



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

Texas Medicaid Managed Care STAR+PLUS Behavioral Health Survey Report

Fiscal Year 2011

Measurement Period:

September 1, 2010 through August 31, 2011

**The Institute for Child Health Policy
University of Florida**

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

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Executive Summary

Introduction

This report provides results from the state fiscal year 2011 STAR+PLUS Behavioral Health Survey, prepared by the Institute for Child Health Policy (ICHP) at the University of Florida, the External Quality Review Organization (EQRO) for the State of Texas Medicaid Managed Care. In fiscal year 2011, STAR+PLUS was administered through four managed care organizations (MCOs), providing services in four geographic service areas (SAs) of Texas. The Texas Health and Human Services Commission (HHSC) contracts with ICHP to evaluate members' experiences and satisfaction with their health care while enrolled in the STAR+PLUS program.

The purpose of the fiscal year 2011 STAR+PLUS Behavioral Health Survey is to:

- Describe the demographic and household characteristics of adult members with behavioral health conditions.
- Assess the health status of the population, including overall health ratings and obesity.
- Document member experiences and general satisfaction with the behavioral health care they receive through STAR+PLUS MCOs and BHOs across six domains of care:
 - Utilization of behavioral health care
 - Access to and timeliness of behavioral health care
 - Patient-centered medical home
 - Behavioral health treatment benefits and assistance
 - Service coordination
 - Perceived outcomes of counseling and treatment
- Test the influence of members' experiences in the clinician's office on their perceived improvement of symptoms.

Methodology

Survey participants were selected from a stratified random sample of STAR+PLUS members with behavioral health conditions who were continuously enrolled in the program for 12 months between January 2010 and December 2010. The EQRO set a target sample of 1,200 completed telephone interviews with members, representing 300 respondents for each of the four STAR+PLUS MCOs. The response rate for this survey was 75 percent and the cooperation rate was 92 percent.

The fiscal year 2011 STAR+PLUS Behavioral Health Survey included:

- The Experience of Care and Health Outcomes (ECHO[®]) Survey 3.0
- Items developed by ICHP pertaining to member demographic and household characteristics, and member experiences and satisfaction with service coordination.

Summary of Findings

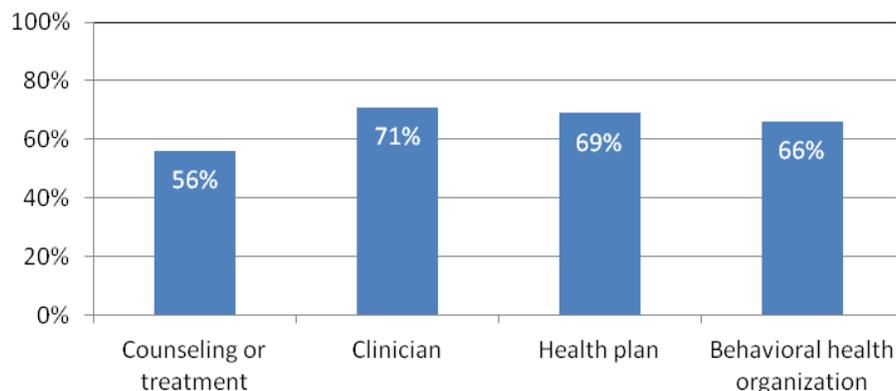
Profile of STAR+PLUS Behavioral Health Survey participants:

- The average age was 47 years old.
- Hispanic members were the most common racial/ethnic group (35 percent), followed by Black, non-Hispanic members (29 percent), and White, non-Hispanic members (28 percent).
- Forty percent of members did not complete high school.
- Ninety-seven percent of members were unemployed.
- Approximately half of members were single (45 percent), one-quarter of members were divorced (24 percent), and 10 percent were married.
- One in four members reported living alone (28 percent).

Positive findings

- *Access to urgent care.* Two-thirds of members reported “usually” or “always” receiving urgent behavioral health care as soon as they thought they needed it.
- *Access to routine care.* Three-quarters of members reported “usually” or “always” being able to make an appointment for routine care as soon as they thought they needed it.
- *Presence of a usual source of behavioral health care.* Three-quarters of members said there was one person who provided most of their counseling or treatment.
- *Clinician and MCO/BHO ratings.* Overall, members rated their clinicians, MCO, and BHO highly on a scale from 0 to 10. The percent of members giving a rating of “9” or “10” was 71 percent for clinicians, 69 percent for MCO, and 66 percent for BHO.

Percent of members rating their behavioral health services a “9” or “10”



- *Clinicians' communication.* A majority of members were satisfied with their clinicians' communication skills and their ability to make them feel safe in the clinical encounter. In particular, 85 percent said they "usually" or "always" felt safe with their clinicians and 84 percent said their clinicians "usually" or "always" showed respect for what they had to say.

Improvement areas

- *Access to phone counseling or treatment.* Less than half (43 percent) of members reported "usually" or "always" being able to obtain phone counseling or treatment when needed.
- *Shared decision-making.* While three-quarters of members felt they were given as much information as they needed to manage their condition, 46 percent were not told about self-help or support groups, and 35 percent were not informed about other counseling or treatment options.
- *Benefits.* Twenty percent of members indicated that they used up all of their benefits for treatment or counseling. Among these members, 72 percent indicated that they still needed counseling or treatment services. These findings suggest that many STAR+PLUS members may not be aware of the full extent of their behavioral health benefits package.
- *Service coordination.* Only one in four members said they had a service coordinator through their STAR+PLUS health plan. This finding is of concern, given the complex needs of members with behavioral health conditions. However, among members who received service coordination, 72 percent said they "usually" or "always" received these services as soon as they thought they were needed.

ECHO® Composite Scores

Composite	Mean (SD)	Range
<i>Getting Treatment Quickly</i>	2.15 (SD = 0.73)	1.00 – 3.00
<i>How Well Clinicians Communicate</i>	2.47 (SD = 0.59)	1.00 – 3.00
<i>Information About Treatment Options</i>	0.60 (SD = 0.43)	0.00 – 1.00
<i>Perceived Improvement</i>	2.60 (SD = 0.81)	1.00 – 4.00

Recommendations

The EQRO recommends the following strategies to Texas HHSC and STAR+PLUS MCOs for improving the delivery and quality of behavioral health care for adults in STAR+PLUS. These strategies are relevant to improving member understanding and utilization of service coordination, and reducing nursing facility admission rates, which are HHSC's over-arching goals for STAR+PLUS MCOs.

Domain	Recommendations	Rationale	HHSC Response
Improving clinician-patient communication for STAR+PLUS members with behavioral health conditions.	<ul style="list-style-type: none"> STAR+PLUS MCOs should implement interventions to improve clinician communication skills that target providers of members with more severe and persistent behavioral health symptoms. In addition, it is possible that members who perceive their providers' communication more positively have more effective communication skills themselves. Tools to enhance communication should also include strategies to help the member communicate more effectively. The AHRQ has developed useful web-based resources for encouraging better two-way communication between clinicians and patients.¹ 	The quality of clinicians' communication was associated with members' perceived improvement of their behavioral health symptoms. Successful strategies for improving clinicians' communication are important for ensuring improvement in behavioral health conditions, and will in turn help to reduce rates of nursing facility admissions related to behavioral health.	HHSC will encourage all STAR+PLUS MCOs to offer behavioral health provider and member training in communication skills and strategies to help providers and members communicate more effectively with one another. Most STAR+PLUS MCOs make available or are open to offering educational training and tools for behavioral health providers and members regarding the recommendation to improve clinician-patient communication.
Improving member understanding of service coordination	<ul style="list-style-type: none"> STAR+PLUS MCOs should ensure that all new members who screen positive for behavioral health 	Only one in four members responding to the survey reported they had a service	Most STAR+PLUS plans assign a Service Coordinator to every member upon enrollment to perform initial assessments that identify

	<p>conditions in their initial health risk assessment are given information on service coordination benefits, and provided the appropriate contact information.</p> <ul style="list-style-type: none"> STAR+PLUS MCO should periodically review their service coordination programs to ensure that their policies and practices are based upon successful innovations implemented by disability care coordination organizations (DCCOs), which include directly linking medical and behavioral health providers in the clinical setting and at the point of provider-patient contact.² 	<p>coordinator. This finding is of particular concern, given that STAR+PLUS members with behavioral health conditions tend to have more complex health care needs and a greater need for service coordination.</p>	<p>medical and behavioral health needs. Service Coordinators are required to be provided to all STAR+PLUS members who request one.</p> <p>One of HHSC's overarching goals for STAR+PLUS in 2012 is to improve members understanding and utilization of service coordination. The STAR+PLUS MCO's developed performance improvement projects that focus on the need for improving service coordination. The EQRO will review the Performance Improvement Projects and provide HHSC a mid-year analysis.</p>
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Introduction and Purpose

The STAR+PLUS Program is a Texas Medicaid Managed Care program designed to integrate the delivery of acute and long-term services and supports for low-income aged and disabled members.³ Members in STAR+PLUS receive acute primary and specialist care, long-term services such as attendant care and adult day health care, and service coordination to address complex medical conditions. Members receive behavioral health services through their STAR+PLUS managed care organization (MCO) – either directly through the MCO as part of its integrated benefits package, or through a sub-contracted behavioral health organization (BHO).

