (NORC) at the University of Chicago to conduct the surveys using computer-assisted telephone interviewing (CATI) between June 2012 and August 2012. NORC telephoned STAR Health members seven days a week between 9 a.m. and 9 p.m. Central Time. Up to 25 attempts were made to reach a member before the member's phone number was removed from the calling circuit. If a respondent was unable to complete the interview in English, NORC referred the respondent to a Spanish-speaking interviewer.

Attempts were made to contact 3,200 STAR Health members sampled for the survey. No financial incentives were offered to participate in the surveys. Fifty percent of families could not be located. Among those located, five percent indicated that the child was not enrolled in STAR Health and four percent refused to participate. The response rate was 73 percent and the cooperation rate was 91 percent.

To test for participation bias, the distributions of members' 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. No significant differences were found between respondents and non-respondents for any of these factors.

Data analysis

Descriptive statistics and statistical tests were performed using SPSS 19.0 (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.

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 comparison of frequencies and means between 2010 and 2012 results, and among different demographic sub-groups within the sample. Differences were considered to be statistically significant at $p < 0.05$. For Chi-square tests that showed significant differences between groups, the Phi coefficient was also calculated as a post-hoc test to determine the degree of association between the groups.

BMI was calculated by dividing the child’s weight in kilograms by their height in meters squared. BMI could be calculated for 360 children in the sample (87 percent) for whom height and weight data were complete. Height data were missing for 44 children (11 percent), and weight data were missing for 16 children (4 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:³⁵

- 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 90 children whose BMI deviated considerably from age- and sex-specific child growth standards provided by the World Health Organization.^{36,37} 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 or caregiver recall.

Lastly, the EQRO conducted a multivariate analysis to examine the association of demographic factors on positive experiences with four CAHPS[®] composite domains – *Getting Needed Care*, *Getting Specialized Services*, *Prescription Medicines*, and *Care Coordination*. The detailed methodology and results for this analysis can be found in Appendix C of this report.

Appendix B. Supplementary Tables and Figures

Table B1. Core CAHPS® Composite Scores by STAR Health Caregiver Race/Ethnicity and Education

	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service
Caregiver Race/Ethnicity				
Hispanic	2.48	2.47 ^a	2.75	2.35
White, NH	2.53	2.72 ^b	2.78	2.29
Black, NH	2.50	2.59 ^{ab}	2.76	2.45
F significance *	N.S.	= 0.03**	N.S.	N.S.
Caregiver Education				
Less than high school degree	2.81	2.38 ^a	2.85 ^a	2.45
High school degree or GED	2.41	2.64 ^b	2.68 ^b	2.40
Some college or college degree	2.47	2.68 ^b	2.78 ^{ab}	2.28
F significance *	N.S.	= 0.02***	< 0.07****	N.S.

* In the case of a significant F, post hoc pairwise comparisons were performed. Superscripts denote statistical significance of these comparisons. Means within a column that share a common superscript do not significantly differ from one another; means within a column that have different superscripts significantly differ from one another.

** Hispanic vs. White, $p < 0.01$, $d = 0.34$

*** Less than high school degree vs. High school degree or GED, $p = 0.03$, $d = 0.32$; Less than high school degree vs. Some college or college degree, $p < 0.01$, $d = 0.38$

**** Less than high school degree vs. High school degree or GED, $p = 0.02$, $d = 0.39$

Table B2. Core CAHPS® Composite Scores by STAR Health Member Race/Ethnicity, Age, and CSHCN Status

	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service
Member Race/Ethnicity				
Hispanic	2.48	2.56	2.75	2.30
White, NH	2.55	2.75	2.80	2.35
Black, NH	2.42	2.59	2.78	2.47
F significance *	N.S.	N.S.	N.S.	N.S.
Child Age				
Age 4 or younger	2.64 ^a	2.67	2.80	2.41
Age 5 thru 10	2.41 ^{ab}	2.59	2.73	2.48
Age 11 or older	2.35 ^b	2.58	2.77	2.11
F significance *	< 0.06**	N.S.	N.S.	N.S.
CSHCN Status				
No Special Needs	2.63	2.59	2.78	2.40
Special Needs	2.39	2.68	2.76	2.33
T-test significance *	= 0.04	N.S.	N.S.	N.S.
Cohen's d	0.32	-	-	-

* In the case of a significant F, post hoc pairwise comparisons were performed. Superscripts denote statistical significance of these comparisons. Means within a column that share a common superscript do not significantly differ from one another; means within a column that have different superscripts significantly differ from one another.

