



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 2014**

**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

The Institute for Child Health Policy (ICHP) serves as the External Quality Review Organization (EQRO) for Texas Medicaid managed care and biennially evaluates the health care experiences and satisfaction of caregivers of STAR Health members using a member telephone survey. This report provides results from the FY 2014 STAR Health Caregiver Survey, which was conducted with caregivers of children and adolescents in foster care who were enrolled in STAR Health between February and July 2014. 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.

### Methodology

This survey incorporated the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey with two instruments developed and pilot tested in both English and Spanish to assess caregivers' experiences with the Texas Health Steps program and psychotropic medications for their children. Pilot and final survey participants were selected from a simple random sample of members enrolled in STAR Health for at least six months between February 2014 and July 2014. The EQRO set a target of 25 completed telephone interviews with caregivers of sampled members for each of the pilot tested instruments, as well as 300 completed telephone interviews for the final caregiver survey. The response rate for the final survey was 33 percent and the cooperation rate was 65 percent.

The FY 2014 STAR Health Caregiver Survey is composed of:

- The CAHPS® Health Plan Survey 5.0H Child Questionnaire with Children with Chronic Conditions (CCC) Measures (Medicaid module).<sup>1</sup>
- Items from the CAHPS® Clinician and Group Surveys.<sup>2</sup>
- 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®.<sup>3</sup>
- Items from the National Survey of CSHCN (NS-CSHCN) addressing issues of transition to adult care.<sup>4</sup>
- Items developed by ICHP pertaining to member and caregiver demographics and household characteristics.
- Pilot tested items developed by ICHP and Texas HHSC pertaining to caregiver knowledge of the Texas Health Steps program as well as child psychotropic medication and behavioral health.

## Summary of Findings

### Profile of STAR Health members:

- The average age of STAR Health members was 7 years old.
- 52 percent were female, and 48 percent were male.
- Hispanic members were the most common racial/ethnic group (46 percent), followed by White, non-Hispanic members (28 percent), and Black, non-Hispanic members (19 percent).
- 33 percent lived in a single-parent household.
- 51 percent were classified as having special health care needs (CSHCN).

### Profile of survey participants (caregivers):

- The average age of survey participants was 48 years old.
- 82 percent were female, and 18 percent were male.
- White, non-Hispanic caregivers were the most common racial/ethnic group (42 percent), followed by Hispanic caregivers (33 percent), and Black, non-Hispanic caregivers (21 percent).
- 83 percent of caregivers had a high school diploma.
- 61 percent of caregivers were married.

## Positive findings

- *Getting Care Quickly.* Eighty-nine percent of caregivers “usually” or “always” had positive experiences with *Getting Care Quickly*, which is in line with the Medicaid national average of 90 percent.
- *Good Access to Routine Care.* Ninety 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 above the HHSC Dashboard standard of 84 percent.
- *How Well Doctors Communicate.* Similar to the Medicaid national standard of 93 percent, 91 percent of caregivers “usually” or “always” had positive experiences communicating with their child’s doctor.
- *Access to Prescription Medicines.* Eighty-eight percent of caregivers reported it was “usually” or “always” easy to get prescription medicines for their child through their child’s health plan, which is similar to the Medicaid national average of 91 percent.

- *Getting Needed Information.* Ninety percent of caregivers reported “usually” or “always” getting information they needed from their child’s doctors or health providers, which is consistent with the Medicaid national average of 89 percent.
- *Health Care 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.

## 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).
- *Specialist Care.* Among caregivers who tried to make an appointment for their child to see a specialist in the last six months, 60 percent indicated that they “usually” or “always” got an appointment for their child as soon as they needed it.
  - Of note, 59 percent of caregivers of teens between 12 and 18 years old reported good access to behavioral health treatment or counseling, compared to 79 percent of children age 3 or younger and 82 percent of children between 4 and 11 years old.
- *Shared Decision-Making for Prescription Medicines.* Although caregivers reported good access to prescription medications for their children, they reported lower participation in shared decision-making about prescription medications, as measured by the CAHPS® *Shared Decision-Making* measure (53 percent). In particular, among caregivers who reported talking with their child’s provider about starting or stopping a prescription medication, one third (33 percent) said the doctor did not speak with them about reasons why they might not want their child to take the medicine.
- *Preparing caregivers and CSHCN for transition to adulthood.* Among children 11 years of age and older, 14 percent of caregivers had a discussion with the child's provider about their child having to eventually see providers who treat adults.
- *Care Coordination and Service Management.* Performance on the CAHPS® *Care Coordination* composite (70 percent) was lower than the Medicaid national average of 76 percent. Two-fifths of caregivers said they had received a call asking whether their child needed service management (38 percent). Among caregivers who participated in the STAR Health service management program, three-fifths said they had received service management in the past six months (59 percent).

## Recommendations

The EQRO recommends the following strategies to Texas HHSC and the STAR Health Managed Care Organization (MCO), Superior HealthPlan, to improve the delivery and quality of care for STAR Health members:

**Table 1. Recommendations**

<b>Domain</b>	<b>Recommendations</b>	<b>Rationale</b>
Specialist care; Behavioral health care	<p>Superior HealthPlan should improve upon access to specialized services in general, with a particular focus on behavioral health treatment and counseling among adolescents. This focused effort may include integrating behavioral health treatment and counseling into other care initiatives for foster care children, such as treatments involving psychotropic medication and trauma-informed care initiatives.</p> <p>In addition, increasing reimbursement rates for treating foster children, as well as increasing coverage for less severe symptoms prior to the development of more serious disorders, would enhance access to and improve upon the behavioral health treatment and counseling options for youth in foster care.<sup>5</sup></p> <p>Finally, increasing care coordination may also be an opportunity to improve access to specialist care in the foster care population. Care coordination is challenging given the numerous individuals and agencies involved. Other states have implemented care coordination initiatives for youth in foster care, such as the BlueCare Tennessee SelectKids Program. Superior HealthPlan may want to consider this initiative to determine if it could be adapted for the STAR Health population.<sup>6</sup></p>	<p>The 2014 STAR Health Survey found low rates of access to specialist appointments. Specialist access is particularly critical for children in foster care, who have a higher incidence of mental health and behavioral problems compared to their peers. The current survey revealed that STAR Health members needed specialized services at a high rate, with 41 percent needing mental health treatment and 33 percent needing specialized therapies, equipment, or home health care.</p> <p>Furthermore, the survey found an age disparity in access to behavioral health treatment and counseling, with a lower rate among teens 12 to 18 years old (59 percent). The age disparity is problematic given that adolescence is a high risk age period/range for the onset of many mental health disorders.<sup>7</sup></p>

Domain	Recommendations	Rationale
Shared decision-making	<p>Providers in the Superior HealthPlan network who serve STAR Health should be encouraged to improve shared decision-making practices with caregivers of children who take medications. This process improvement may include training and information on best practices. Additionally, shared decision-making practices may address some malpractice liability concerns, which include concerns that a provider may be sued due to adverse outcomes where “shared decisions, even evidence-based, conflict with local practice”.<sup>8</sup></p> <p>Superior HealthPlan should also take into account other known barriers to implementing strategies for improving shared decision-making. These barriers include ambiguities in how shared decision-making is defined and measured in clinical practice, the absence of a certification process for decision aids (which reduces provider confidence in their use), provider reimbursement and engagement to incorporate shared decision-making practices, and resistance by providers in relation to workflow concerns.<sup>9</sup></p>	<p>Although caregivers reported a relatively high rate of access to prescription medicines for their children (88 percent on CAHPS® <i>Prescription Medicine</i>), they reported lower participation in discussions about these medications with their children’s providers (53 percent on CAHPS® <i>Shared Decision-Making</i>).</p> <p>There is evidence that the practice of shared decision-making is associated with positive affective-cognitive outcomes (such as patient satisfaction with care),<sup>10</sup> and is particularly suited for long-term decisions, especially in the context of chronic illness.<sup>11</sup> Shared decision-making is particularly relevant for children in STAR Health who have been prescribed psychotropic medications. Nearly one in five caregivers reported their child had taken a psychotropic medication in the last six months (18 percent), and half of these caregivers said that their child’s doctors discussed non-pharmacological treatments with them (53 percent). These findings should be interpreted with caution given the low number of respondents (N = 34).</p>

## Introduction

Children and adolescents in foster care are a vulnerable population 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 adolescents 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 adolescents 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.<sup>12</sup>

Through a contract with HHSC, the Institute for Child Health Policy (ICHP) at the University of Florida serves as the Texas External Quality Review Organization (EQRO). ICHP evaluates caregivers' experiences and satisfaction with their children's health care in STAR Health on a biennial basis.

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

- Describe the sociodemographic characteristics of the children and adolescents in foster care enrolled in STAR Health, as well as of their caregivers.
- Describe the health status of children and adolescents in STAR Health.
- Document caregivers' experiences and satisfaction with their children's health care.
- Use the 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 caregivers' experiences and satisfaction of care across member characteristics.
- Report on new measures, developed by ICHP in collaboration with HHSC, that assess caregivers' knowledge of and experiences with the Texas Health Steps program and with psychotropic medications for their children.

In addition, this report compares results on CAHPS® items, caregiver ratings, and HHSC Dashboard Indicators with results reported in the FY 2012 STAR Health Caregiver Survey Report.

## 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 February 2014 and September 2014. 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 300 completed telephone interviews with caregivers of sampled members for the final survey. Two instruments were pilot tested in both English and Spanish from this same simple random sample with a target of 25 completed telephone interviews for each pilot survey.

### Survey Instruments

The 2014 STAR Health Caregiver Survey is composed of:

- The CAHPS® Health Plan Survey 5.0H Child Questionnaire with Children with Chronic Conditions (CCC) Measures (Medicaid module).<sup>1</sup>
- Items from the CAHPS® Clinician and Group Surveys.<sup>2</sup>
- 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®.<sup>3</sup>
- Items from the National Survey of CSHCN (NS-CSHCN) addressing issues of transition to adult care.<sup>4</sup>
- Pilot tested items developed by ICHP and Texas HHSC pertaining to caregiver knowledge of the Texas Health Steps program as well as child psychotropic medication and behavioral health.
- 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.

Four survey questions function as indicators of health plan performance for children in STAR Health, as listed on HHSC's Performance Indicator Dashboard for CY 2014.<sup>13</sup> These are: (1) Good access to urgent care; (2) Good access to specialist referral; (3) Good access to routine care; and (4) Good access to behavioral health treatment and counseling.

In conjunction with HHSC, ICHP developed six new survey items pertaining to caregiver knowledge of Texas Health Steps and ten new items relating to child psychotropic medication use and behavioral health. These 16 items were pilot tested in English and Spanish and the results analyzed prior to being incorporated into the final caregiver survey.

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

## **Data Collection**

Data collection for this survey was conducted in three phases: pilot data collection, final survey data collection, and follow-up data collection for a subsample of the final survey respondents.

The EQRO sent letters written in English and Spanish to 3,000 caregivers of sampled STAR Health members requesting their participation in the survey.

The University of Florida Survey Research Center (UFSRC) conducted the surveys using computer-assisted telephone interviewing (CATI) between August 2014 and November 2014. UFSRC telephoned caregivers of STAR Health members seven days a week between 9:00 a.m. and 9:00 p.m. Central Time. Spanish speakers were specifically recruited for participation in the Spanish pilot surveys which were conducted by a Spanish-speaking interviewer. For the final and follow-up surveys, if a respondent was unable to complete the interview in English, UFSRC referred the respondent to a Spanish-speaking interviewer.

Recruitment for the Spanish pilot was challenging given that only six percent of the sample was expected to speak Spanish as their primary language based on previous samples of the STAR Health population (2012). Follow-up contact after screening for the Spanish pilot survey resulted in lower response rates than is traditionally observed in the STAR Health population. Twenty-two percent of families could not be located. Among those located, three percent indicated that the child was not enrolled in STAR Health and 13 percent refused to participate. The response rates for the final survey and follow-up survey were 33 percent and 80 percent, respectively. The cooperation rates were 65 percent and 80 percent, respectively.

### **Data Analysis**

Descriptive statistics and statistical tests were performed using IBM SPSS Statistics 22.0. Overall performance of the individual survey items were evaluated for the pilot surveys. The final survey focused on the CAHPS® composite measures and ratings and HHSC Performance Dashboard Indicators. Statistical tests of differences were conducted among relevant demographic sub-groups in the STAR Health sample. Pilot analyses revealed excellent performance of the individual survey items in both English and Spanish. Minor edits were made prior to inclusion in the final survey.