With the increasing prevalence and rising cost of behavioral health conditions in Texas Medicaid, the quality of behavioral health care in Medicaid Managed Care has become a topic of concern.⁴ In 2009, the Texas Legislative Budget Board Staff (LBBS) published a set of recommendations for improving the transparency and accountability of behavioral health services in Texas Medicaid and CHIP.⁵ Among these, the LBBS recommended that the state implement surveys to assess member satisfaction and experiences with the behavioral health services they receive through their Medicaid MCO or BHO. Patients' rating of satisfaction with health care is an indicator of quality of care, and has been associated with positive health-related behaviors, such as compliance with treatment.^{6, 7}

In fiscal year 2011, as part of external quality review activities for the State of Texas, the Institute for Child Health Policy (IHP) conducted a survey of adult STAR+PLUS members who had been diagnosed with a behavioral health condition in the past 12 months. At the beginning of fiscal year 2011, the STAR+PLUS program operated in 29 counties in the Travis, Bexar, Nueces, and Harris Service Areas.⁸ In February 2011, STAR+PLUS expanded to the Dallas and Tarrant Service Areas and now operates in 42 counties. This report presents data collected from members who were in STAR+PLUS before the expansion.

The purpose of the fiscal year 2011 STAR+PLUS Behavioral Health Survey is to:

- Describe the demographic and household characteristics of adult members with behavioral health conditions.
- Assess the health status of the population, including overall health ratings and obesity.
- Document member experiences and general satisfaction with the behavioral health care they receive through STAR+PLUS MCOs and BHOs across five domains of care:
 - Utilization of behavioral health care
 - Access to and timeliness of behavioral health care
 - Patient-centered medical home
 - Behavioral health treatment benefits and assistance
 - Service coordination
 - Perceived outcomes of counseling and treatment
- Test the influence of members' experiences in the clinician's office on their perceived improvement of symptoms.

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 used a stratified sampling strategy to permit comparison of survey responses across the four MCOs operating in STAR+PLUS in fiscal year 2011:

- AMERIGROUP
- Evercare
- Molina
- Superior

A stratified random sample of adult STAR+PLUS members was selected, with a target of 1,200 completed telephone interviews (representing 300 respondents per MCO). STAR+PLUS members 18 years of age and older were considered for inclusion in this survey if they met the following criteria: 1) Continuous STAR+PLUS MCO enrollment for one year (allowing for a 30-day gap in enrollment) between January 2010 and December 2010; and 2) Having record of one or more mental health or chemical dependency diagnoses (ICD-9-CM code) and procedural (CPT code) combinations, as determined from MCO claims data (**Table B1** in Appendix B). Members who were eligible for both Medicaid and Medicare (dual-eligibles) and members who participated in the fiscal year 2011 STAR+PLUS Adult Member Survey were excluded.

Survey Instruments

The fiscal year 2011 STAR+PLUS Behavioral Health Survey included:

- The Experience of Care and Health Outcomes (ECHO[®]) Survey 3.0.⁹
- Items developed by ICHP pertaining to member demographic and household characteristics, and member experiences and satisfaction with service coordination.

The ECHO[®] Survey is part of the Consumer Assessment of Healthcare Providers and Systems (CAHPS[®]) family of surveys. The adult version assesses patients' experiences and satisfaction with various aspects of their behavioral health care. The survey allows for calculation and reporting of behavioral health care composites, which are scores that combine results for closely related survey items. ECHO[®] composite scores were calculated in the following domains:

- *Getting Treatment Quickly*
- *How Well Clinicians Communicate*
- *Information About Treatment Options*
- *Perceived Improvement*

Researchers at ICHP scored the composites following CAHPS® specifications. Values for *Getting Treatment Quickly* and *How Well Clinicians Communicate* range from 1.00 to 3.00 (from low to high quality/satisfaction). Values for *Information About Treatment Options* range from 0.00 to 1.00. Values for *Perceived Improvement* range from 1.00 to 4.00.

Survey Data Collection Techniques

The EQRO sent letters written in English and Spanish to 7,722 sampled STAR+PLUS members, requesting their participation in the survey. Of the advance letters sent, 13 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 2011 and September 2011. NORC telephoned STAR+PLUS members seven days a week between 9 am and 9 pm 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. Thirteen percent of interviews were completed in Spanish.

Table 1 shows the number of targeted interviews and the number of completed interviews in each of the four MCO quotas. Overall, a total of 993 interviews were completed. The targets were met for all MCOs except Molina, for which only 66 completed interviews were collected. The low number of completed interviews for Molina was due to a considerably smaller eligible population from which the sample was drawn.

Table 1. Number of Completed Interviews by STAR+PLUS MCO

MCO	Targeted # of completes	# of completes
AMERIGROUP	300	313
Evercare	300	308
Molina	300	66
Superior	300	306
Total	1,200	993

Attempts were made to contact 8,281 STAR+PLUS members sampled for the survey. Sixty-seven percent of members could not be located. Among those located, less than one percent indicated that they were not enrolled in STAR+PLUS, and three percent refused to participate. The response rate was 75 percent and the cooperation rate was 92 percent.

Data Analysis

Descriptive statistics and statistical tests were performed using the statistical software package SPSS 17.0 (Chicago, IL: SPSS, Inc.). Frequency tables showing descriptive results for each survey question are provided in a separate Technical Appendix. The statistics presented in the

report exclude “do not know” and “refused” responses. Percentages shown in most figures and tables are rounded to the nearest whole number; therefore, percentages may not add up to 100 percent.

Analysis of differences in frequencies used the Pearson Chi-square test of independence, and analysis of differences in means used t-tests and analysis of variance (ANOVA). These tests allowed comparison of frequencies and means among the four MCOs and other demographic sub-groups within the sample.

In addition, researchers conducted a multivariate analysis to examine the effects of demographic, health status, and health delivery factors on members’ perceived improvement in their behavioral health.

Survey Results

This section presents survey findings for adults with behavioral health conditions in STAR+PLUS 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 care; 5) Behavioral health benefits; 6) Service coordination; and 7) Perceived outcomes of behavioral health care.

Demographic Characteristics

The majority of survey respondents were female (71 percent), and the mean age among all respondents was 47 years old. Hispanic members represented the largest racial/ethnic group (35 percent), followed by Black, non-Hispanic members (29 percent) and White, non-Hispanic members (28 percent). However, 89 percent of respondents stated the language spoken in their home was English. Seven percent of surveyed members were of “Other” race/ethnicity, which included American Indian/Alaskan Native (4 percent) and Asian/Pacific Islander (2 percent).

Overall, STAR+PLUS members had low educational and employment status, were more likely to be single or divorced than to be married, and were more likely to live in a single-parent household and in rented housing.