** Age 4 or younger vs. Age 11 or older, $p = 0.03$, $d = 0.40$

Table B3. CAHPS® Composite Scores for Children with Chronic Conditions by STAR Health Caregiver Race/Ethnicity and Education

	Prescription Medicines	Getting Specialized Services	Personal Doctor	Shared Decision -Making	Getting Needed Information	Care Coordination
Caregiver Race/Ethnicity						
Hispanic	2.74	2.35	0.85	0.93	2.81	0.65
White, NH	2.78	2.47	0.92	0.89	2.77	0.51
Black, NH	2.75	2.38	0.87	0.84	2.65	0.54
F significance *	N.S.	N.S.	N.S.	N.S.	N.S.	N.S.
Caregiver Education						
Less than high school degree	2.91	2.57	0.91 ^{ab}	0.87	2.72	0.78 ^a
High school degree or GED	2.72	2.41	0.82 ^a	0.88	2.72	0.50 ^b
Some college or college degree	2.73	2.35	0.91 ^b	0.90	2.76	0.53 ^b
F significance *	N.S.	N.S.	< 0.06 ^{**}	N.S.	N.S.	< 0.06 ^{***}

* In the case of a significant F, post hoc pairwise comparisons were performed. Superscripts denote statistical significance of these comparisons. Means within a column that share a common superscript do not significantly differ from one another; means within a column that have different superscripts significantly differ from one another.

** High school degree or GED vs. Some college or college degree, $p < 0.01$, $d = 0.27$

*** Less than high school degree vs. High school degree or GED, $p = 0.03$, $d = 0.61$; Less than high school degree vs. Some college or college degree, $p = 0.02$, $d = 0.56$

Table B4. CAHPS® Composite Scores for Children with Chronic Conditions by STAR Health Member Race/Ethnicity, Age, and CSHCN Status

	Prescription Medicines	Getting Specialized Services	Personal Doctor	Shared Decision-Making	Getting Needed Information	Care Coordination
Member Race/Ethnicity						
Hispanic	2.78	2.34	0.87	0.89	2.76 ^{ab}	0.54
White, NH	2.76	2.49	0.90	0.91	2.84 ^a	0.50
Black, NH	2.73	2.46	0.89	0.88	2.65 ^b	0.63
F significance *	N.S.	N.S.	N.S.	N.S.	= 0.06 ^{**}	N.S.
Child Age						
Age 4 or younger	2.76	2.41	0.92 ^a	0.88	2.76	0.61
Age 5 thru 10	2.78	2.40	0.90 ^{ab}	0.90	2.73	0.55
Age 11 or older	2.73	2.41	0.82 ^b	0.89	2.73	0.48
F significance *	N.S.	N.S.	= 0.03 ^{***}	N.S.	N.S.	N.S.
CSHCN Status						
No Special Needs	2.83	2.36	0.88	0.88	2.77	0.54
Special Needs	2.71	2.41	0.89	0.90	2.70	0.56
T-test significance *	N.S.	N.S.	N.S.	N.S.	N.S.	N.S.
Cohen's d	-	-	-	-	-	-

* In the case of a significant F, post hoc pairwise comparisons were performed. Superscripts denote statistical significance of these comparisons. Means within a column that share a common superscript do not significantly differ from one another; means within a column that have different superscripts significantly differ from one another.