## **Results**

This section presents survey results for children in STAR Health regarding: (1) Demographic characteristics; (2) Health status; (3) Caregivers' overall satisfaction with their children's health care; (4) Patient-Centered Medical Home; (5) Seeking help and advice; (6) Care coordination; and (7) Health plan. Frequency data for all survey items are available in a separate technical appendix.

## Demographic Information

**Table 2. STAR Health Caregiver Demographic Characteristics**

<b>Mean Age (years)</b>	48 (SD = 11.64)
<b>Sex</b>	
Female	82%
Male	18%
<b>Race/Ethnicity</b>	
Hispanic	33%
White, non-Hispanic	42%
Black, non-Hispanic	21%
Other	4%
<b>Education</b>	
8 <sup>th</sup> grade or less	4%
Some high school, but did not graduate	13%
High school graduate or GED	28%
Some college or 2-year degree	31%
4-year college graduate	17%
More than 4-year college degree	7%

**Table 3. STAR Health Child and Adolescent Demographic Characteristics**

<b>Mean Age (years)</b>	7 (SD = 5.37)
<b>Sex</b>	
Female	52%
Male	48%
<b>Race/Ethnicity</b>	
Hispanic	46%
White, non-Hispanic	28%
Black, non-Hispanic	19%
Other	8%

**Table 4. STAR Health Household Demographic Characteristics**

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<b>Relation to Child</b>	
Biological Parent	8%
Other Parent	29%
Grandparent	31%
Aunt/Uncle	9%
Brother/Sister	1%
Other Relative	7%
Non-Relative	4%
Other	13%
<b>Marital Status</b>	
Married	61%
Unmarried partner	3%
Divorced	10%
Separated	4%
Single	16%
Widowed	6%
<b>Caregiver Language Spoken at Home</b>	
English	91%
Spanish	5%
Other	4%

## **Health Status**

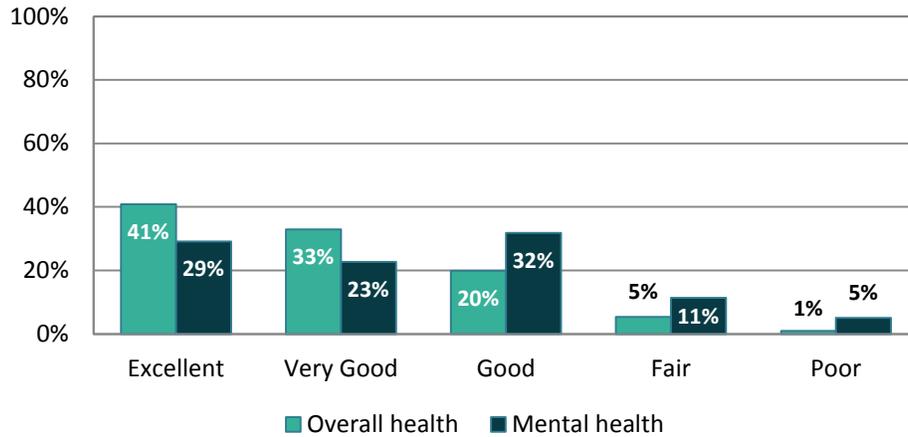
### Overall and Mental Health

Figure 1 shows caregiver assessment of their child's overall health and mental health.

- Seventy-four percent of children and adolescents in STAR Health were reported as having excellent or very good overall health in 2014, a slight increase from 2012 (68 percent).
- The percent of caregivers rating their child's health as fair or poor decreased from nine percent in 2012 to six percent in 2014.

Similar to 2012 results, children and adolescents had better overall health than mental health. This discrepancy is expected, as children and adolescents in foster care tend to have high mental health needs.<sup>14</sup>

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

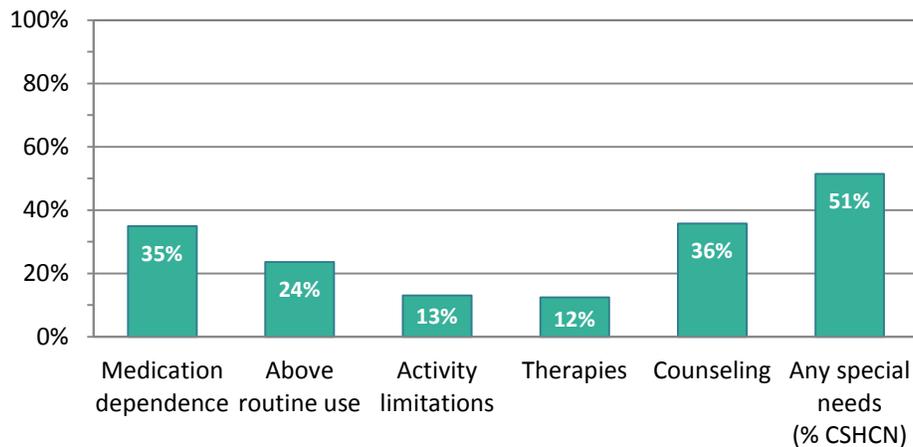


Special Health Care Needs of Members

Over half of children and adolescents were identified as having “special needs” (51 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 other children their age);
- 4) Problems that required special therapy; and
- 5) Problems that required counseling.

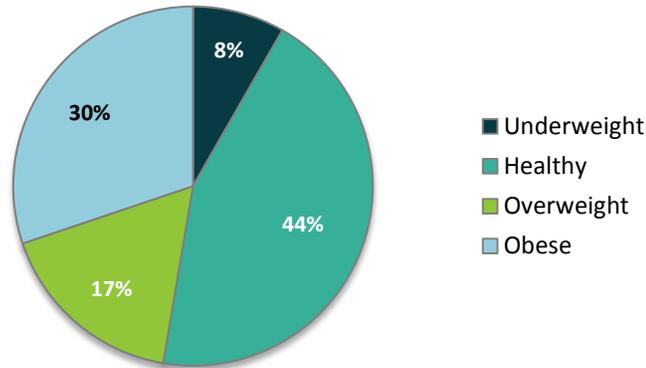
**Figure 2. Percent of Children with Special Health Care Needs**



Body Mass Index

Figure 3 provides the BMI results for STAR Health members based on caregiver reports of their child's weight and height. STAR Health members had a higher rate of obesity (30 percent) compared to the national rate for children and adolescents (17 percent)<sup>15</sup> and to the rate for Texas children and adolescents (20 percent).<sup>16</sup>

**Figure 3. Caregiver-Reported Member BMI Classification**



**Table 5. Obesity Prevalence by Sex and Race/Ethnicity**

	% Obese in U.S. population (age 2 – 19) <sup>17</sup>	% Obese in STAR Health (age 0 – 17)
<b>Girls, overall</b>	17%	34%
Hispanic	21%	38%
non-Hispanic White	16%	35%
non-Hispanic Black	21%	36%
<b>Boys, overall</b>	17%	25%
Hispanic	24%	30%
non-Hispanic White	13%	22%
non-Hispanic Black	20%	13%

Among STAR Health members, girls had higher rates of obesity compared to boys, in contrast to national trends indicating no gender differences in obesity.

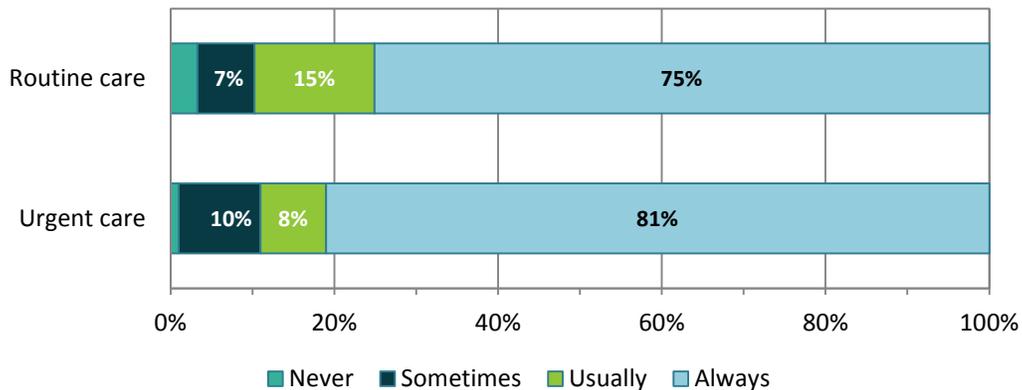
## Access to and Timeliness of Care

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

### Urgent and Routine Care

One in three members had an illness, injury, or condition that required urgent medical care (34 percent), and the vast majority of children were scheduled for routine care (91 percent). For those children who received urgent or routine medical care, Figure 4 illustrates how quickly they were able to access that care.

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



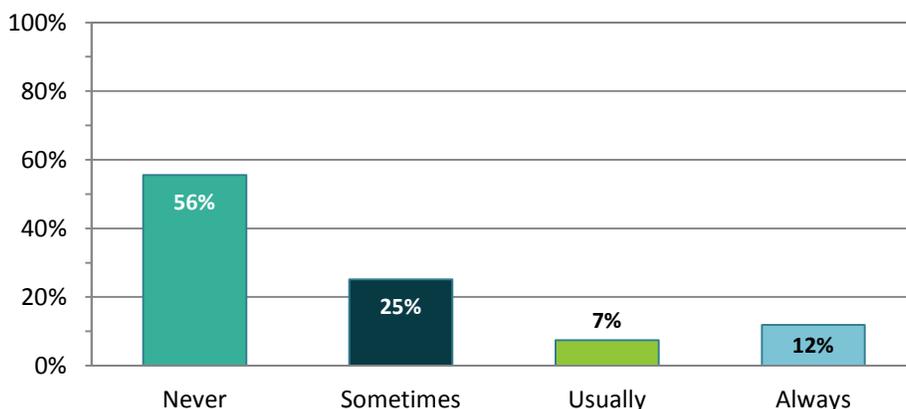
These two survey items are HHSC Performance Dashboard Indicators:

- *Good Access to Urgent Care.* While the 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 it (89 percent), this percentage fell short of the HHSC Dashboard standard of 96 percent.
- *Good Access to Routine Care.* Ninety percent of caregivers reported that they “usually” or “always” were able to make a routine appointment for their child as soon as they needed. This percentage surpasses the HHSC Dashboard standard of 84 percent.

The above indicators also represent the individual items that comprise the CAHPS® composite *Getting Care Quickly*. Eighty-nine percent of caregivers reported “usually” or “always” having positive experiences with *Getting Care Quickly* for their child, which almost meets the AHRQ national Medicaid standard of 90 percent.

Caregivers also reported the number of days their child usually had to wait between making an appointment for routine care and the child actually being seen by a health provider. Two-thirds of members were able to be seen by a health provider within three days (68 percent); however, a small percentage of members had to wait longer than one week to be seen (17 percent). Nineteen percent of caregivers reported that they “usually” or “always” had to wait for a routine appointment because their provider worked limited hours or had few appointment slots available (see Figure 5).

**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 children. Eighteen percent said their child had needed to visit a doctor’s office or clinic for after-hours care; almost two thirds (65 percent) of these said it was “usually” or “always” easy to get after-hours care.

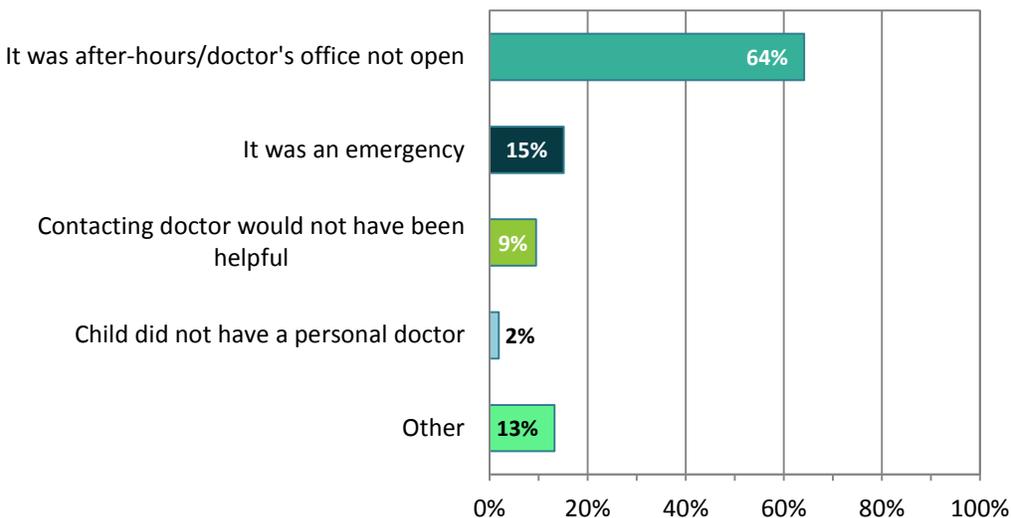
Caregivers of children age two or younger were asked about access to and timeliness of well-child care. Most children age two or younger had visited a doctor or other health provider at some point for a check-up, shots, or drops (92 percent), and the vast majority of caregivers said that their child got a well-child appointment as soon as their child needed it (97 percent).