	STAR+PLUS Members
Mean Age (years)	47 (SD = 11)
Sex	
Female	71%
Male	30%
Race/Ethnicity	
Hispanic	35%
Black, Non-Hispanic	29%
White, Non-Hispanic	28%
Other	7%

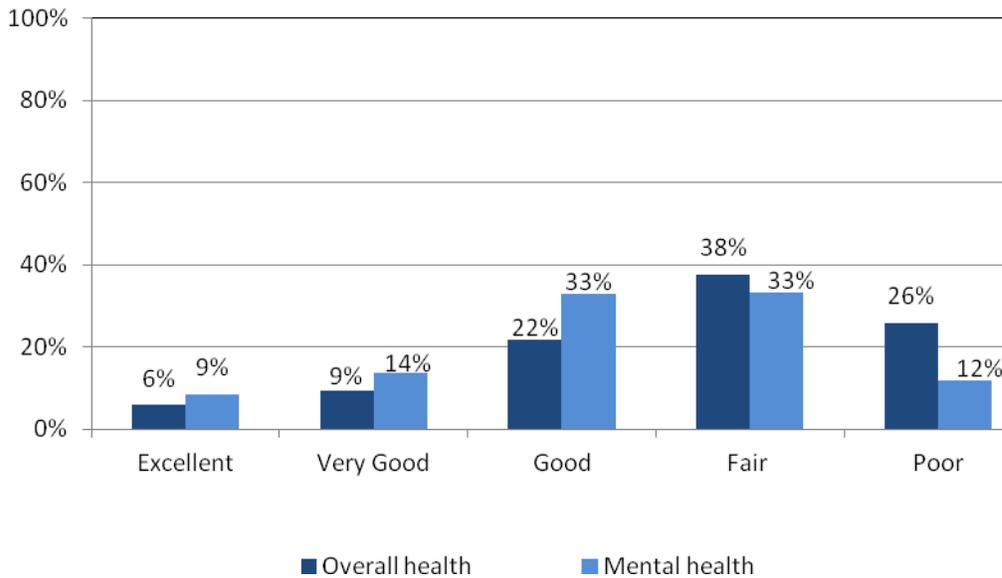
- Forty percent of respondents had not attained a high school diploma, while more than half had a high school diploma or equivalent (56 percent), and four percent of respondents had attained a college degree (4 percent).

- The vast majority of respondents said they were not employed at the time of the survey (97 percent).
- Approximately half of respondents reported they were single (45 percent), which was the most common marital status in the sample. Divorced individuals represented 24 percent of the sample, and married individuals represented 10 percent of the sample.
- Greater than half of respondents lived in a single-parent household (54 percent). One out of three reported they were not a parent (31 percent), indicating that no children lived in the household. One in four members reported living alone (28 percent).
- The most common type of housing reported by respondents was rented housing (48 percent). One in five reported they owned their home (21 percent). Seventeen percent lived in public or subsidized housing.

Health Status

Figure 1 presents member ratings of their overall health and mental health. Members provided slightly more favorable ratings of their mental health compared to their overall health, with more members reporting fair and poor overall health.

Figure 1. Member Reports of Overall Health and Mental Health



Only 15 percent of members rated their *overall health* as very good or excellent, compared to 23 percent who rated their *mental health* as very good or excellent. Almost half of members (45 percent) indicated that they had fair or poor mental health and more than half (64 percent) reported fair or poor overall health.

Body Mass Index

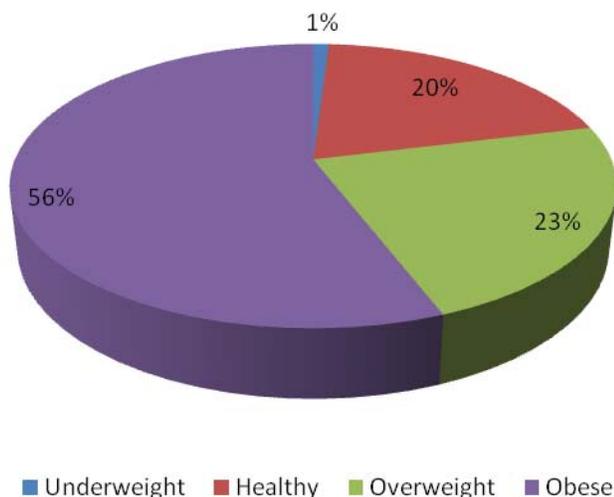
Figure 2 provides the Body Mass Index (BMI) results for members in the sample. Based on their weight and height data, more than half of members were classified as obese (56 percent), and close to one quarter were classified as overweight (23 percent). The obesity rate was considerably greater among members than among adults in the national population (34 percent) or the Texas population (31 percent), as reported by the Centers for Disease Control and Prevention in 2010.¹⁰

- Female members had a significantly higher rate of obesity than male members (62 percent vs. 40 percent).¹² The gender difference in the sample was greater than that observed for the U.S. adult population.
- Obesity rates were higher among Hispanic members (59 percent) and Black, non-Hispanic members (58 percent) than among White, non-Hispanic members (50 percent).¹³ The racial/ethnic difference in STAR+PLUS was similar to that observed for the U.S. adult population, although in STAR+PLUS, Hispanic members had the highest rate of obesity.

Obesity Prevalence in the U.S. by Sex and Race/Ethnicity^a	
	% obese in population
Men	32%
Women	36%
Hispanic	38%
Non-Hispanic Black	44%
Non-Hispanic White	33%

Based on the National Health Examination and Nutrition Survey, 2007-2008¹¹

Figure 2. BMI Classification of STAR+PLUS Members



Utilization of Behavioral Health Care

Members were asked about their utilization of behavioral health services in the STAR+PLUS program during the last 6 months. Seventy-seven percent reported utilizing behavioral health counseling, treatment, and/or medicine in the past 12 months.

- 67 percent reported making an appointment for counseling or treatment.
- 17 percent said they called someone to get professional telephone counseling.
- 97 percent indicated that they took prescription medicine as part of their treatment.
- 42 percent stated they needed emergency counseling or treatment.
- 38 percent reported that they visited an emergency room or crisis center one or more times to get counseling or treatment.

Females were significantly more likely to report utilizing behavioral health counseling, treatment, and/or medicine in the past 12 months as compared to male members (81 and 68 percent, respectively).¹⁴ White, non-Hispanic members were also significantly more likely to report utilizing behavioral health services (85 percent), followed by Hispanic (78 percent), Other, Non-Hispanic (74 percent), and Black, non-Hispanic (69 percent) members.¹⁵

Members who reported visiting an emergency room or crisis center for counseling or treatment were also asked the reason/s why they visited the emergency room or crisis center. This type of open-ended question can provide detailed information on how members are utilizing emergency services for behavioral health related issues.

Table 2 shows the ten main reasons members visited the emergency room or crisis center for counseling or treatment.¹⁶ Of the 708 participants asked the question, 285 participants responded (29 percent).

Table 2. Reasons Why Members Visited the Emergency Room or Crisis

Reason for trip to ED or Crisis Center	N	% Reported
Anxiety/ "stressed out"/ panic attacks	24	20.2%
Depression	22	18.5%
Migraine/Headache/Dizziness/Nausea/Pain	19	16.0%
Generic statement of mental health	15	12.6%
Suicide Attempt	11	9.2%
Family Issues	8	6.7%
Hallucinations / Psychosis	7	5.9%
Schizophrenia/Bipolar	7	5.9%
Medication or Treatment Issues	7	5.9%
Nervous breakdown / Traumatic Experience	6	3.4%

^a Total exceeds 100 percent because some respondents discussed multiple issues.

Anxiety and depression were the most common reasons reported (20 and 19 percent). The category “Migraine/Headache/Dizziness/Nausea/Pain” was included as mental health issues often present with physical symptoms. This category represented the next most common response (16 percent). This category should be interpreted with caution as these physical symptoms could also be associated with non-behavioral health related issues. Of particular note is the high rate of suicide attempts among those who sought emergency care (9 percent).