** White vs. Black, $p = 0.02$, $d = 0.32$

*** Age 4 or younger vs. Age 11 or older, $p < 0.01$, $d = 0.32$

Table B5. HHSC Performance Indicator Results in STAR Health by Caregiver Race/Ethnicity and Education

	1	2	3	4	5	6
STAR Health	96%	84%	84%	69%	30%	78%
HHSC Standard	88%	75%	76%	69%	50%	79%
Caregiver Race/Ethnicity						
Hispanic	93%	76%	76%	58%	21%	78%
White, NH	97%	92%	90%	73%	35%	84%
Black, NH	97%	87%	81%	68%	28%	71%
Chi square significance	N.S.	N.S.	< 0.01	N.S.	= 0.05	N.S.
Phi/Cramer's V	-	-	0.17	-	0.12	-
Caregiver Education						
Less than high school degree	79%	78%	71%	46%	35%	84%
High school degree or GED	100%	83%	84%	66%	30%	80%
Some college or college degree	97%	85%	87%	74%	27%	74%
Chi square significance	< 0.01	N.S.	= 0.01	N.S.	N.S.	N.S.
Phi/Cramer's V	0.32	-	0.16	-	-	-

^a Percentage of members who...

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

Table B6. HHSC Performance Indicator Results in STAR Health by Member Race/Ethnicity, Age, and CSHCN Status

	1	2	3	4	5	6
STAR Health	96%	84%	84%	69%	30%	78%
HHSC Standard	88%	75%	76%	69%	50%	79%
Member Race/Ethnicity						
Hispanic	96%	83%	81%	70%	25%	73%
White, NH	95%	88%	90%	70%	35%	89%
Black, NH	97%	88%	83%	68%	31%	77%
Chi square significance	N.S.	N.S.	N.S.	N.S.	N.S.	N.S.
Phi/Cramer's V	-	-	-	-	-	-
Child Age						
Age 4 or younger	94%	93%	89%	79%	28%	77%
Age 5 thru 10	100%	80%	79%	68%	34%	75%
Age 11 or older	96%	75%	81%	56%	28%	81%
Chi square significance	N.S.	N.S.	N.S.	= 0.05	N.S.	N.S.
Phi/Cramer's V	-	-	-	0.20	-	-
CSHCN Status						
No Special Needs	92%	89%	82%	85%	34%	79%
Special Needs	100%	81%	86%	61%	26%	76%
Chi square significance	= 0.02	N.S.	N.S.	< 0.01	N.S.	N.S.
Phi/Cramer's V	0.21	-	-	0.24	-	-

^a Percentage of members who...

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

Appendix C. Multivariate Analysis – STAR Health Member Demographics and Satisfaction with Care

In 2007, the National Survey of Adoptive Parents found that children adopted through the foster care system have significantly higher rates of emotional and behavioral disorders than other adopted children or children in the general population.³⁸ Children in foster care have particularly high rates of attachment disorder (21 percent), moderate or severe ADHD (20 percent), and moderate or severe conduct problems (14 percent).

Children in foster care who are hospitalized for mental illness may be more likely to have a readmission than other children, and to experience their first admission at younger ages.³⁹ In fiscal year 2011, HHSC targeted the reduction of mental health readmissions as one of two Overarching Goals for performance improvement projects (PIP) in the STAR Health MCO. Based on high need for and utilization of behavioral health (BH) services, and a mental health readmission rate of 22 percent (using fiscal year 2010 data), the EQRO recommended that HHSC retain this goal for STAR Health in fiscal year 2012.

The key to reducing readmissions is ensuring that adequate outpatient BH care is available to members. Demographic factors such as child's age, sex, and race/ethnicity have been found to influence outpatient mental health service use among children in foster care.^{40,41} The age of children in foster care, in particular, is associated with meeting national standards for mental health screening and referrals, with adolescents being more likely than younger children to receive care.⁴²

Using data from the fiscal year 2012 STAR Health Caregiver Survey, the EQRO conducted a set of multivariate analyses to test the association of demographic factors with caregiver-reported measures of health care experience and satisfaction. While the CAHPS[®] survey does not include composites specific to mental health care, four of the CAHPS[®] composites address aspects of care that are important to the effective delivery of outpatient BH care:

- *Getting Needed Care* – including questions regarding access to specialists, and care, tests, or treatment through the member's health plan
- *Getting Specialized Services* – including questions regarding access to special medical equipment, special therapies, and behavioral health treatment or counseling
- *Prescription Medicines* – a single-item measure regarding access to prescription medicines through the member's health plan
- *Care Coordination* – including questions about coordination between the member's healthcare providers and schools, and care coordination help provided through the member's health plan, doctor's office, or clinic

Methodology

The EQRO first conducted bivariate analyses to identify appropriate demographic factors for testing in the multivariate models. Mean scores for each of the four CAHPS® composites were compared across six caregiver factors (sex, age, race/ethnicity, language, education, marital status), five member factors (sex, age, race/ethnicity, language, health status), one family factor (household type), and one geographic factor (region).