#### Emergency Department Use

Seventeen percent of members had visited the emergency department at least once in the last six months to get care, and seven percent of members had visited the emergency department on multiple occasions. 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 where higher values represented better care. Over half gave a rating of 9 or 10 (56 percent), and the mean emergency department care rating was 8.4 (SD = 1.91).

Of caregivers who said their child visited the emergency department at least once, one quarter said that they had contacted their child’s personal doctor before going to the emergency department (25 percent). The most common reason for not contacting a child’s personal doctor was that the doctor’s office was not open, largely because the need for services occurred after-hours (Figure 6).

**Figure 6. Reasons for Not Contacting Child's Personal Doctor Before Visiting the Emergency Department**



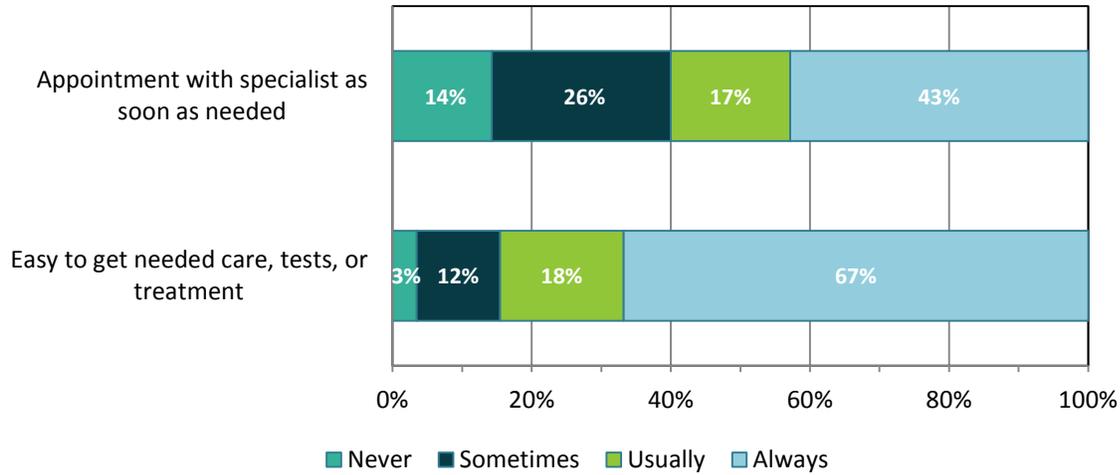
About a third of caregivers reported that they used emergency department services because they could not get an appointment with their child’s doctor in a timely manner (32 percent), which suggests that some of these visits might have been prevented with increased access to members’ health care providers.

Access to Specialist Care

Twenty-four 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, 60 percent indicated that they “usually” or “always” got a specialist appointment for their child as soon as their child needed.

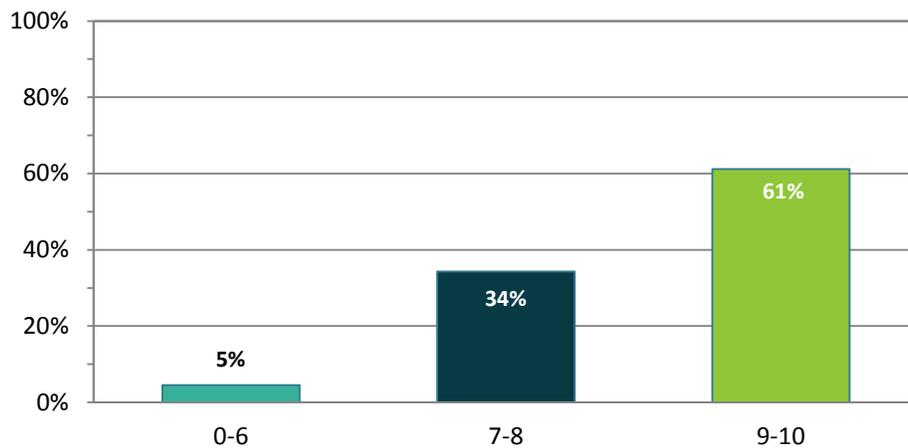
Figure 7 shows caregiver satisfaction with two aspects of access to needed care: (1) how often caregivers got appointments with specialists as soon as their child needed; and (2) how often it was easy to get the care, tests, or treatment their child needed. These items comprise the CAHPS® composite *Getting Needed Care*. Combining responses to both questions, 72 percent of members “usually” or “always” had positive experiences with *Getting Needed Care*, which is below the rate of the national Medicaid population (85 percent).

**Figure 7. CAHPS® Getting Needed Care Composite**



When asked to rate their child’s specialist on a scale of 0 to 10, caregivers seemed generally satisfied. Sixty-one percent gave a rating of 9 or 10, which is lower than the 70 percent national Medicaid average. STAR Health caregivers gave a high mean specialist rating of 8.7 (SD = 1.60).

**Figure 8. Caregiver Rating of Their Child’s Specialist**



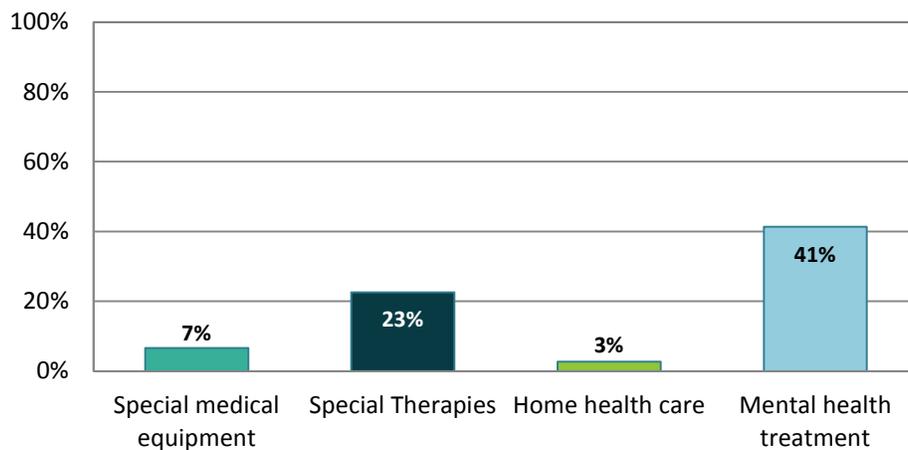
Caregivers were also asked about access to specialist referrals for their child. This question is an HHSC Performance Dashboard Indicator.

*Good Access to Specialist Referrals.* Seventy-eight percent of caregivers reported it was “usually” or “always” easy to get a referral to a specialist their child needed to see. This percentage falls below the HHSC Dashboard standard of 84 percent for this indicator.

## Access to Specialized Services

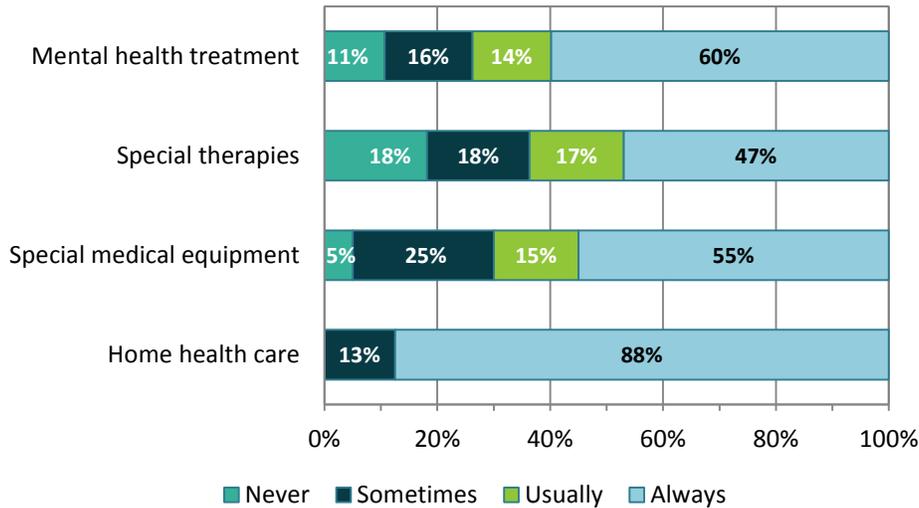
Over a third of caregivers reported that their child had medical, behavioral, or other health conditions that have lasted for more than three months (37 percent). Figure 9 shows the percentage of STAR Health members who needed specialized services due to these conditions. The most-utilized type of specialized service was mental health treatment for an emotional, developmental, or behavioral problem. Special therapies such as physical, occupational, or speech therapy were the second most common type of treatment. Few members required special medical equipment or treatments such as walkers or nebulizers, oxygen equipment, or home health care.

**Figure 9. Percentage of Members Needing Specialized Services**



Caregivers whose children needed specialized services reported on their ability to get the specialized services their children needed (Figure 10). Only eight caregivers responded that their children needed home health care or assistance, limiting the interpretability of this result; seven of the respondents reported that they always found it easy to get the service they needed, suggesting that the health plan may be serving these members well.

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



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-four percent of STAR Health caregivers whose children needed special therapies said it was “usually” or “always” easy to get this therapy. This percentage is similar to the HHSC Dashboard standard of 79 percent for this indicator.

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, 69 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.

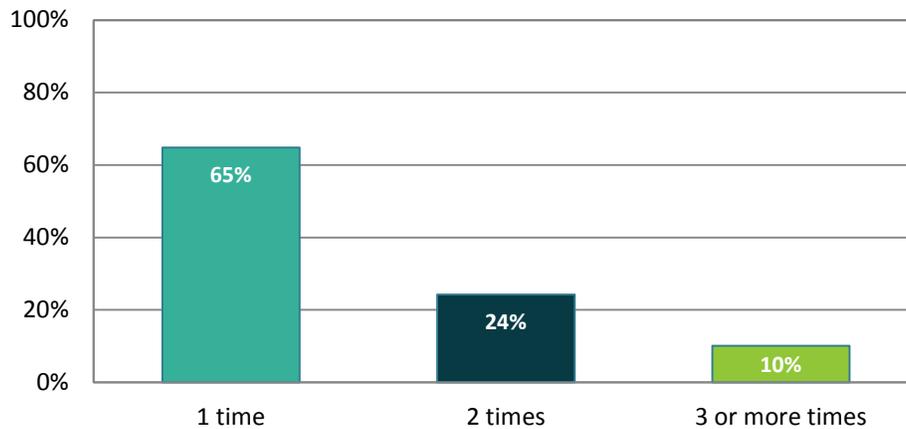
Prescription Medicines

Sixty-one percent of STAR Health caregivers said their child got new prescription medicines or had a medication refilled during the past six months. Among these caregivers, 88 percent said it was “usually” or “always” easy to get their child’s prescription medicine from their child’s health plan (CAHPS® *Prescription Medicines*), which is slightly below the 91 percent reported for this measure in Medicaid plans nationally. About half said that someone from their child’s health plan, doctor’s office, or clinic helped them get their child’s prescription medicine (49 percent).

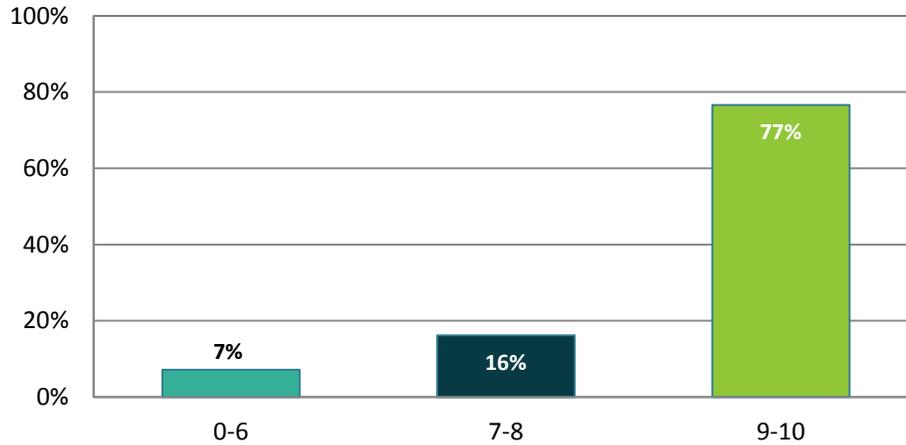
## Dental Care

Nine out of ten STAR Health members received dental care in the last six months (89 percent). Of members who received such care, more than one third went to the dentist on multiple occasions (35 percent). When asked to rate their child's dental care in the last six months on a scale of 0 to 10, 77 percent of caregivers gave a rating of 9 or 10. The mean dental rating was 9.1 (SD = 1.68).