Access to and Timeliness of Behavioral Health Care

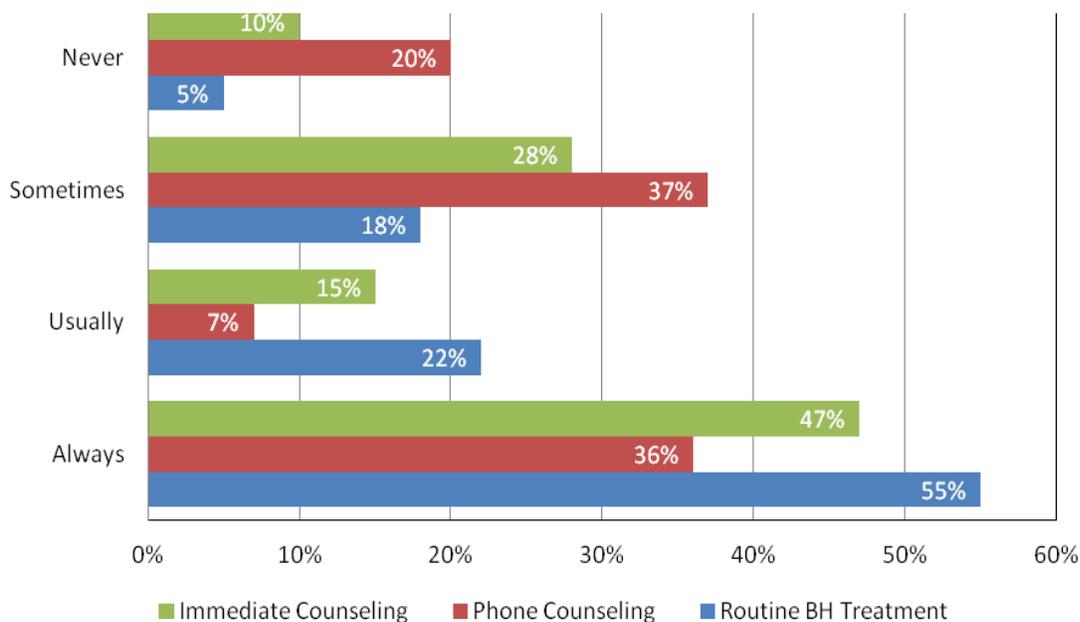
This section provides member reports of access to and timeliness of receiving behavioral health counseling and treatment while enrolled in STAR+PLUS.

Getting Treatment Quickly

Three ECHO® survey questions comprise the composite *Getting Treatment Quickly* and assess how often members were able to get routine and urgent treatment or counseling, and treatment or counseling over the telephone. The mean for *Getting Treatment Quickly* was 2.15 (SD = 0.73) on a 3-point scale.

Figure 3 displays member responses regarding how well they were able to obtain routine, immediate, and phone counseling and treatment services for themselves when they were needed. A majority of members were always or usually able to obtain a routine appointment for counseling (77 percent) or immediate counseling (62 percent) when needed. By contrast, only 43 percent of members were able to obtain phone counseling or treatment when needed.

Figure 3. Percentage of Members Reporting Getting Needed Counseling or Treatment

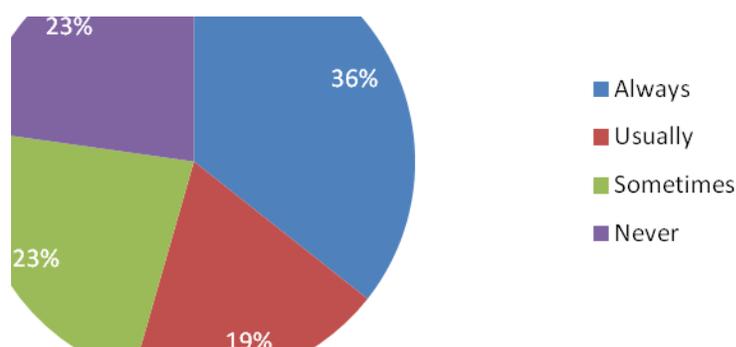


The results reveal that the timeliness of receiving counseling or treatment depends on the type of care (e.g., routine appointment, urgent, and telephone) that members need. Members were more likely to receive timely routine behavioral health care than telephone or immediate care. Less than half of members were able to get timely professional counseling over the telephone.

Office Wait

Members were asked how often they were seen within 15 minutes of their appointment in the past 12 months. **Figure 4** provides the results for how often members reported they waited less than 15 minutes before they were seen for counseling or treatment.

Figure 4. How Often Member Was Seen Within 15 Minutes of Appointment



A majority of members indicated they were usually or always seen within 15 minutes of their scheduled appointment (55 percent). However, 23 percent said they were never seen within 15 minutes, and 23 percent said they were only sometimes seen within 15 minutes.

Members' Rating of Counseling or Treatment

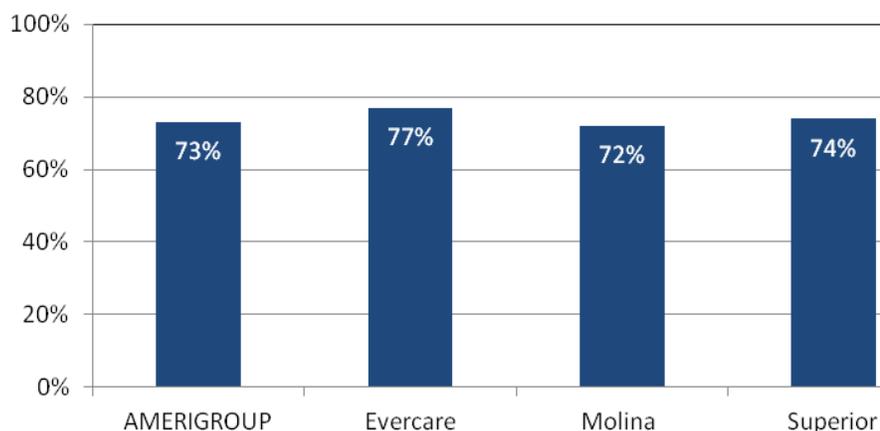
When asked to rate their overall perceptions of their behavioral health counseling and treatment on a scale of 0 to 10, 56 percent of members gave a rating of 9 or 10. The mean rating for behavioral health counseling and treatment was 8.4 (SD = 2.1).

Patient-Centered Care

Presence of a Usual Source of Care

The majority of STAR+PLUS members had a usual source of behavioral health care. Seventy-five percent of members reported there was one person who provided most of their counseling and treatment in the past year. **Figure 5** provides the percentage of members with a usual source of behavioral health care, by STAR+PLUS Managed Care Organization.

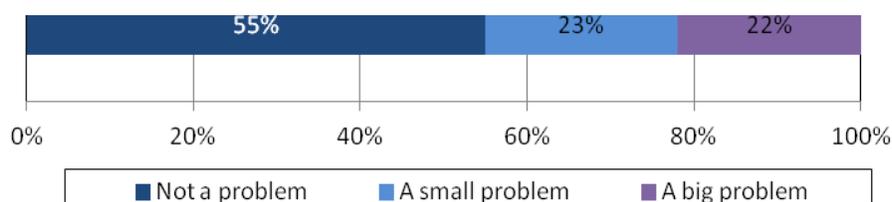
Figure 5. The Percentage of Members With a Usual Source of Behavioral Health Care



Members were asked, “When you joined your health plan or at any time since then, did you get someone new for counseling or treatment?” Forty-one percent of members said “yes,” and 59 percent said “no.”

Among members who had to seek a new clinician after joining the health plan, 45 percent said they had problems finding someone they were happy with (**Figure 6**). This finding suggests that some members may have experienced discontinuity in their behavioral health care as a result of joining the health plan and being unable to quickly find a provider they were satisfied with.