- Members were grouped into three age categories – infant (0 to 3 years), child (4 to 11 years), and adolescent (12 to 18 years).
- Caregivers were grouped into four age categories, which roughly follow the quartiles of age distribution in the survey data – 19 to 34 years, 35 to 49 years, 50 to 59 years, and 60 years and older.
- Members and caregivers were grouped into three racial/ethnic groups: White, non-Hispanic, Hispanic, and Black, non-Hispanic. Members of “other” race/ethnicity represented only four percent of the sample and were excluded from analysis. Race/ethnicity was considered independently between members and caregivers, because of low levels of concordance (member-caregiver pairs having the same race/ethnicity). Among White, non-Hispanic caregivers, for example, 59 percent had White, non-Hispanic foster children, 31 percent had Hispanic foster children, and 10 percent had Black, non-Hispanic foster children.
- Primary language of members and caregivers (English or Spanish) was also considered independently for reasons of low concordance, although concordance was higher for language. Among English-speaking caregivers, two percent had foster children who spoke Spanish. It is important to note that in the sample overall, Spanish was the primary language for only six percent of caregivers, and four percent of members.
- Caregivers were grouped into three education categories – less than a high school, a high school diploma or GED, and some college or a college degree.
- Caregivers were grouped into two marital status categories – married, and not married.
- Member health status was assigned using the caregiver-reported CSHCN screener – with members classified as either CSHCN or not having special healthcare needs.
- Household type included two categories – single-parent households and two-parent households.
- The survey sample included members living in 10 non-rural regions (Bexar, Dallas, El Paso, Harris, Hidalgo, Jefferson, Lubbock, Nueces, Tarrant, and Travis) and 3 rural regions in West, Central and Northeast Texas. However, a number of regions were underrepresented in the sample, including Hidalgo (4 percent), Nueces (4 percent), and particularly, El Paso (1 percent). Due to the unbalanced distribution of regions in the sample, regions were grouped into two broader categories – urban and rural.

Tables C1 and C2 show mean scores for each of the four composites, stratified by caregiver factors, child factors, household type, and region. Very few of the demographic factors showed significant associations with any of the four CAHPS® composites, with the following exceptions (shown in the tables in bold text):

- CSHCN had lower scores than non-CSHCN on *Getting Needed Care*.
- Girls had higher scores than boys on *Prescription Medicines*.
- Unmarried caregivers had lower scores than married caregivers on *Getting Specialized Services*.
- *Care Coordination* scores showed a bimodal relationship with caregiver age, with higher scores among the youngest and oldest caregivers.
- Scores for *Getting Needed Care* were higher in rural than in urban regions.

Table C1. Mean Scores for Four CAHPS® Composites, by Caregiver Factors

Factor	<i>Getting Needed Care</i>		<i>Prescription Medicines</i>		<i>Specialized Services</i>		<i>Care Coordination</i>	
	N	Mean	N	Mean	N	Mean	N	Mean
Caregiver sex								
Male	30	2.40	25	2.72	31	2.53	27	0.67
Female	164	2.50	214	2.76	194	2.39	148	0.53
Caregiver age ^a								
19 to 34 years	37	2.55	34	2.91	30	2.13	29	0.76
35 to 49 years	71	2.55	76	2.78	75	2.45	58	0.47
50 to 59 years	55	2.42	82	2.68	78	2.45	58	0.47
60 years+	29	2.34	43	2.72	38	2.45	28	0.69
Caregiver race/ethnicity								
White-NH	101	2.53	116	2.78	96	2.47	90	0.51
Hispanic	41	2.48	54	2.74	61	2.35	43	0.65
Black-NH	42	2.50	59	2.75	57	2.38	35	0.54
Caregiver language								
English	184	2.48	231	2.76	213	2.43	165	0.54
Spanish	10	2.60	8	2.63	12	2.04	10	0.70
Caregiver education								
Less than high school	18	2.81	32	2.91	38	2.57	23	0.78
High school or GED	53	2.41	58	2.72	51	2.41	37	0.50
Some college or college degree	122	2.47	146	2.73	134	2.35	114	0.53
Caregiver marital status ^b								
Not married	78	2.51	91	2.80	85	2.22	57	0.47
Married	116	2.47	147	2.73	139	2.52	118	0.59