**Figure 11. Number of Dental Visits in Past Six Months**



**Figure 12. Caregiver Rating for Child's Dental Care**



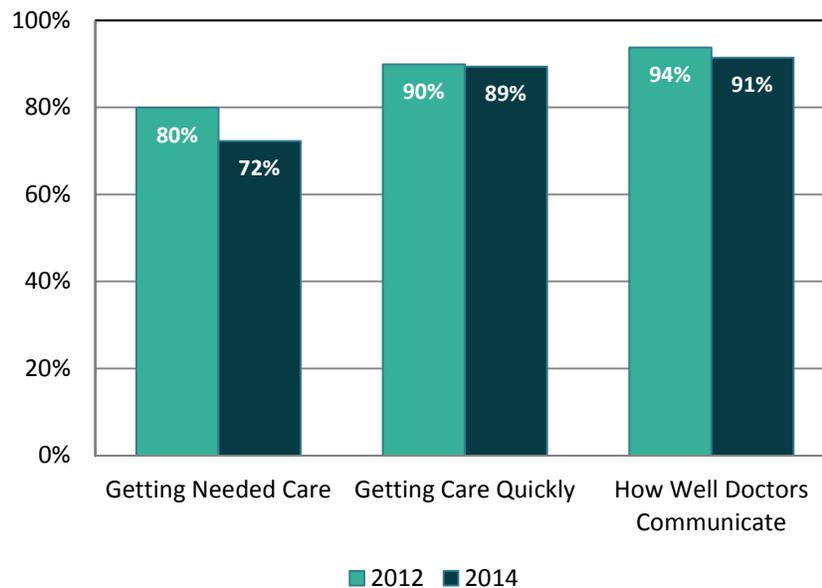
## Caregivers' Overall Satisfaction with Their Children's Health Care

Ten CAHPS® composites summarize caregiver satisfaction with their child's health care overall:

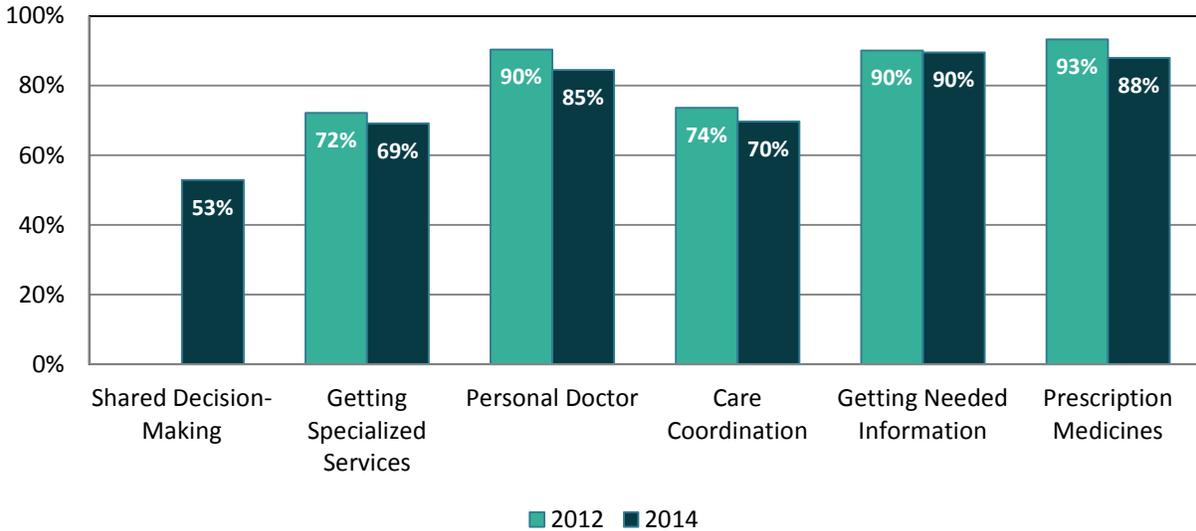
- *Getting Needed Care*
- *Getting Care Quickly*
- *How Well Doctors Communicate*
- *Health Plan Information and Customer Service*
- *Prescription Medicines*
- *Getting Specialized Services*
- *Personal Doctor*
- *Shared Decision-Making*
- *Getting Needed Information*
- *Care Coordination*

Most of these composites indicate that caregivers are satisfied with the services they are receiving from their health plan. Areas that could use improvement include shared decision-making, getting specialized services, and care coordination. Improvements could also be made in getting needed care among children with chronic conditions, as shown in Appendix B (Table B2). Due to wording changes in 2013, the *Shared Decision-Making* composite could not be trended from 2012 to 2014. Additionally, the *Health Plan Information and Customer Service* composite had low denominators in both 2012 and 2014, and therefore could not be reported.

**Figure 13. Percent of Caregivers Usually or Always Having Positive Experiences (Core CAHPS® Composites)**

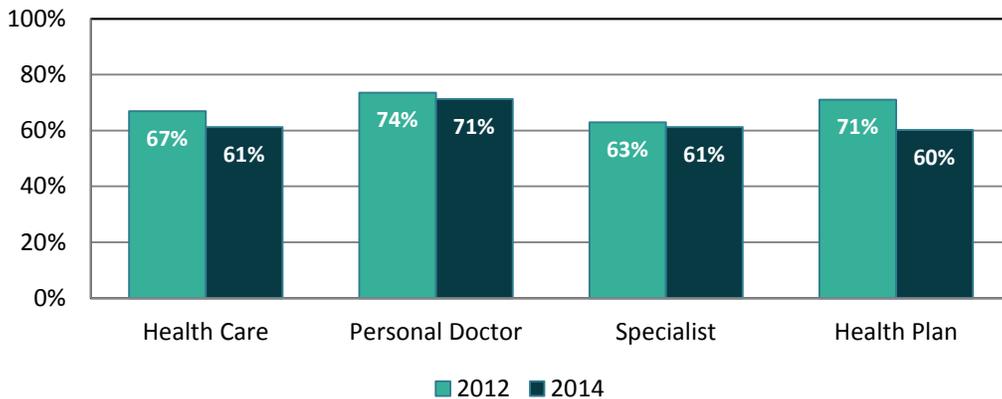


**Figure 14. Percent of Caregivers Usually or Always Having Positive Experiences (CAHPS® Composites for Children with Chronic Conditions)**



When asked to rate all of their child’s health care in the past six months on a scale of 0 to 10, 61 percent of caregivers gave a rating of 9 or 10, which is below the national Medicaid average of 66 percent. The mean rating for overall health care from all the STAR Health caregivers was 8.6 (SD = 2.09).

**Figure 15. Percent of Caregivers Rating Their Child's Health Services "9" or "10"**



### Patient-Centered Medical Home

A patient-centered medical home (PCMH) is defined by the American Academy of Family Physicians as a "system of comprehensive coordinated primary care for children, youth and adults."<sup>18</sup> The PCMH model is built on the idea that a personal physician coordinates care amongst a team of healthcare 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 comprises seven principles:<sup>19</sup>

- 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 structure

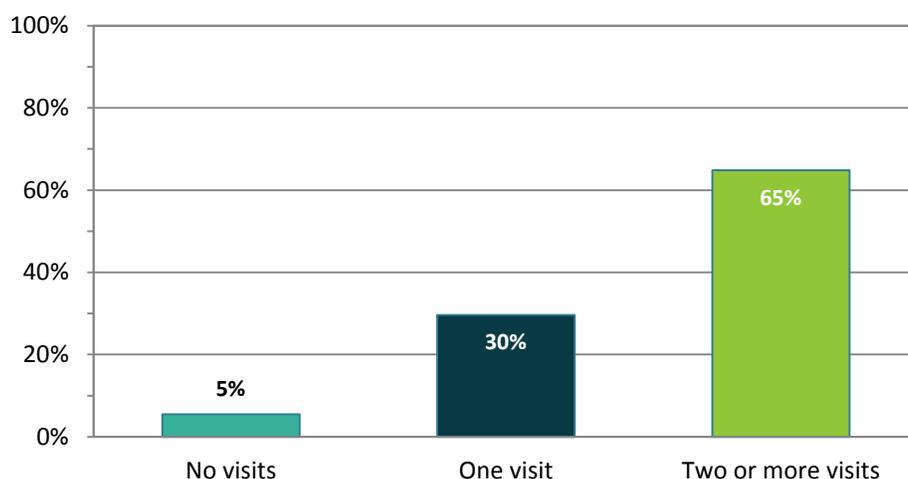
This survey addressed several components of the medical home model, specifically whether members have an ongoing relationship with a personal doctor, have access to advice and care during and after regular business hours, and receive high quality, patient-centered, and compassionate care from their personal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

#### Having a Personal Doctor

Most caregivers reported that their child had a personal doctor (92 percent). Among these children, nearly two in five had been going to their doctor for less than one year (38 percent).<sup>20</sup>

Caregivers were also asked how many times their child had a visit with their personal doctor in the past six months, with most children having visited their doctor on two or more occasions (65 percent).

**Figure 16. Number of Times Child Visited Their Personal Doctor in the Last Six Months**



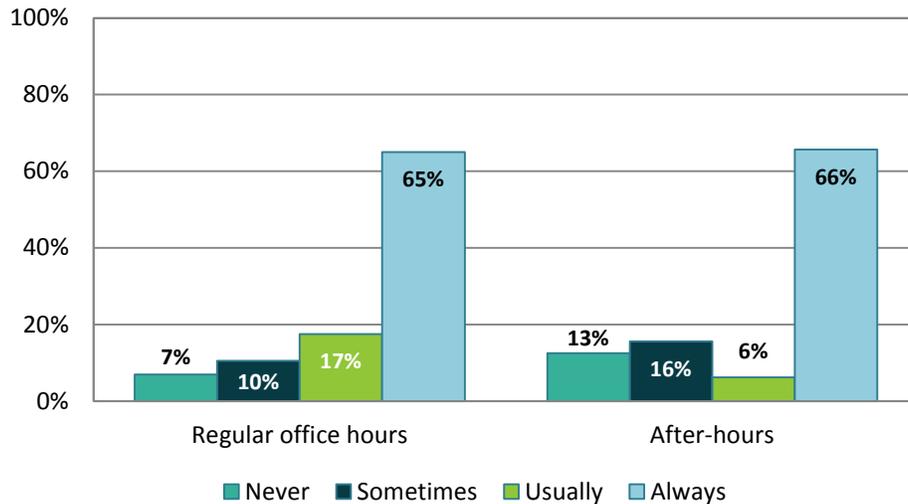
## Seeking Help and Advice

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.

Just over half of caregivers called their child's personal doctor's office during regular office hours to get help or advice for their child (52 percent). Among these caregivers, most (83 percent) reported that they "usually" or "always" received the help or advice they needed.

More than one in ten caregivers sought help or advice for their child after regular office hours (12 percent). Seventy-two percent of these caregivers reported that they received the after-hours help or advice they needed for their child; however, the remaining 28 percent of caregivers had some difficulty receiving after-hours help.

**Figure 17. Percent of Caregivers Who Received the Help or Advice Required when Calling During and After Regular Office Hours**



### Satisfaction with Doctors' Communication

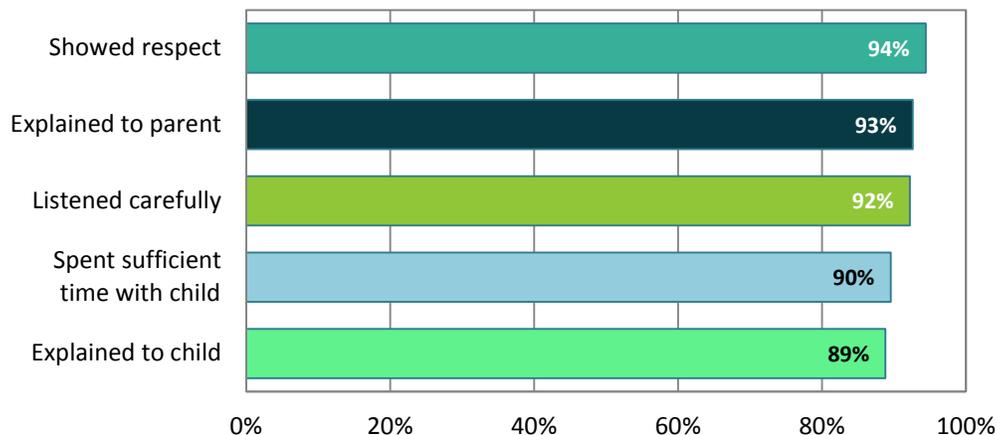
Several survey items assessed personal doctors' communication skills and ability to relate to the caregiver and child. Specifically, these items assessed a provider's ability to communicate effectively during visits and to respect caregivers' preferences and needs. These particular skills reflect essential 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 (Figure 18). A strong majority of caregivers reported that they were “usually” or “always” satisfied with the quality of communication they had with their child’s personal doctor.