Figure 6. The Percentage of Members Reporting Whether it was a Problem to Find a Clinician They Were Happy with after Joining the Health Plan



Satisfaction with Clinicians' Communication

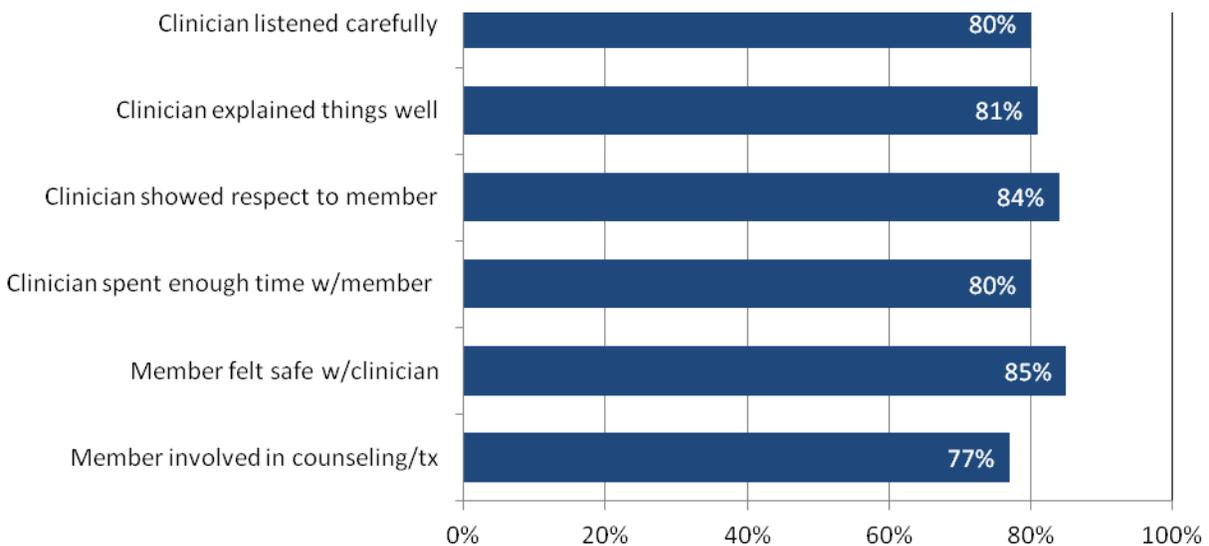
Six ECHO® survey questions comprise the composite *How Well Clinicians Communicate*. This composite assesses how often the clinician or therapist explained things well, listened carefully, showed respect for their patients, spent enough time with them, made them feel safe, and involved them in treatment. The mean for *How Well Clinicians Communicate* was 2.47 (SD = 0.59) on a 3-point scale.

Figure 7 provides members' responses to the six individual survey items that comprise the composite *How Well Clinicians Communicate*. The figure depicts the percentage of members that reported they “usually” or “always” had positive communication experiences with their clinician.

The majority of members were satisfied with their provider's communication skills and ability to make them feel comfortable and safe in the clinical encounter. In addition, 77 percent of members reported they were usually or always involved as much as they wanted in their counseling or treatment, which suggests that providers generally encouraged their patients to be active participants in their healing process.

About one in five members expressed some level of dissatisfaction with their clinicians – saying they “never” or only “sometimes” had positive communication experiences.

Figure 7. The Percentage of Members Who Reported They “Usually” or “Always” Had Positive Communication Experiences with Their Clinician



Patient Information about Treatment and Managing their Condition

Two ECHO[®] survey items comprise the composite *Information about Treatment Options*. This composite assesses whether the clinician or therapist informed members about self-help or support groups, and the different kinds of counseling or treatment available to them. The mean for the *Information about Treatment Options* composite was 0.60 (SD = 0.43) on a scale from 0 to 1.

The results of the individual items that comprise this composite indicate that many members are not receiving information about community resources and treatment options that might help them to better manage their condition:

- 46 percent reported they were not told about self-help or support groups, such as consumer-run groups or 12-step programs.
- 35 percent reported they were not informed about the counseling or treatment options available to them.

Members were also asked about whether their clinician provided them with information about prescription medication and associated side effects. Almost half of members reported experiencing side effects from their medication (47 percent). The following percentages of members were informed about medication side effects and other medications that could be used to treat their behavioral health conditions:

- 80 percent reported they were told which medication side effects to watch for.
- 46 percent reported they were told about medicine, different from those they were already taking, that might be helpful in their mental health treatment.

This survey also assessed whether members were provided support by their clinician to better manage their behavioral condition:

- 52 percent reported that their clinician discussed with them whether to include family and friends in their counseling or treatment.
- 75 percent were given as much information as they needed to manage their condition.

In addition, 78 percent of members felt they could refuse a specific type of medicine or treatment, which suggests that most clinicians encouraged patient autonomy and were willing to share in treatment decision-making with their patients.

Patient Privacy

Members were asked if anyone they saw for treatment or counseling shared information with others that should have been kept private. The vast majority of respondents reported their clinician did not inappropriately share information about their treatment or counseling with others (90 percent). However, 1 in 10 indicated that their clinician had shared information with others that should have been kept private (10 percent).

Cultural Competence

Members' access to culturally appropriate and competent behavioral health care was evaluated in the survey. Specifically, members were asked whether their race/ethnicity, language and culture, or religion made any difference in the kind of counseling or treatment they needed.

Nine percent indicated that their race/ethnicity, language and culture, or religion was important to the type of counseling and treatment they received. Among these members, 76 percent reported their behavioral health care was responsive to those needs. However, approximately one in four said their care was not responsive to their racial, cultural, or religious needs (24 percent).

Members' Rating of Their Clinician

The survey also assessed members' overall satisfaction with their primary clinician who provided most of their counseling and treatment. Members were asked to rate the quality of their clinician on a 0- to 10-point scale (from worst to best). Seventy-one percent gave their clinician a high satisfaction rating (a "9" or "10"). The mean clinician rating was 8.8 (SD = 2.0).

Behavioral Health Treatment Benefits and Assistance

This section provides results for members' experiences with their health plan or the behavioral health organization that provides counseling or treatment.

Benefits

Members were asked about their benefits for counseling or treatment under their health plan in the past 12 months. Specifically, members were asked about whether they had used up all of their benefits and were still in need of counseling or treatment, and whether they were informed about other ways to get counseling or treatment for themselves.

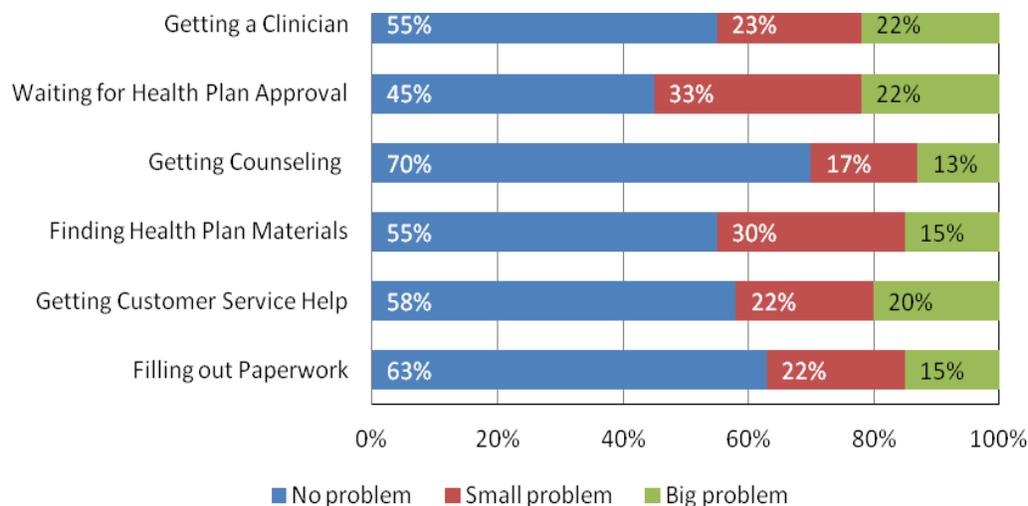
- 20 percent reported they had used up all of their benefits for counseling or treatment.
- 72 percent of these members indicated they still needed counseling or treatment.
- 54 percent reported they were told about other ways to get counseling, treatment, or medicine for themselves.

Behavioral health benefits in Texas Medicaid are limited to 30 encounters/visits per calendar year, with prior authorization required for extended encounters/visits that are determined to be medically necessary.¹⁷ Results of this survey suggest that a small percentage of members in STAR+PLUS may still be in need of behavioral health services after exhausting their counseling or treatment benefits. It is possible that members do not understand the health plan's behavioral benefits package. It is also possible that members may disagree with their provider and/or health plan regarding which extended benefits are "medically necessary." If a clinician requests prior authorization for additional counseling or treatment visits and the health plan denies the request based on lack of medical necessity, the member may still believe that they are in need of additional treatment.

Getting Treatment Information and Assistance

Figure 8 presents members' experiences with getting treatment information and assistance from their health plan and/or behavioral health organization in the past 12 months. The *Getting Treatment and Information from the Health Plan* composite was not calculated due to the small number of respondents answering the majority of these questions.