^a Differences in *Care Coordination* scores differed significantly by caregiver age group ($F = 3.52, p = 0.016$).

^b Differences in *Getting Specialized Service* scores differed significantly between married and unmarried caregivers ($t = -2.63, p = 0.009$).

Table C2. Mean Scores for Four CAHPS® Composites, by Member Household, and Regional Factors

Factor	Getting Needed Care		Prescription Medicines		Specialized Services		Care Coordination	
	N	Mean	N	Mean	N	Mean	N	Mean
Child sex ^a								
Male	106	2.55	129	2.68	127	2.45	92	0.61
Female	88	2.41	110	2.85	98	2.35	83	0.49
Child age								
0 to 3 years	67	2.58	84	2.77	56	2.33	54	0.59
4 to 11 years	82	2.49	102	2.78	112	2.43	76	0.53
12 to 18 years	44	2.32	53	2.68	56	2.42	45	0.54
Child race/ethnicity								
White-NH	67	2.55	79	2.76	67	2.49	63	0.50
Hispanic	67	2.48	85	2.78	86	2.34	69	0.54
Black-NH	42	2.42	62	2.73	56	2.46	32	0.63
Child language								
English	181	2.48	226	2.77	211	2.42	165	0.53
Spanish	8	2.50	6	2.83	8	1.94	7	0.86
Child health status ^b								
No special healthcare needs	66	2.63	92	2.83	63	2.36	58	0.54
CSHCN	118	2.39	136	2.71	149	2.41	106	0.56
Household type								
Single-parent	66	2.46	79	2.76	76	2.27	45	0.47
Two-parent	125	2.50	157	2.75	147	2.48	127	0.57
Region ^c								
Urban	147	2.43	172	2.38	178	2.75	136	0.52
Rural	47	2.68	53	2.49	61	2.79	39	0.65

^a Differences in *Prescription Medicines* scores differed significantly between male and female members ($t = -2.25$, $p = 0.026$).

^b Differences in *Getting Needed Care* scores differed significantly between CSHCN and children with no special healthcare needs ($t = 2.05$, $p = 0.042$).

^c Differences in *Getting Needed Care* scores differed significantly between members living urban regions and members living in rural regions ($t = -2.07$, $p = 0.040$).

Based on these findings and evidence from the literature, the EQRO selected the following eight factors to include in subsequent multivariate models, in which all factors are tested simultaneously: (1) Child age (reference group: 0 to 3 years); (2) Child sex (reference group: male); (3) Child race/ethnicity (reference group: White, non-Hispanic); (4) Child health status (reference group: no special needs); (5) Caregiver age (reference group: 19 to 34 years); (6) Caregiver race/ethnicity (reference group: White, non-Hispanic); (7) Household type (reference group: single-parent household); and (8) Region type (reference group: urban).

The multivariate analysis was conducted using unconditional logistic regression, with the outcomes dichotomized – coded as 1 for members who had positive health care experiences, and 0 for members who did not have positive health care experiences. A separate model was tested for each of the four CAHPS® composite domains. For *Getting Needed Care*, *Getting Specialized Services*, and *Prescription Medicines*, scores range from 1 to 3 (following NCQA specifications), and a score of 3.00 was chosen as an appropriate cutoff point for defining “positive” health care experiences. For *Care Coordination*, scores range from 0 to 1, and a score of 1.00 was chosen as the cutoff.