**Figure 18. How Well Doctors Communicate: Percentage of Caregivers Who Reported Their Child’s Doctor Usually or Always:**



Combining responses to all five questions, 91 percent of caregivers “usually” or “always” had positive experiences with *How Well Doctors Communicate*. This percentage is similar to the 93 percent reported for Medicaid plans nationally.

*Doctors’ ability to answer caregivers’ questions*

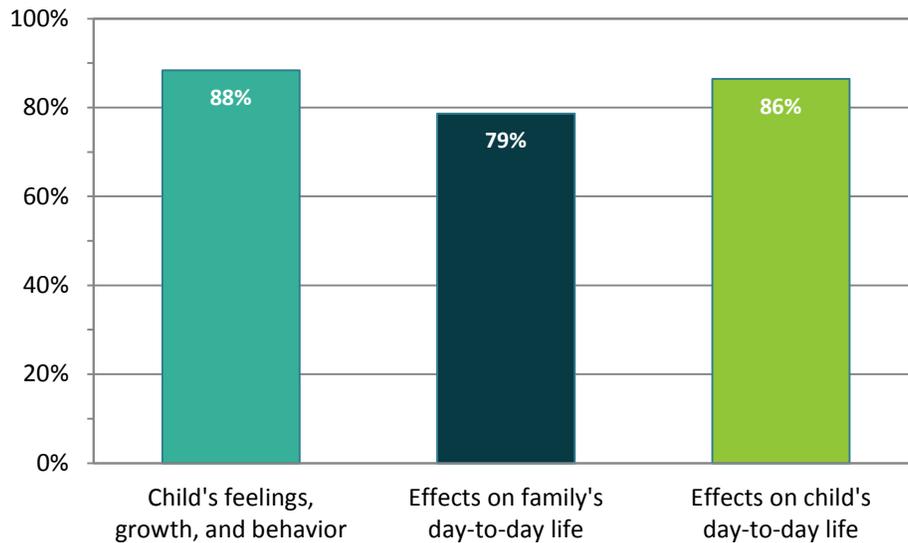
Caregivers were asked how often their child’s personal doctor and other health care providers were able to answer their questions. This item forms the CAHPS® composite *Getting Needed Information*. Ninety percent of caregivers stated that they “usually” or “always” had positive experiences with *Getting Needed Information*. This percentage is consistent with the Medicaid national average of 89 percent.

*Doctors’ ability to communicate about child’s health and development*

Lastly, three survey items assessed designated 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 whether members’ personal doctors were able to understand how medical and behavioral health conditions affect 2) the child’s and 3) the family’s day-to-day life.

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 (85 percent).

**Figure 19. Personal Doctor Composite: Percentage of Caregivers Who Reported Their Child's Doctor Usually or Always Discussed:**



### Shared Decision-Making

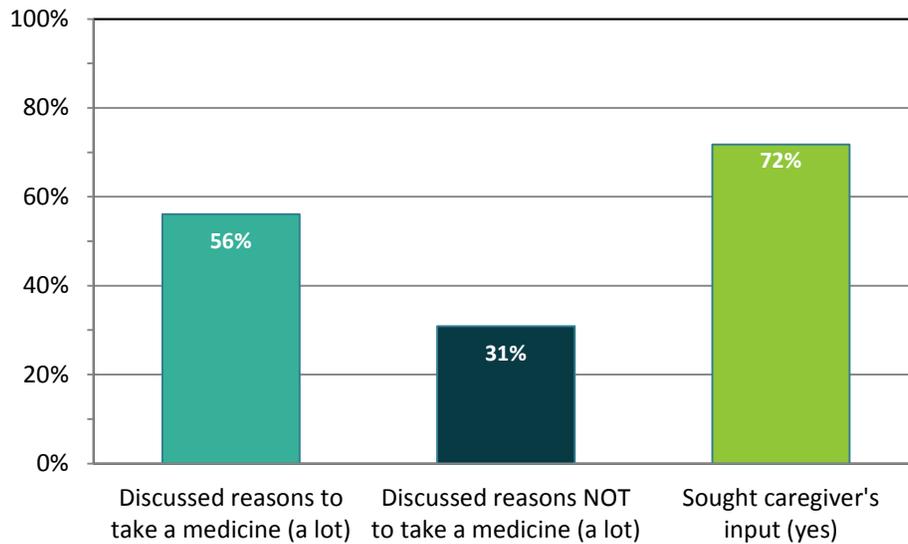
In 2012, the wording of the items and response sets comprising the *Shared Decision Making* composite were substantially changed. Due to these changes the composite was not publically reported in 2013 and trending is not possible from the 2012 STAR Health results. These new questions now focus on decision-making relating to prescription medications rather than general treatment decisions.

Forty-eight percent of caregivers said they talked with their child's provider about starting or stopping a prescription medication for their child. Among these caregivers:

- Fifty-six percent said the provider talked to them "a lot" about reasons they might want their child to take a medication.
- Thirty-one percent said the provider talked to them "a lot" about reasons they might *not* want their child to take a medication.
- Seventy-two percent said the provider asked them which choice they thought was best for their child.

Together, these new CAHPS® survey items form the composite *Shared Decision-Making*, for which 53 percent of caregivers had an aggregate positive experience (see composites on Figure 14).

**Figure 20. Shared Decision-Making Composite: Percent of Doctors Who:**

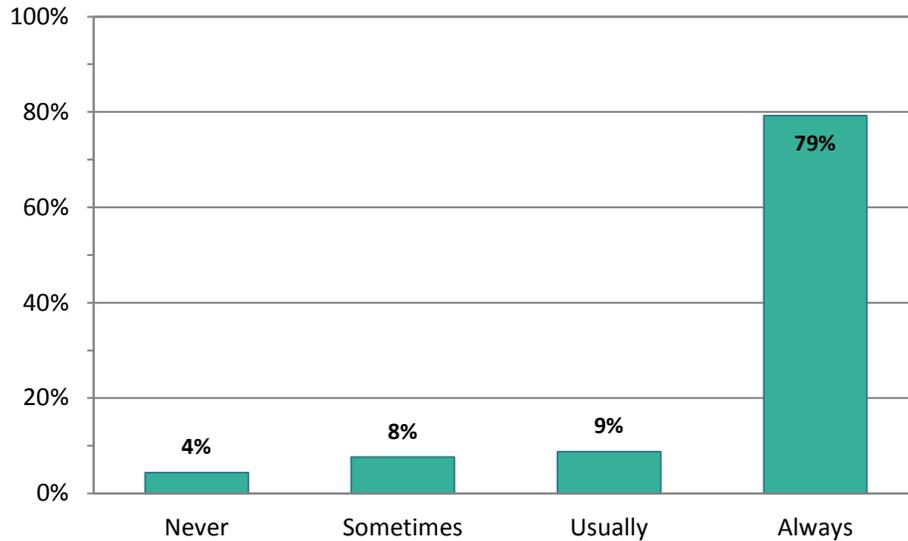


#### Communication about Prescription Medicines

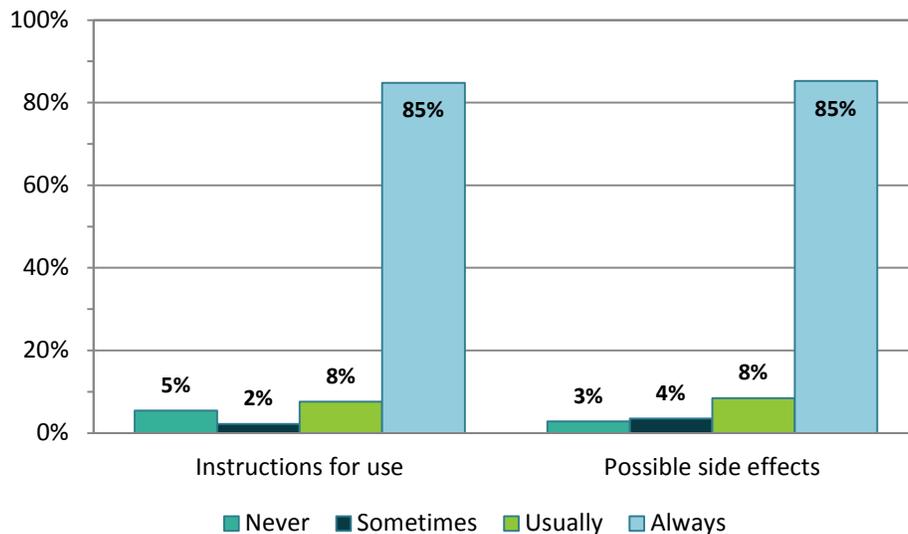
Caregivers were asked a series of questions regarding instructions provided by their child’s personal doctor on how to use prescription medicines. Nearly two-thirds of caregivers reported that their child uses prescription medicines (61 percent). Eighty-eight percent of these caregivers reported that it was “usually” or “always” easy to get these prescriptions through their child’s health plan. Among these caregivers:

- Ninety-two 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.
- 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 (51 percent).
- Seventy-eight percent of caregivers reported that their child’s personal doctor explained the side effects of their child’s medicines. Among those caregivers who received explanations of side effects for their child’s medicines, the vast majority reported that their child’s doctor “usually” or “always” explained possible side effects in a way that was easy to understand (94 percent).

**Figure 21. Percent of Caregivers Who Found It Easy to get Prescription Medicines Through Their Child's Health Plan**



**Figure 22. Percent of Caregivers Reporting Their Child's Personal Doctor Provided Easily Understood Explanations**

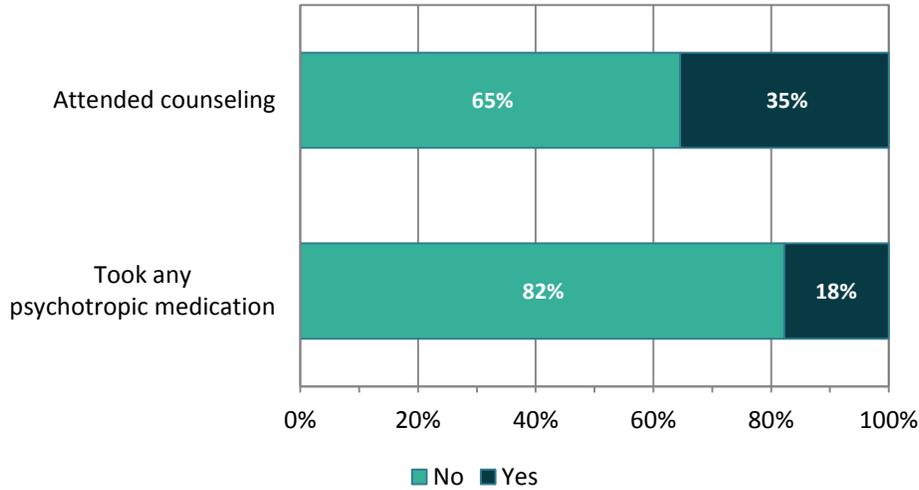


### Mental and Behavioral Health Treatment

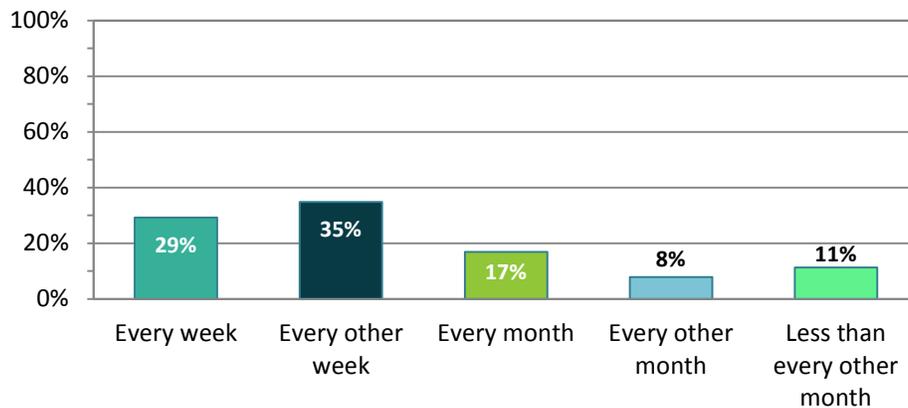
Several items assessed caregivers' experiences with their child or adolescent's mental and behavioral health providers, including receipt of counseling or psychotropic medications as part of a mental health treatment plan. Psychotropic medications are a type of prescription medication that specifically alter or affect perception, emotion, or behavior and include stimulants, antidepressants, antipsychotics, and mood stabilizers.