Figure 8. Member Experiences Getting Treatment Information and Assistance



The results suggest that members had the most problems with: 1) Getting a clinician they were happy with; 2) Waiting for health plan approval; and 3) Finding health plan materials:

- Forty-one percent of members reported that, after joining the health plan, they got someone new for counseling or treatment. Among these members, 55 percent reported it was not a problem to get a clinician they were happy with. Twenty-three percent reported it was a small problem and 22 percent reported that it was a big problem to get a clinician with which they were happy.
- Twenty-eight percent of members reported needing approval for counseling or treatment from the health plan. Among these members, 45 percent indicated they experienced no problems with delays in counseling or treatment while waiting for approval; 33 percent experienced a small problem, and 22 percent experienced a big problem with delays from their health plan.
- Seventy percent of members reported it was not a problem to get the counseling or treatment they thought they needed.
- Twenty-nine percent of members said they looked for information about counseling or treatment from their health plan in written materials or over the Internet. Of these members, 55 percent reported it was not a problem to find or understand health plan information.

- Twenty-five percent stated they called the health plan's customer service to get information or help about counseling or treatment for themselves. Fifty-eight percent said it was not a problem to get the help they needed for themselves when calling the health plan's customer service.
- Thirty-two percent of members said they had to fill out paperwork for their health plan regarding counseling or treatment. Sixty-three percent said it was not a problem to fill out and complete this paperwork, 22 percent said it was a small problem, and 15 percent said it was a big problem to fill out the paperwork.

Members' Rating of Their Health Plan or BHO

Members were asked to provide an overall rating of their health plan or behavioral health organization related to counseling and treatment on a scale from 0 to 10, with 0 indicating the worst care and 10 indicating the best care. Sixty-nine percent of members gave a rating of 9 or 10 for their health plan and 66 percent gave a rating of 9 or 10 for their behavioral health organization. Mean ratings were 8.6 for the health plan (SD=2.2) and 8.7 for the behavioral health organization (SD=2.0).

Service Coordination

Only 26 percent of the members said that they had a service coordinator, although all members with behavioral health conditions should be assigned a service coordinator upon enrollment. This indicates that three-fourths of the sample were unaware of this benefit provided by their STAR+PLUS MCO. In lieu of an MCO-provided service coordinator, 22 percent of the members reported having another person coordinate services for them, the majority being a family member or friend (61 percent).

About half of the members reported needing a service coordinator to help arrange services such as doctor visits, transportation, or meals (52 percent). Among these members, 48 percent reported that they would like to have a service coordinator assist with these tasks. This suggests members would like to utilize service coordination through the STAR+PLUS program.

Over half of the members reported having a service coordinator contact them in the last 6 months (58 percent). One third of the members reported having a service coordinator contact them over 10 times (29 percent), with 36 percent of the members reporting receiving a call from a service coordinator one to four times over the last 6 months. This high rate of calls suggests the service coordinators are staying in contact with the members.

Members reported usually or always having positive interactions with the service coordinators:

- 86 percent reported the service coordinator explained things in a way they could understand.
- 69 percent reported the service coordinator involved them in making decisions.

A large majority of the members reported being satisfied with the help they received over the last 6 months from their service coordinator (89 percent). This compilation of results suggests that members utilizing service coordinators are pleased with their experience, but that greater awareness of these services is needed for all members.

STAR+PLUS MCO was significantly related to member's knowledge of having a service coordinator.¹⁸ In both Molina and Evercare, 32 percent of members said they knew about their service coordinator, while the percentages for AMERIGROUP and Superior were lower (21 and 23 percent, respectively).

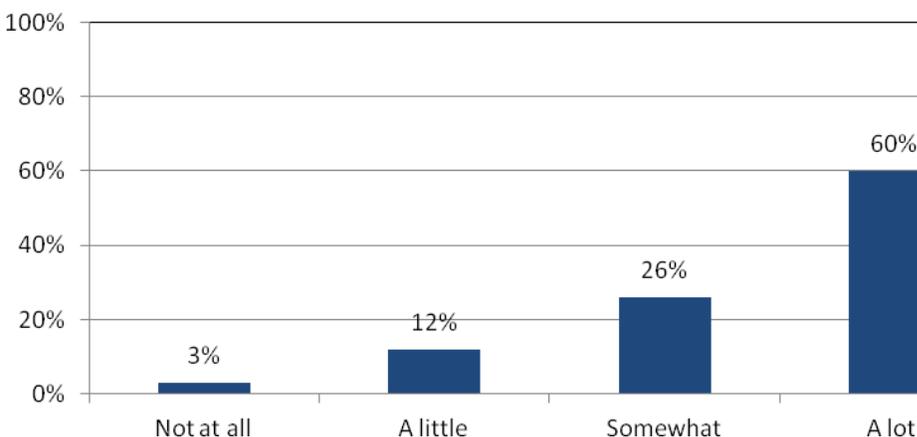
- *Good Access to Service Coordination.* Seventy-two percent of members reported they usually or always received service coordination as soon as they needed it. This was not significantly different among the MCOs. AMERIGROUP had the highest performance on this measure (81 percent), followed by Evercare (72 percent), and Superior (70 percent). The number of responses to this question in Molina (n = 10) was too small to produce a reliable estimate. This HHSC Dashboard indicator does not currently have a standard.

Perceived Outcomes of Behavioral Health Care

Members were asked a series of questions about how much behavioral health counseling or treatment has helped them by improving their quality of life and daily functioning. Most members felt they had benefited to some extent from the behavioral health counseling or treatment they received in the past 12 months.

When, asked “In the last 12 months, how much were you helped by the counseling or treatment you got,” 60 percent said “a lot” (**Figure 9**). For over one-third of members (38 percent), treatment and counseling had less of an impact, helping them “somewhat” or “a little.”

Figure 9. How Much Was the Member Helped by Counseling or Treatment?



White, non-Hispanic members were more likely than their Hispanic and Black, non-Hispanic counterparts to report they were helped by behavioral health treatment or counseling.¹⁹ This finding suggests that Hispanic and Black, non-Hispanic members may have different

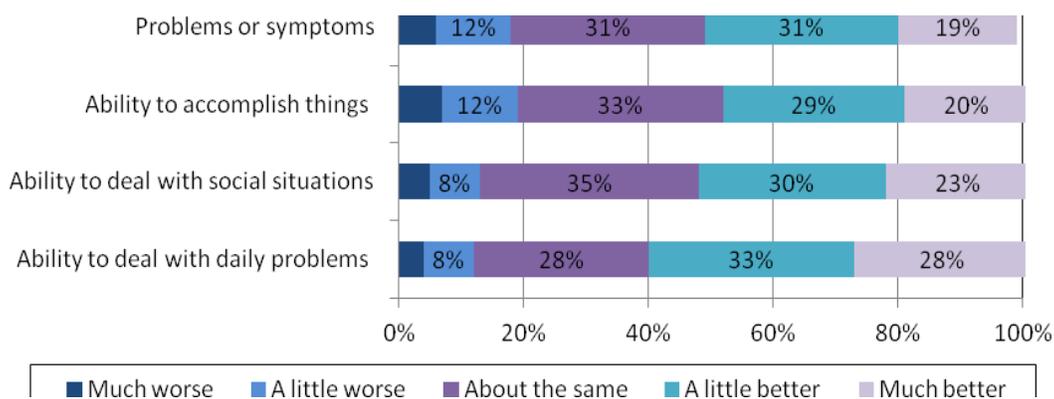
perceptions of and experiences with behavioral health services than White, non-Hispanic members, perhaps due to cultural beliefs about mental health and/or the failure of clinicians to provide care that is sensitive to members' cultural beliefs and practices.

The impact of counseling or treatment on member's quality of life (i.e., overall well-being in physical, social, and emotional functioning) was also assessed. Fifty-nine percent of members reported that counseling or treatment was "very helpful" in improving their quality of life, and 29 percent reported that counseling or treatment was "a little helpful" in improving their quality of life. A much smaller percentage of members (8 percent) reported that the counseling or treatment they received was "a little or very harmful" to their well-being.