Results

Results of the multivariate analysis are presented in **Tables C3** through **C6** as odds ratios. The odds ratios represent the likelihood of a caregiver having positive experiences in the CAHPS® domain, compared to caregivers in the reference group. For any particular test variable or covariate, an odds ratio above 1.0 suggests that caregivers in the specified category were more likely to have had positive experiences than those in the reference group. Conversely, an odds ratio below 1.0 suggests that caregivers in the specified category were less likely to have positive experiences than those 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 $p < 0.05$.

Very few of the demographic factors were found to be significant predictors of caregiver satisfaction, partly due to small sample sizes in the models – ranging from 160 members for *Getting Needed Care* to 206 members for *Prescription Medicines*.

- For *Getting Needed Care*, region group was the only significant factor in the model, with members living in rural regions being about four times more likely to have scores of 3.00 than members living in urban regions. While this finding reflects results of prior member surveys conducted by the EQRO (in which rural members report better access to certain types of care), it should be noted that the confidence interval for this factor is large, ranging from 1.6 to 10.6. The magnitude of the effect of region can therefore not be precisely estimated.
- None of the factors were significant in the model for *Getting Specialized Services*. Although bivariate analyses found a significant difference in scores between married and unmarried caregivers, this difference was no longer significant after controlling for the other factors in the model.
- For *Prescription Medicines*, caregiver age was the only significant factor in the model. Caregivers in the 50- to 59-year-old age group were about 80 percent less likely than those in the 19- to 34-year-old age group to report positive experiences with access to prescription medicines. It should be noted that the confidence interval for this factor was large, ranging from 0.04 to 0.91. The magnitude of the effect of caregiver age on access to prescription medicines can therefore not be precisely estimated.

- Associations between caregiver age and *Care Coordination* were much stronger. The bimodal relationship found in the bivariate models was still present after controlling for the other factors. Effects were significant for caregivers in the 35- to 49-year-old and 50- to 59-year-old age groups, who were about 70 percent less likely to report good care coordination than caregivers in the 19- to 34-year-old age group. In addition, Black, non-Hispanic children were found to be about 4.7 times more likely than White, non-Hispanic children to have had good care coordination. However, as with most significant factors in the models, the confidence interval was wide, making a precise estimate of the effect magnitude difficult to determine.

Findings from these analyses did not support findings from the literature that member's sex, age, or race/ethnicity are independently associated with positive experiences getting care from specialists, specialized treatment, prescriptions, or care coordination. However, the cited literature is specific to outpatient behavioral health care, whereas the composites tested in the models are more general – addressing issues that may be relevant to BH care, but which are not directly connected. A survey tool that is more specific to BH care, such as the ECHO[®] Survey, could be more appropriate for evaluating access to BH care in STAR Health from the caregiver's perspective.

Nevertheless, the findings do suggest demographics that can be targeted for improving access to care – particularly in regard to caregiver age and access to prescription medicines and care coordination. STAR Health members whose caregivers were 35 to 50 years old reported lower access to these types of care after controlling for other factors. *Care Coordination*, in particular, tends to have lower scores for children in Texas Medicaid. In efforts to improve care coordination for children in foster care, the STAR Health MCO should determine reasons for these discrepancies in *Care Coordination* across caregiver age groups, and target interventions to help caregivers 35 to 50 years old coordinate care for their children among different types of health services.

Table C3. Multivariate Analysis – Getting Needed Care

Factor	Getting Needed Care	Odds Ratio	95% C.I.	
	% with positive experiences (N = 160)		Lower	Upper
Child age				
0 to 3 years	69.0%	Ref	-	-
4 to 11 years	67.2%	0.76	0.32	1.78
12 to 18 years	46.3%	0.41	0.15	1.08
Child sex				
Male	65.9%	Ref	-	-
Female	58.7%	0.57	0.27	1.19
Child race/ethnicity				
White, non-Hispanic	62.7%	Ref	-	-
Hispanic	64.5%	1.26	0.47	3.41
Black, non-Hispanic	59.0%	0.42	0.12	1.46
Child health status				
No special needs	72.1%	Ref	-	-
CSHCN	56.6%	0.58	0.27	1.26
Caregiver age				
19 to 34 years	69.7%	Ref	-	-
35 to 49 years	62.7%	0.74	0.27	2.03
50 to 59 years	59.1%	0.95	0.32	2.84
60 years or older	58.3%	0.75	0.22	2.53
Caregiver race/ethnicity				
White, non-Hispanic	62.2%			
Hispanic	61.1%	0.82	0.28	2.40
Black, non-Hispanic	64.7%	1.95	0.56	6.81
Caregiver marital status				
Not married	69.8%			
Married	57.7%	0.48	0.22	1.07
Region				
Urban	57.1%			
Rural	78.0%	4.15	1.63	10.55