Thirty-eight percent of children and adolescents in STAR Health received mental health treatment during the past six months, including any psychotropic medication or any behavioral health counseling, treatment, or therapy. Among those who had a behavioral health appointment in the past six months, most (64 percent) attended appointments at least every two weeks (see Figure 24).

**Figure 23. Mental Health Treatment Needs: Percent of Members Who:**

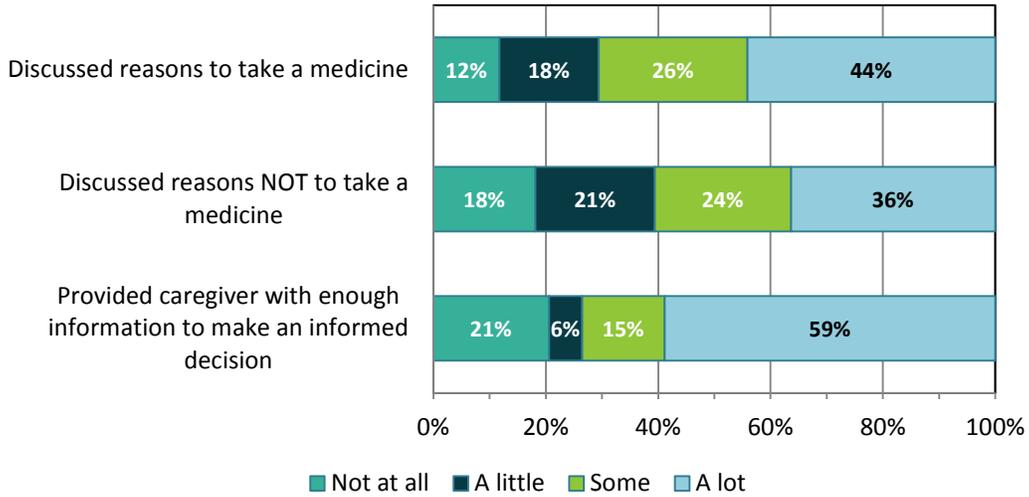


**Figure 24. Frequency of Counseling Appointments**



Doctors' communication with caregivers about reasons for starting, stopping, or continuing the use of psychotropic medications was also assessed. Just over one in four caregivers (27 percent) did not feel adequately informed to make decisions about starting, stopping, or continuing their child's medication. Figure 25 shows that slightly more doctors discussed reasons to take medication than reasons to avoid taking a medication. Slightly over half of doctors (53 percent) discussed non-pharmacological alternatives.

**Figure 25. Psychotropic Medications: Percent of Doctors Who:**



Most doctors (92 percent) provided the opportunity for adolescents 13 to 17 years of age to ask questions about psychotropic medications. Nonetheless, nearly one third of caregivers (31 percent) reported that their child was not provided enough information to make an informed decision about starting, stopping, or continuing with a psychotropic medication.

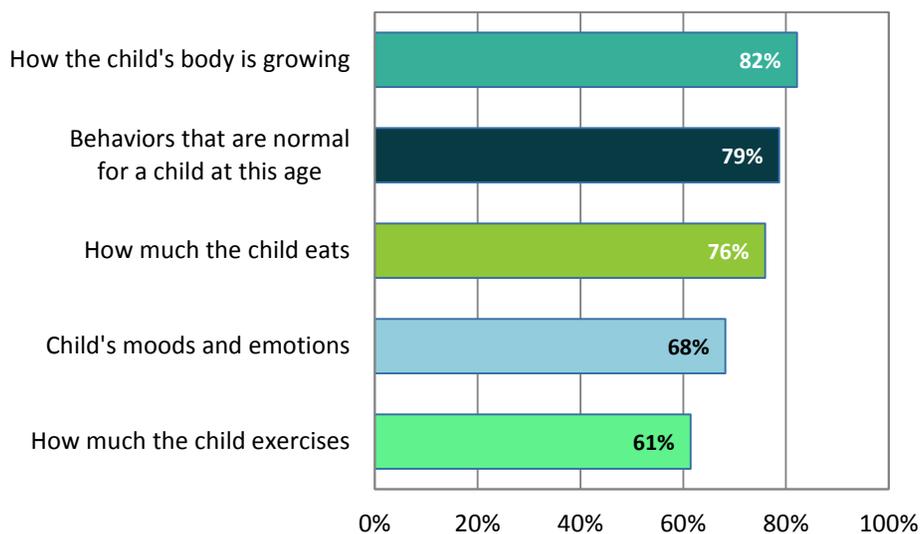
The findings on psychotropic medications in Figure 25 should be interpreted with caution given the small number of caregivers who responded to the questions (N = 34).

Preventive Care and Health Promotion

Caregivers of children up to two years of age were asked about appointments and reminders for check-ups or other health care services. More than nine in ten caregivers (93 percent) reported that their child had been to see a doctor or other health provider for a check-up or for shots or drops at any point since birth, with nearly seven in ten caregivers (68 percent) reporting that they received a reminder from their doctor’s office for the visit. Almost all caregivers (97 percent) said they were able to schedule these check-ups for their child as soon as they needed.

All caregivers were asked a set of supplemental CAHPS® survey items from the Clinician and Group Surveys to assess caregiver experiences with their child or adolescent’s personal doctor in discussing developmental and preventive care issues. Figure 26 provides the percentages of caregivers who reported that their child’s personal doctor discussed their child’s growth, moods and emotions, and behavior.

**Figure 26. Developmental and Preventive Care: Percent of Doctors Who Discussed:**



#### Preparing Caregivers and CSHCN for Transition to Adulthood

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

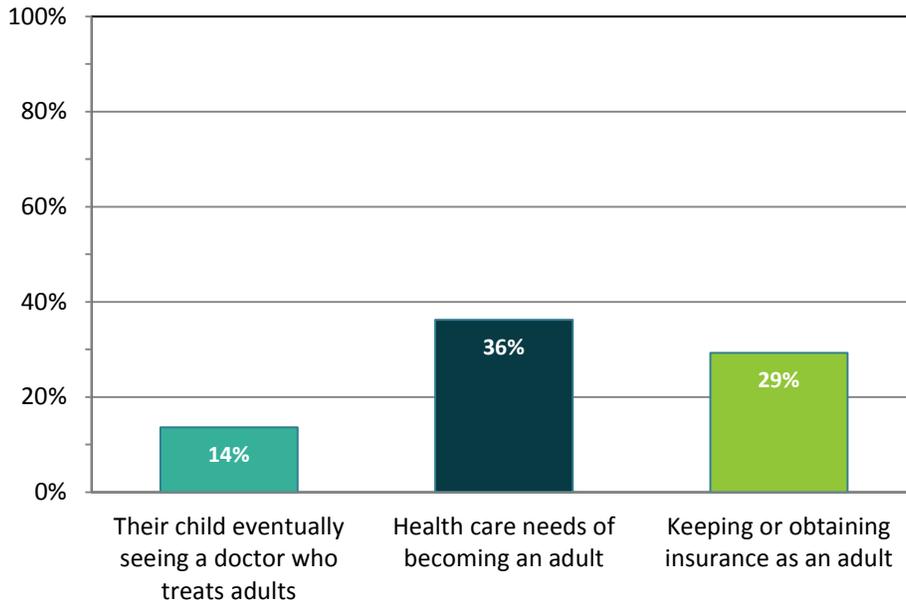
More than three in four caregivers reported that their child's doctor treats only children (77 percent). Among these caregivers:

- Fourteen percent said that their child's doctor spoke to them about their child eventually having to see providers who treat adults.
- Thirty-two 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 healthcare needs of their child as he or she becomes an adult (36 percent). Among all caregivers, 49 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. Less than one in three reported that a doctor or other health care provider spoke with them about how to keep or obtain health insurance coverage as their child becomes an adult (29 percent). Among all caregivers, 56 percent reported that a discussion about their child's insurance would have been helpful to them.

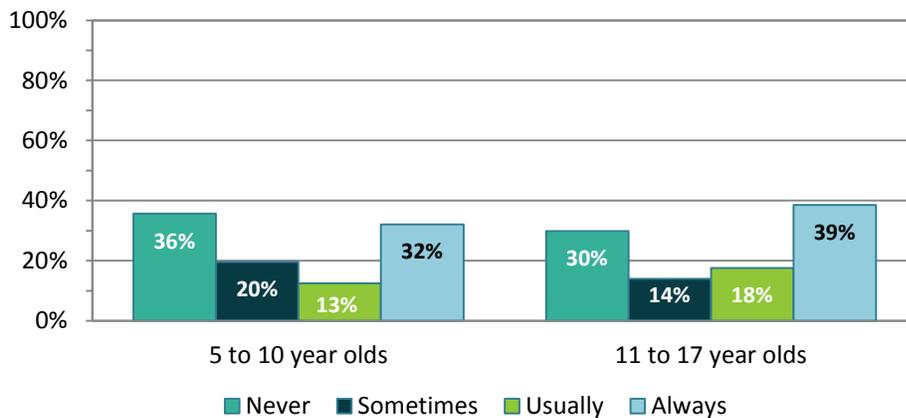
**Figure 27. Discussion of Changing Health Care Needs as an Adolescent Becomes an Adult**



Lastly, caregivers were asked how often their child’s doctor or other personnel encouraged their child to take responsibility for his or her health care needs. Caregivers of children aged eleven to seventeen were asked how often healthcare providers encouraged their children to take responsibility by taking their medications and following medical advice; fifty-seven percent responded that their child's provider “usually” or “always” gave such encouragement.

Caregivers of children age five to ten were only asked how often their child’s doctor encouraged their children to take responsibility by learning about and helping with their medications; forty-five percent responded that their child's provider “usually” or “always” gave such encouragement.

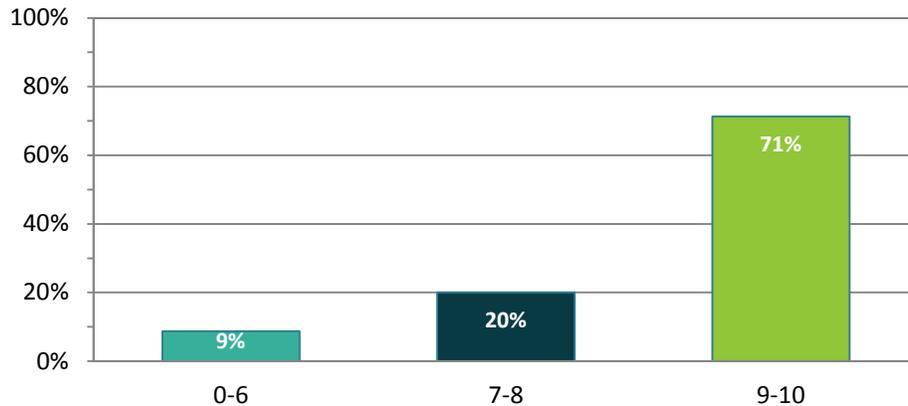
**Figure 28. How Often Doctors Talked with Members About Taking Personal Responsibility for Their Own Health**



### Caregiver Rating of Personal Doctor

Caregivers were asked to rate their child’s personal doctor on a scale of 0 to 10. Seventy-one percent of caregivers gave a rating of 9 or 10, compared to 73 percent nationally. The mean personal doctor rating for STAR Health was 8.9 (SD = 1.80).