Evaluating members' perceptions of their improvement provides a proxy for the quality and effectiveness of the behavioral health counseling and treatment they received in the past year. Four ECHO[®] survey items comprise the composite *Perceived Improvement*, which assesses respondents' perceptions of their ability to deal with daily problems and social situations, to accomplish the things they want to do, and the overall improvement in their problems or symptoms. The mean for the *Perceived Improvement* composite was 2.60 (SD = 0.81) on a 4-point scale. Male members were significantly more likely than female members to report that they experienced improvements in their symptoms and functioning as a result of the treatment and counseling they received in the past year (2.72 vs. 2.55).²⁰

Figure 10 presents respondents' ratings of their improvement on each of the four survey items that comprise the *Perceived Improvement* composite.

Figure 10. Compared to 12 Months Ago Members' Ratings of Improvement in...



The greatest area of improvement was in members' ability to deal with daily problems. Sixty-one percent said they were "a little better" or "much better" in their ability to deal with daily problems, compared to 12 months ago. In addition, half of respondents reported they were "a little better" or "much better" in their ability to deal with social situations (53 percent), and in their problems or symptoms (50 percent).

A fairly large percentage of members reported their problems, symptoms, and ability to manage their lives had not changed in the last year (between 28 and 35 percent), and for some members had become “a little worse” or “much worse” (between 12 and 19 percent). These results indicate that certain members are not benefitting from their behavioral health counseling and treatment.

Summary Points and Recommendations

This report provides results from the fiscal year 2011 STAR+PLUS Adult Member Survey focused on members who had been diagnosed with a behavioral health condition in the past 12 months. The survey focuses on: (1) Demographic and household characteristics of STAR+PLUS members with behavioral health conditions; (2) the health status of STAR+PLUS members, including body mass index and overall ratings of health; and (3) member experiences and satisfaction with the behavioral health care they receive through STAR+PLUS MCOs and BHOs across the following domains: access and timeliness of their routine, urgent, and specialized care; elements of patient-centered care, such as having a usual source of care, doctor’s communication, preventive care, and shared decision-making; access to and utilization of service coordination; and experiences with their health plan, including health plan information and customer service.

Demographic and household characteristics

- **Member demographics.** A majority of the members were female (71 percent) with a mean age of 47 years old. Hispanic members represented the largest ethnic group (35 percent), followed by Black, non-Hispanic (29 percent), White, non-Hispanic (28 percent), and Other, non-Hispanic (7 percent). Members reported high rates of unemployment (97 percent) and 40 percent of the members did not receive a high school diploma.
- **Member household characteristics.** A majority of the members reported living in a single-parent household (54 percent), and about one in three (31 percent) indicated no children lived in the home. One-quarter of members reported living alone (28 percent). Rented housing was reported as the most common type of housing (48 percent). One in five members reported owning their own home (21 percent). Seventeen percent lived in subsidized housing.

Health status

- **Overall health and mental health.** Close to two-thirds of members rated their overall health as fair or poor (64 percent). Almost half of members rated their mental health as fair or poor (45 percent). These findings are expected, as this population has higher rates of chronic illness and disability as compared to other Medicaid programs.
- **Body mass index.** Reported obesity rates were higher than national averages and greater for women (62 percent) than men (40 percent). Hispanic members reported higher rates of obesity (59 percent), followed by Black, non-Hispanic members (58 percent), and White non-Hispanic members (50 percent).

Access to and timeliness of care

- **Good access to phone counseling or treatment.** Less than half (43 percent) of members reported usually or always being able to obtain phone counseling or treatment when needed.
- **Good access to urgent care.** About two-thirds of the members reported usually or always receiving urgent care when needed (62 percent).
- **Good access to routine care.** About three-quarters of members reported usually or always being able to make a routine appointment (77 percent).
- **Office wait.** One-third of members said they were always taken to exam room within 15 minutes of their appointment (36 percent). Nearly one in four members reported never being taken to the exam room within 15 minutes (23 percent).
- **Rating of Counseling or Treatment.** Members rated the behavioral health care they received from their health plan in the past six months on a scale from 0 to 10, with an average rating of 8.4. Sixty-nine percent of the members assigned a rating of 9 or 10 to their health plan.

Patient-centered care

- **Presence of a usual source of care.** A majority of members did not have to find someone new for counseling or treatment when they joined their health plan (59 percent) and more than half of members reported having no trouble finding a clinician they were happy with (55 percent).
- **Satisfaction with doctors' communication.** A majority of members were satisfied with their provider's communication skills and their ability to make them feel comfortable and safe during the clinical encounter. Between 80 and 85 percent of members reported satisfaction across multiple domains. Thirty percent of members, however, felt that clinicians did not spend enough time with them making this the most common complaint from members.
- **Shared decision-making.** Three quarters of members felt they were given as much information as they needed to manage their condition, but fewer were given information about community resources and treatment options that might help them better manage their condition. Forty-six percent were not told about self help or support groups and 35 percent were not informed about counseling or treatment options.
- **Patient Privacy.** A vast majority of members reported that their clinician did not share private information with others (90 percent).
- **Cultural Competency.** Only 9 percent of members felt that their race/ethnicity, language, culture or religion was important to the type of counseling or treatment they received. Of this group, three-quarters reported that the treatment they received was responsive to these needs.

- **Ratings of Clinician.** Members were generally satisfied with their primary clinicians with 71 percent giving their clinician the highest satisfaction rating (a 9 or 10 on a scale of 0 to 10). The overall rating of clinicians was 8.8 out of 10.

Behavioral Health Benefits

- **Benefits.** Twenty percent of members indicated that they used up all of their benefits and 72 percent of this group indicated that they still needed counseling or treatment services. Of this group 54 percent reported being told of other ways to receive counseling or treatment. These findings suggest that many members may not understand the full scope of the behavioral health benefits offered through their STAR+PLUS MCO.
- **Getting Treatment information and Assistance.** Most members said they did not have trouble getting the treatment information or assistance they needed. However, more than half reported problems waiting for health plan approval (55 percent), and slightly less than half reported problems getting a clinician they were happy with (45 percent) or finding health plan materials (45 percent).
- **Rating of Health Plan or Behavioral Health Care Organization.** Members also rated their health plan or the BHO that handled their behavioral health benefits, using a scale from 0 to 10. Members provided an average rating of 8.6 for their health plan, with 69 percent giving a rating of 9 or 10. Members provided an average rating of 8.7 for their BHO, with 66 percent giving a rating of 9 or 10.

Service Coordination

- **Presence of a Service Coordinator.** Only one in four members said they had a service coordinator (26 percent). Among members who did not have a service coordinator, over half said they needed one (55 percent).
- **Good Access to Service Coordination.** More than half of members indicated that a service coordinator contacted them in the past 12 months (58 percent). Of this group, 86 percent reported that the service coordinator usually or always explained things in a way that was easy to understand, and 69 percent reported the service coordinator usually or always involved them in decisions related to their care. Overall, 72 percent of members indicated they usually or always received service coordination as soon as they needed it.

Perceived Outcomes of Behavioral Health Care

- **Perceived Improvement.** Members were asked to report how much they were helped by the behavioral health care they engaged in over the past 12 months. A majority of members reported being helped “a lot” by their care (60 percent), and another 38 percent reported being helped “somewhat” or “a little”. Additionally, 59 percent of members stated that their treatment was very helpful in improving their quality of life.

- **Improvement in Work/School.** Members were asked to report their perceptions of improvement compared to 12 months ago related to their behavioral health issues. The biggest area of improvement for members in the survey was their ability to deal with daily problems, with 61 percent of members reporting improvement.

Recommendations

The EQRO recommends the following strategies to Texas HHSC and STAR+PLUS MCOs for improving the delivery and quality of behavioral health care for adults in STAR+PLUS. These strategies are relevant to improving member understanding and utilization of service coordination, and reducing nursing facility admission rates, which are HHSC’s over-arching goals for STAR+PLUS MCOs.