Table C4. Multivariate Analysis – Getting Specialized Services

	Specialized Services	Odds Ratio	95% C.I.	
	% with positive experiences (N = 186)		Lower	Upper
Child age				
0 to 3 years	60.4%	Ref	-	-
4 to 11 years	64.8%	1.27	0.58	2.78
12 to 18 years	58.0%	0.77	0.31	1.89
Child sex				
Male	61.8%	Ref	-	-
Female	61.9%	1.08	0.58	2.01
Child race/ethnicity				
White, non-Hispanic	63.8%	Ref	-	-
Hispanic	58.2%	0.90	0.37	2.19
Black, non-Hispanic	65.3%	0.99	0.34	2.90
Child health status				
No special needs	58.9%	Ref	-	-
CSHCN	63.1%	1.30	0.65	2.58
Caregiver age				
19 to 34 years	50.0%	Ref	-	-
35 to 49 years	64.1%	1.60	0.63	4.08
50 to 59 years	66.1%	1.58	0.60	4.15
60 years or older	59.4%	1.25	0.43	3.69
Caregiver race/ethnicity				
White, non-Hispanic	63.5%	Ref	-	-
Hispanic	53.8%	0.83	0.33	2.10
Black, non-Hispanic	67.3%	1.34	0.47	3.82
Caregiver marital status				
Not married	54.4%	Ref	-	-
Married	66.1%	1.88	0.95	3.70
Region				
Urban	61.7%	Ref	-	-
Rural	62.2%	0.82	0.38	1.76

Table C5. Multivariate Analysis – Prescription Medicine

	Prescription Medicines	Odds Ratio	95% C.I	
	% with positive experiences (N = 206)		Lower	Upper
Child age				
0 to 3 years	80.3%			
4 to 11 years	87.5%	2.31	0.88	6.06
12 to 18 years	78.0%	1.30	0.49	3.49
Child sex				
Male	78.9%			
Female	86.6%	1.57	0.68	3.63
Child race/ethnicity				
White, non-Hispanic	85.7%			
Hispanic	82.7%	0.82	0.27	2.49
Black, non-Hispanic	78.2%	0.53	0.17	1.72
Child health status				
No special needs	90.9%			
CSHCN	76.3%	0.32	0.13	0.79
Caregiver age				
19 to 34 years	93.5%			
35 to 49 years	82.9%	0.31	0.06	1.56
50 to 59 years	75.8%	0.18	0.04	0.91
60 years or older	84.6%	0.37	0.06	2.13
Caregiver race/ethnicity				
White, non-Hispanic	82.2%			
Hispanic	84.0%	1.08	0.33	3.58
Black, non-Hispanic	81.6%	1.50	0.47	4.82
Caregiver marital status				
Not married	84.6%			
Married	81.3%	0.97	0.40	2.37
Region				
Urban	81.6%			
Rural	85.2%	1.33	0.50	3.48

Table C6. Multivariate Analysis – Care Coordination

	Care Coordination	Odds Ratio	95% C.I.	
	% with positive experiences (N = 149)		Lower	Upper
Child age				
0 to 3 years	58.3%			
4 to 11 years	48.3%	0.82	0.32	2.07
12 to 18 years	53.5%	1.03	0.36	2.91
Child sex				
Male	61.0%			
Female	44.4%	0.58	0.28	1.23
Child race/ethnicity				
White, non-Hispanic	44.4%			
Hispanic	53.8%	0.98	0.37	2.61
Black, non-Hispanic	66.7%	4.73	1.20	18.72
Child health status				
No special needs	54.7%			
CSHCN	52.1%	0.94	0.43	2.07
Caregiver age				
19 to 34 years	74.1%			
35 to 49 years	42.3%	0.29	0.10	0.89
50 to 59 years	45.7%	0.28	0.09	0.90
60 years or older	66.7%	0.61	0.16	2.29
Caregiver race/ethnicity				
White, non-Hispanic	47.6%			
Hispanic	67.6%	2.57	0.86	7.75
Black, non-Hispanic	50.0%	0.54	0.15	2.03
Caregiver marital status				
Not married	51.0%			
Married	54.0%	1.45	0.63	3.33
Region				
Urban	50.9%			
Rural	60.6%	1.87	0.76	4.57