**Figure 29. Personal Doctor Rating**

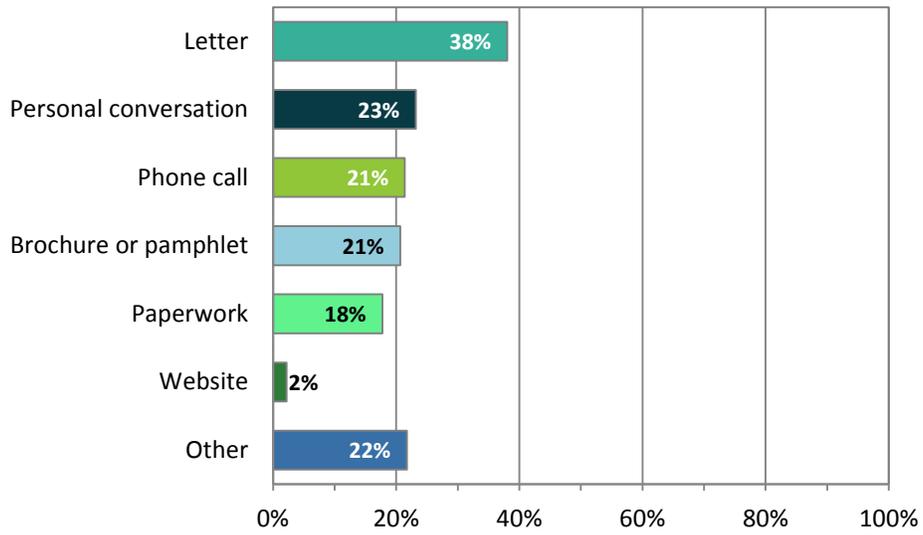


### **Care Coordination**

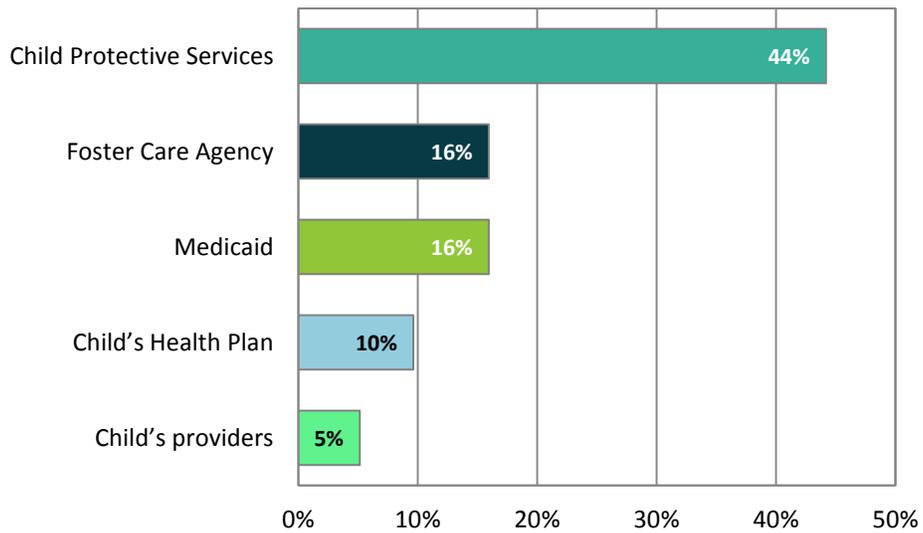
#### Texas Health Steps

Texas Health Steps is Medicaid’s wellness program for babies, children, teens, and young adults age 20 and younger. This program reminds caregivers to schedule their children’s medical and dental check-ups. The following items assessed caregivers’ awareness of and communications regarding the Texas Health Steps program. Ninety-two percent of caregivers were aware that their child is eligible for Texas Health Steps. Among those caregivers who were aware of the Texas Health Steps program, most received a letter about the program (see Figure 30) and most reported learning about the program through Child Protective Services (see Figure 31). Regardless of awareness of Texas Health Steps, almost three out of four caregivers (72 percent) reported receiving reminders to schedule both medical and dental check-ups for their child within the last 12 months (see Figure 32).

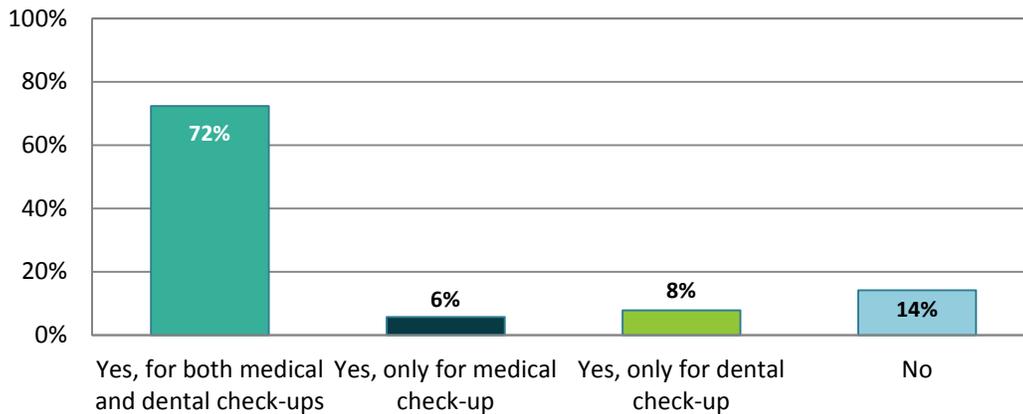
**Figure 30. Types of Communication for Learning about Texas Health Steps**



**Figure 31. Source of Information about Texas Health Steps**



**Figure 32. Percent of Caregivers Who Received a Scheduling Reminder from Texas Health Steps**

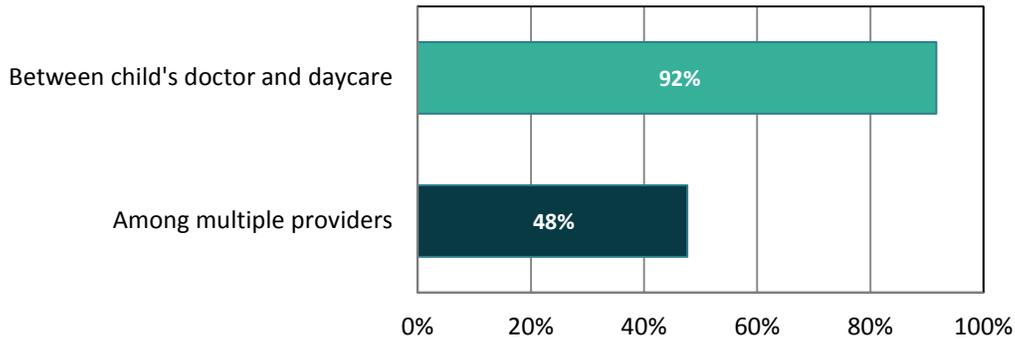


### General Care Coordination

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 regarding their child's healthcare services. Forty-two percent of caregivers said that their child received care from a doctor or a health provider other than his or her personal doctor. Similarly, 36 percent of caregivers said that their child received care from more than one kind of healthcare provider or used more than one kind of healthcare service.

Two CAHPS® survey items form 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 33 shows caregivers' responses to the individual items that comprise *Care Coordination*. Combined, 70 percent of caregivers said that they got the care coordination they needed, which is below the 76 percent reported for this composite in the national Medicaid population.

**Figure 33. Care Coordination: Percent of Caregivers Reporting They Received 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 such management is needed. Thirty-five percent of caregivers said they received a call to assess the need for service management. Of caregivers who did receive a call, more than half said that the service manager recommended service management for their child’s healthcare needs (55 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 healthcare services. A majority of caregivers for whose child service management was recommended agreed to participate in the program (85 percent).

Among caregivers who agreed to participate, more than half said they had received any service management for their child in the last six months (56 percent). Of these caregivers, more than five out of six were either satisfied or very satisfied with the care coordination (86 percent).

**Health Plan**

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

Health Plan Approval

Nearly half of all caregivers (45 percent) attempted to access care, tests, or treatment for their child or adolescent through the STAR Health Superior HealthPlan. Of these, 32 percent reported experiencing at least some delay while waiting for approval from the health plan.

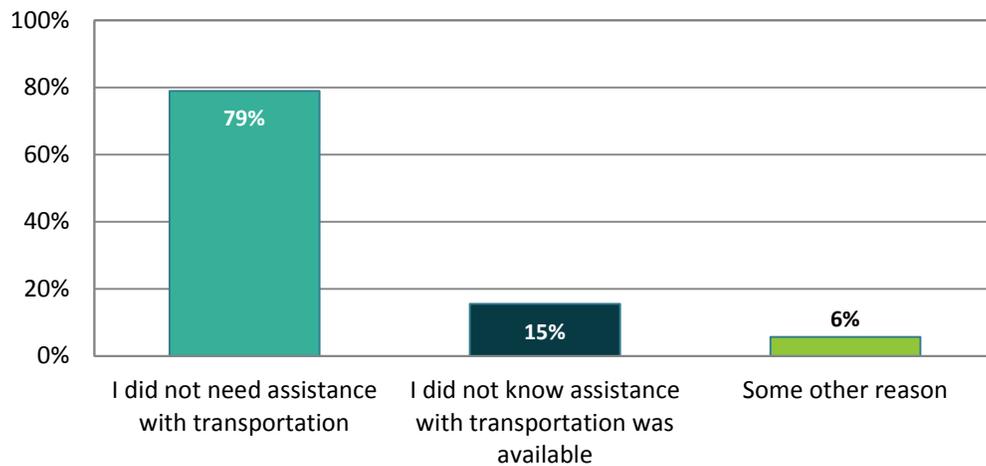
### Health Plan Information and Customer Service

Most caregivers (82 percent) did not utilize the customer service line for their child or adolescent's health plan. The number of respondents who interacted with the health plan's customer service line was too low for further analysis, and the CAHPS® *Customer Service* composite measure is reported as "Low Denominator." Most caregivers (84 percent) were not given any forms to fill by their child or adolescent's health plan.

### Transportation

One in 20 caregivers phoned their STAR Health plan to facilitate transportation for their child in the last six months (5 percent). The number of respondents who called for assistance with transportation was too low for more in depth analysis of service received. Most caregivers (79 percent) who did not call for assistance with transportation did not require such assistance, but a substantial fraction of caregivers (15 percent) were unaware that the service might be available.

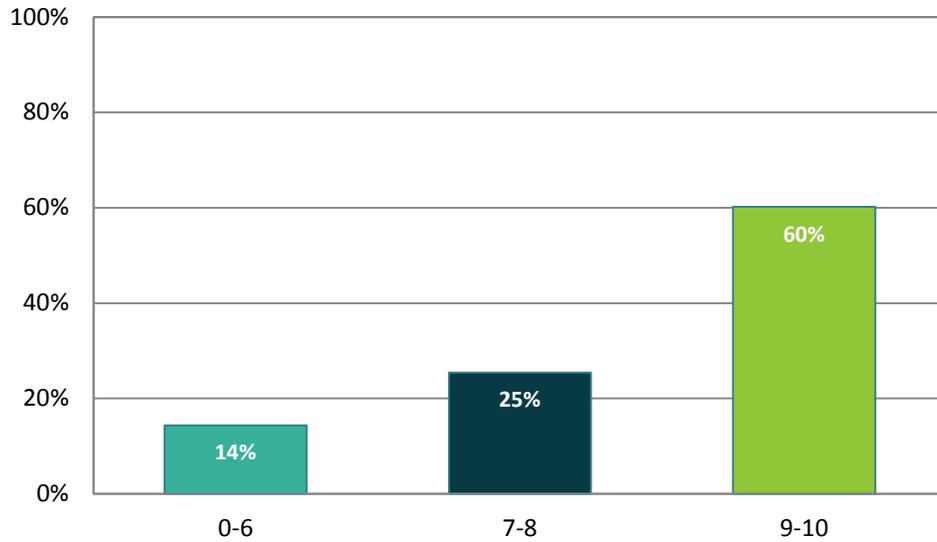
**Figure 34. Why did Caregivers Not Call for Assistance with Transportation?**



### 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, 60 percent of caregivers gave a rating of 9 or 10, which is below the percentage of the national Medicaid population who gave their health plan a rating of 9 or 10 (67 percent). The mean caregiver rating of their child's health plan was 8.4 (SD = 2.24).

**Figure 35. Health Plan Rating**



## 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 6 continuous months or longer between February 2014 and September 2014. 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. The EQRO set a target of 300 completed telephone interviews with caregivers of sampled members. This sample size was selected to provide a reasonable confidence interval for the survey responses.

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.

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 3,000 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 to identify any participation biases in the final sample.

### Survey Instruments

The FY 2014 STAR Health Caregiver Survey is comprised of:

- The CAHPS® Health Plan Survey 5.0H Child Questionnaire with CCC Measure (Medicaid module).<sup>1</sup>
- Items from the CAHPS® Clinician and Group Surveys.<sup>2</sup>
- 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®.<sup>3</sup>
- Items from the National Survey of CSHCN (NS-CSHCN) addressing issues of transition to adult care.<sup>4</sup>
- Items developed by ICHP pertaining to member and caregiver demographics and household characteristics.
- Pilot tested items developed by ICHP and Texas HHSC pertaining to caregiver knowledge of the Texas Health Steps program as well as child psychotropic medication and behavioral health.

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.<sup>21</sup> Composite scores were calculated following AHRQ specifications for all domains. 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.

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 approach 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 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 5.0H.

In 2014, the EQRO moved from using CAHPS® 5.0 to CAHPS® 5.0H with CCC measure. This version of the CAHPS® survey incorporates several supplementary items the EQRO has historically included, as well as the CSHCN Screener. 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.