Endnotes

¹ Consumer Assessment of Healthcare Providers and Systems (CAHPS®). 2011a. *CAHPS® Health Plan Survey 4.0, Child Medicaid Questionnaire*. Available at: <https://www.cahps.ahrq.gov/Surveys-Guidance/HP.aspx>.

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⁴ Gillis, D., M. Bauner, and E. Granot. 2007. "A community-based behavior modification intervention for childhood obesity." *Journal of Pediatric Endocrinology and Metabolism*, 20, 197-203.

⁵ Latner, J.D. and A.J. Stunkard. 2012. "Getting worse: The stigmatization of obese children." *Obesity Research*, 11, 452-456.

⁶ Texas Health and Human Services Commission (HHSC). 2013. *Texas Medicaid in Perspective, Ninth Edition*. "Chapter 7: Medicaid Managed Care." Available at: <http://www.hhsc.state.tx.us/medicaid/reports/PB9/PinkBook.pdf>.

⁷ CAHPS® 2011a.

⁸ CAHPS® 2011b.

⁹ CAHMI. 2008.

¹⁰ National Survey of Children with Special Health Care Needs (NS-CSHCN). 2009/10. Available at: <http://cshcndata.org>.

¹¹ HHSC. 2012. *CY 2012 STAR Health MCO Quality Performance Indicators*. Available at: http://www.hhsc.state.tx.us/medicaid/umcm/Chp10/10_1_8.pdf.

¹² The FY 2011 HHSC Overarching Goals for STAR Health are: (1) Increase provider use of the Health Passport; and (2) Decrease mental health readmissions.

¹³ Cooper, J.L., P. Banghart, Y. Aratani. 2010. *Addressing the Mental Health Needs of Young Children in the Child Welfare System: What Every Policymaker Should Know*. National Center for Children in Poverty, Mailman School of Public Health, Columbia University. September 2010.

¹⁴ Centers for Disease Control and Prevention (CDC). 2012. U.S. Obesity Trends. Available at: <http://www.cdc.gov/obesity/data/childhood.html>.

¹⁵ Trust for America's Health. 2011. *F as in Fat: How Obesity Threatens America's Future*. Available at: <http://healthyamericans.org/reports/obesity2011/release.php?stateid=TX>.

¹⁶ Ogden, C.L., and M.D. Carroll. 2008. "Prevalence of Obesity Among Children and Adolescents: United States, Trends 1963-1965 Through 2007-2008." Available at http://www.cdc.gov/nchs/data/hestat/obesity_child_07_08/obesity_child_07_08.htm.

¹⁷ Chi-square = 3.54, $p = N.S.$, $\phi = 0.12$

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- ¹⁸ American Academy of Family Physicians. 2012. *Patient-Centered Medical Home*. Available at: <http://www.aafp.org/online/en/home/policy/policies/p/patientcenteredmedhome.html>.
- ¹⁹ ACP (American College of Physicians). 2007. *Joint Principles of the Patient-Centered Medical Home*. Available at: http://www.acponline.org/running_practice/pcmh/demonstrations/jointprinc_05_17.pdf.
- ²⁰ It is likely that many STAR Health members periodically exit conservatorship and disenroll from the program, resulting in discontinuity of care that is beyond the control of the STAR Health MCO. However, a six-month continuous enrollment period was required for inclusion in this study. Therefore, the STAR Health members represented in this survey are those for whom continuity of a regular personal doctor may be reasonably expected.
- ²¹ 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.
- ²² Gillis, D., M. Bauner, and E. Granot. 2007.
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