Seven survey questions function as indicators of health plan performance for STAR Health members, as listed on HHSC's Performance Indicator Dashboard for CY 2014.<sup>12</sup> These include: (1) Good access to urgent care; (2) Good access to specialist referral; (3) Good access to routine care; (4) Good access to behavioral health treatment or counseling; (5) Rating child's personal doctor a "9" or "10"; (6) Rating child's health plan a "9" or "10"; and (7) Good experience with doctor's communication.

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.<sup>22,23,24</sup>

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 University of Florida Survey Research Center (UFSRC) conducted the surveys using computer-assisted telephone interviewing (CATI) between August 2014 and November 2014. UFSRC telephoned caregivers of STAR Health members seven days a week between 9:00 a.m. and 9:00 p.m. Central Time. Spanish speakers were recruited for participation in the Spanish pilot surveys which were conducted by a Spanish-speaking interviewer. For the final and follow-up surveys, if a respondent was unable to complete the interview in English, UFSRC referred the respondent to a Spanish-speaking interviewer.

The EQRO sent letters written in English and Spanish to caregivers of 3,000 sampled STAR Health members, requesting their participation in the survey. Of the advance letters sent, five were returned undeliverable.

Up to 20 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, UFSRC referred the respondent to a Spanish-speaking interviewer.

Attempts were made to contact 2,041 STAR Health members sampled for the survey. No financial incentives were offered to participate in the surveys. Twenty-two percent of families could not be located. Among those located, three percent indicated that the child was not enrolled in STAR Health and 14 percent refused to participate. The response rate was 33 percent and the cooperation rate was 65 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 IBM SPSS Statistics 22.0<sup>®</sup>. Frequency tables showing descriptive results for each survey question are provided in a separate Technical Appendix. The statistics presented in this report exclude "don't 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 analysis of variance (ANOVA). These tests allowed comparison of frequencies and means among different demographic sub-groups within the sample. Differences were considered to be statistically significant at  $p < 0.05$ .

BMI was calculated by dividing the child's weight in kilograms by their height in meters squared. BMI could be calculated for 214 children in the sample (71 percent) for whom height and weight data were complete. Height data were missing for 84 children (28 percent), and weight data were missing for 23 children (eight 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:<sup>25</sup>

- 1) Underweight (less than 5<sup>th</sup> percentile)
- 2) Healthy (5<sup>th</sup> percentile to less than 85<sup>th</sup> percentile)
- 3) Overweight (85<sup>th</sup> to less than 95<sup>th</sup> percentile)
- 4) Obese ( $\geq$ 95<sup>th</sup> 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 45 children whose BMI deviated considerably from age- and sex-specific child growth standards provided by the World Health Organization.<sup>26,27</sup> 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.

## 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	Shared Decision Making
<b>Caregiver race/ethnicity</b>				
Hispanic	2.45	2.63	2.71	2.32
White-NH	2.43	2.64	2.76	2.20
Black-NH	2.65	2.74	2.70	2.19
F-Significance	N.S.	N.S.	N.S.	N.S.
<b>Caregiver education</b>				
Less than high school	2.58	2.76	2.65	2.28
High school or GED	2.60	2.77	2.84	2.23
Some college or college degree	2.38	2.57	2.71	2.22
F-Significance	N.S.	<b>0.03</b>	N.S.	N.S.

\* In the case of a significant F, Bonferroni-corrected post hoc pairwise comparisons were performed. While the overall F-test indicated a significant difference in getting care quickly by caregiver education, the post hoc comparisons did not reach statistical significance.

\*\*Specifications by NCQA produce scaled scores, rather than percentage-based scores. These scores range from 0 to 3 for most composites.

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

	<b>Getting Needed Care</b>	<b>Getting Care Quickly</b>	<b>How Well Doctors Communicate</b>	<b>Shared Decision Making</b>
<b>Child Sex</b>				
Male	2.49	2.62	2.71	2.24
Female	2.46	2.68	2.75	2.23
F-Significance	N.S.	N.S.	N.S.	N.S.
<b>Child Age</b>				
Birth to 3 years	2.52	2.62	2.77	2.25
4 to 11 years	2.42	2.64	2.66	2.23
12 to 18 years	2.47	2.73	2.74	2.17
F-Significance	N.S.	N.S.	N.S.	N.S.
<b>Child Race/Ethnicity</b>				
Hispanic	2.42	2.62	2.72	2.28
White-NH	2.45	2.67	2.77	2.14
Black-NH	2.71	2.69	2.67	2.33
F-Significance	N.S.	N.S.	N.S.	N.S.
<b>Any Special Needs</b>				
No	2.62 <sup>a</sup>	2.68	2.75	2.12
Yes	2.38 <sup>b</sup>	2.65	2.73	2.25
F-Significance	<b>&lt;0.01</b>	N.S.	N.S.	N.S.
<b>Child BMI</b>				
Healthy	2.50	2.74	2.77	2.22
Overweight	2.55	2.63	2.75	2.17
Obese	2.59	2.71	2.68	2.10
F-Significance	N.S.	N.S.	N.S.	N.S.

\* In the case of a significant F, Bonferroni-corrected post hoc pairwise comparisons were performed. Superscripts denote statistical differences between groups. 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.

\*\* Specifications by NCQA produce scaled scores, rather than percentage-based scores. These scores range from 0 to 3 for most composites.

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

	<b>Getting Specialized Services</b>	<b>Personal Doctor</b>	<b>Care Coordination</b>	<b>Getting Needed Information</b>	<b>Prescription Medicines</b>
<b>Caregiver race/ethnicity</b>					
Hispanic	2.29	0.90	0.64	2.65	2.49
White-NH	2.28	0.85	0.49	2.62	2.75
Black-NH	2.35	0.89	0.52	2.69	2.76
F-Significance	N.S.	N.S.	N.S.	N.S.	N.S.
<b>Caregiver education</b>					
Less than high school	2.11	0.94	0.68	2.65	2.54
High school or GED	2.44	0.90	0.65	2.62	2.59
Some college or college degree	2.25	0.84	0.49	2.65	2.73
F-Significance	N.S.	N.S.	N.S.	N.S.	N.S.

\*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.

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

	Getting Specialized Services	Personal Doctor	Care Coordination	Getting Needed Information	Prescription Medicines
<b>Child sex</b>					
Male	2.33	0.85	0.60	2.62	2.77
Female	2.23	0.89	0.50	2.67	2.59
F-Significance	N.S.	N.S.	N.S.	N.S.	N.S.
<b>Child age</b>					
Birth to 3 years	2.31	0.89	0.54	2.77 <sup>a</sup>	2.62
4 to 11 years	2.39	0.84	0.57	2.61 <sup>ab</sup>	2.68
12 to 18 years	2.06	0.88	0.52	2.40 <sup>b</sup>	2.77
F-Significance	N.S.	N.S.	N.S.	<b>&lt;0.01</b>	N.S.
<b>Child race/ethnicity</b>					
Hispanic	2.32	0.87	0.58	2.62	2.56
White-NH	2.24	0.87	0.49	2.66	2.79
Black-NH	2.22	0.89	0.54	2.64	2.68
F-Significance	N.S.	N.S.	N.S.	N.S.	N.S.
<b>Any special needs</b>					
No	2.43	0.88	0.61	2.75 <sup>a</sup>	2.63
Yes	2.27	0.86	0.54	2.58 <sup>b</sup>	2.70
F-Significance	N.S.	N.S.	N.S.	<b>0.03</b>	N.S.
<b>Child BMI</b>					
Healthy	2.38	0.91	0.65	2.52	2.76
Overweight	2.30	0.89	0.45	2.57	2.83
Obese	2.49	0.85	0.61	2.78	2.74
F-Significance	N.S.	N.S.	N.S.	N.S.	N.S.

\* In the case of a significant F for tests with predictors that have three categories, Bonferroni-corrected post hoc pairwise comparisons were performed. Superscripts denote statistical differences between groups. 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.

\*\* 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.

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

<b>Caregiver race/ethnicity</b>	<b>Had good access to urgent care</b>	<b>Had good access to specialist referral</b>	<b>Had good access to routine care</b>	<b>Had good access to behavioral health treatment or counseling</b>	<b>Personal Doctor rated 9 or 10</b>	<b>Health Plan rated 9 or 10</b>
Hispanic	85%	76%	90%	68%	76%	75% <sup>a</sup>
White-NH	90%	78%	90%	77%	66%	49% <sup>b</sup>
Black-NH	94%	86%	90%	79%	77%	66% <sup>ab</sup>
Chi square significance	N.S.	N.S.	N.S.	N.S.	N.S.	<b>&lt;0.001</b>
Phi/Cramer's V	-	-	-	-	-	0.233
<b>Caregiver education</b>						
Less than high school	94%	83%	90%	69%	71%	78.8% <sup>a</sup>
High school or GED	91%	79%	96%	80%	76%	67.9% <sup>b</sup>
Some college or college degree	86%	78%	88%	72%	69%	50.6% <sup>c</sup>
Chi square significance	N.S.	N.S.	N.S.	N.S.	N.S.	<b>&lt;0.001</b>
Phi/Cramer's V	-	-	-	-	-	0.231

\* In the case of a significant  $\chi^2$ , Bonferroni-corrected post hoc pairwise comparisons were performed. Superscripts denote statistical differences between groups. Ratings within a column that share a common superscript do not significantly differ from one another; Ratings within a column that have different superscripts significantly differ from one another.

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

	Had good access to urgent care	Had good access to specialist referral	Had good access to routine care	Had good access to behavioral health treatment or counseling	Personal Doctor rated 9 or 10	Health Plan rated 9 or 10
<b>Child Sex</b>						
Male	83%	79%	90.0%	76%	77% <sup>a</sup>	63%
Female	94%	77%	90%	72%	66% <sup>b</sup>	58%
Chi square significance	N.S.	N.S.	N.S.	N.S.	<b>0.05</b>	N.S.
Phi/Cramer's V	-	-	-	-	0.12	-
<b>Child Age</b>						
Birth to 3 years	87%	85%	90%	79% <sup>ab</sup>	70%	62%
4 to 11 years	92%	70%	89%	82% <sup>a</sup>	71%	61%
12 to 18 years	88%	73%	90%	59% <sup>b</sup>	73%	55%
Chi square significance	N.S.	N.S.	N.S.	<b>0.04</b>	N.S.	N.S.
Phi/Cramer's V	-	-	-	0.23	-	-
<b>Child Race/Ethnicity</b>						
Hispanic	86%	82%	90%	71%	76%	67%
White-NH	89%	67%	90%	76%	66%	53%
Black-NH	94%	100.0%	88%	75%	71%	60%
Chi square significance	N.S.	N.S.	N.S.	N.S.	N.S.	N.S.
Phi/Cramer's V	-	-	-	-	-	-
<b>Any Special Needs</b>						
No	83%	85%	91%	85%	77%	69% <sup>a</sup>
Yes	93%	75%	90%	72%	68%	52% <sup>b</sup>
Chi square significance	N.S.	N.S.	N.S.	N.S.	N.S.	<b>&lt;0.01</b>
Phi/Cramer's V	-	-	-	-	-	0.17
<b>Child BMI</b>						
Healthy	89%	82%	91%	75%	74%	55%
Overweight	90%	50%	92%	80%	79%	55%
Obese	94%	80%	93%	82%	68%	73%
Chi square significance	N.S.	N.S.	N.S.	N.S.	N.S.	N.S.
Phi/Cramer's V	-	-	-	-	-	-

\* In the case of a significant  $\chi^2$ , Bonferroni-corrected post hoc pairwise comparisons were performed. Superscripts denote statistical differences between groups. Ratings within a column that share a common superscript do not significantly differ from one another; ratings within a column that have different superscripts significantly differ from one another.

## Endnotes

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<sup>18</sup> American Academy of Family Physicians. 2012. *Patient-Centered Medical Home*. Available at: <http://www.aafp.org/online/en/home/policy/policies/p/patientcenteredmedhome.html>.

<sup>19</sup> American College of Physicians (ACP). 2007. *Joint Principles of the Patient-Centered Medical Home*. Available at: [http://www.acponline.org/running\\_practice/pcmh/demonstrations/jointprinc\\_05\\_17.pdf](http://www.acponline.org/running_practice/pcmh/demonstrations/jointprinc_05_17.pdf).

<sup>20</sup> It is expected that many STAR Health members will periodically exit conservatorship and disenroll from the program, resulting in discontinuity of care that is beyond the control of the STAR Health MCO. 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.

<sup>21</sup> Consumer Assessment of Healthcare Providers and Systems (CAHPS®). CAHPS Database. Available at: <https://cahpsdatabase.ahrq.gov/>.

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