Domain	Recommendations	Rationale	HHSC Response
Improving clinician-patient communication for STAR+PLUS members with behavioral health conditions.	<ul style="list-style-type: none"> • STAR+PLUS MCOs should implement interventions to improve clinician communication skills that target providers of members with more severe and persistent behavioral health symptoms. In addition, it is possible that members who perceive their providers’ communication more positively have more effective communication skills themselves. Tools to enhance communication should also include strategies to help the member communicate more effectively. The AHRQ has developed useful web-based resources for encouraging better two-way communication between clinicians and patients, including:²¹ • A series of videos featuring real patients and clinicians discussing 	<p>The quality of clinicians’ communication was associated with members’ perceived improvement of their behavioral health symptoms.</p> <p>In particular, members were more likely to report improvement if they said clinicians spent enough time with them, showed respect for what they had to say, involved them in treatment decisions, and made them feel safe.</p> <p>Successful strategies for improving clinicians’ communication are important for ensuring</p>	<p>HHSC will encourage all STAR+PLUS MCOs to offer behavioral health provider and member training in communication skills and strategies to help providers and members communicate more effectively with one another. Most STAR+PLUS MCOs make available or are open to offering educational training and tools for behavioral health providers and members regarding the recommendation to improve clinician-patient communication.</p>

	<p>the importance of asking questions and sharing information.</p> <ul style="list-style-type: none"> • An interactive “Question Builder” tool that enables patients to create a personalized list of questions based on their health conditions. • Notepads designed for use in medical offices to help patients prioritize their questions for the clinician. 	<p>improvement in behavioral health conditions, and will in turn help to reduce rates of nursing facility admissions related to behavioral health.</p>	
<p>Improving member understanding of service coordination</p>	<ul style="list-style-type: none"> • STAR+PLUS MCOs should ensure that all new members who screen positive for behavioral health conditions in their initial health risk assessment are given information on service coordination benefits, and provided the appropriate contact information. The following strategies can help to facilitate this process: <ul style="list-style-type: none"> • Ensure that members are given informational materials on service coordination prior to the conclusion of their health risk assessment. • MCO staff conducting health risk assessments should collect up-to-date contact information on members, to ensure that mailed informational 	<p>Only one in four members responding to the survey reported they had a service coordinator. This finding is of particular concern, given that STAR+PLUS members with behavioral health conditions tend to have more complex health care needs and a greater need for service coordination.</p> <p>The percentage of members reporting they had a service coordinator was lower in AMERIGROUP (21 percent) and</p>	<p>Most STAR+PLUS plans assign a Service Coordinator to every member upon enrollment to perform initial assessments that identify medical and behavioral health needs. Service Coordinators are required to be provided to all STAR+PLUS members who request one.</p> <p>One of HHSC’s overarching goals for STAR+PLUS in 2012 is to improve members understanding and utilization of service coordination. The STAR+PLUS MCO’s developed</p>

	<p>materials and telephone contact attempts successfully reach the member.</p> <ul style="list-style-type: none"> • Evaluate existing practices that connect service coordinators with their assigned members. Home visits may be warranted for service coordinators who are not successful in reaching members by telephone for an initial consultation. • STAR+PLUS MCOs should periodically review their service coordination programs to ensure that their policies and practices are based upon successful innovations implemented by disability care coordination organizations (DCCOs), which include directly linking medical and behavioral health providers in the clinical setting and at the point of provider-patient contact.²² 	<p>Superior (23 percent).</p>	<p>performance improvement projects that focus on the need for improving service coordination. The EQRO will review the Performance Improvement Projects and provide HHSC a mid-year analysis.</p>
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Appendix A. Detailed Methodology

The EQRO used a stratified sampling strategy to permit comparison of survey responses across the four MCOs operating in STAR+PLUS in fiscal year 2011:

- AMERIGROUP
- Evercare
- Molina
- Superior

A stratified random sample of adult STAR+PLUS members was selected, with a target of 1,200 completed telephone interviews (representing 300 respondents per MCO). STAR+PLUS members 18 years of age and older were considered for inclusion in this survey if they met the following criteria: 1) Continuous STAR+PLUS MCO enrollment for one year (allowing for a 30-day gap in enrollment) between January 2010 and December 2010; and 2) Having record of one or more mental health or chemical dependency diagnoses (ICD-9-CM code) and procedural (CPT code) combinations, as determined from MCO claims data (**Table B1** in Appendix B). Members who were eligible for both Medicaid and Medicare (dual-eligibles) and members who participated in the fiscal year 2011 STAR+PLUS Adult Member Survey were excluded.

Table A1 presents the stratification strategy by MCO, showing both the number of targeted interviews (N = 1,200) and the number of completed interviews (N = 993).

Table A1. STAR+PLUS Behavioral Health Survey Sampling Strategy

MCO	Targeted Interviews	Completed Interviews
AMERIGROUP	300	313
Evercare	300	308
Molina	300	66
Superior	300	306

Using a 95 percent confidence interval, the responses provided in the tables and figures are within ± 2.9 percentage points of the “true” responses in the STAR+PLUS member population and ± 5.4 percentage points of the “true” responses at the MCO level with the exception of Molina. For this MCO, the results are within ± 11.6 percentage points of the “true” responses of its members.

Enrollment data were used to identify the members who met the sample selection criteria and to obtain their contact information. Member names, mailing addresses, and telephone contact information for eligible STAR+PLUS members were collected and provided to interviewers. For households with multiple members enrolled in STAR+PLUS, one member from the household was randomly chosen as the member to respond to the survey. 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 2011 STAR+PLUS Behavioral Health Survey included:

- The Experience of Care and Health Outcomes (ECHO[®]) Survey 3.0.²³
- Items developed by ICHP pertaining to member demographic and household characteristics, and member experiences and satisfaction with service coordination.

The ECHO[®] Survey is part of the Consumer Assessment of Healthcare Providers and Systems (CAHPS[®]) family of surveys. The adult version assesses patients' experiences and satisfaction with various aspects of their behavioral health care. The survey allows for calculation and reporting of behavioral health care composites, which are scores that combine results for closely related survey items. ECHO[®] composite scores were calculated in the following domains:

- *Getting Treatment Quickly*
- *How Well Clinicians Communicate*
- *Information About Treatment Options*
- *Perceived Improvement*

A fifth domain, *Getting Treatment and Information from the Plan or MBHO*, was not included in analyses because of the low number of respondents who answered its corresponding questions.

Researchers scored the composites following CAHPS[®] specifications, with the range of values depending on the domain's type of response set. For *Getting Treatment Quickly* and *How Well Clinicians Communicate*, which have frequency-based response sets (Never, Sometimes, Usually, Always), scores range from 1.00 to 3.00. For *Information about Treatment Options*, which has a dichotomous response set (Yes or No), scores range from 0.00 to 1.00. For *Perceived Improvement*, which has a problem-based response set (Much Better to Much Worse), scores range from 1.00 to 4.00. For each of the four domains, a respondent's composite score was not calculated or considered in analysis if the respondent answered less than half of the questions in the composite.

The survey also includes questions regarding the demographic and household characteristics of members. 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.

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

Survey data collection

The EQRO sent letters written in English and Spanish to 7,722 sampled STAR+PLUS members, requesting their participation in the survey. Of the advance letters sent, 13 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 2011 and September 2011. NORC telephoned STAR+PLUS 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. Of the 993 completed interviews, 128 (13 percent) were completed in Spanish

Attempts were made to contact 8,281 STAR+PLUS members sampled for the survey. Sixty-seven percent of members could not be located. Among those located, less than one percent indicated that they were not enrolled in STAR+PLUS, and three percent refused to participate. The response rate was 75 percent and the cooperation rate was 92 percent.

To test for participation bias, the distributions of member age, sex, and race/ethnicity were collected from the enrollment data and compared between members who responded to the survey and members who did not participate. Differences in member age and sex between respondents and non-respondents were small, but statistically significant because of the size of the sample. In addition, there was a significant difference between members' race/ethnicity and their participation in the survey. Participants were more likely than non-participants to be White, non-Hispanic (37 percent vs. 31 percent), and less likely than non-participants to be Hispanic (31 percent vs. 36 percent).²⁴ Thus, when interpreting results of this report, it should be taken into account that those who participated were more likely to be White, non-Hispanic than Hispanic.

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

Data analysis

Descriptive statistics and statistical tests were performed using the statistical software package SPSS 17.0 (Chicago, IL: SPSS, Inc.). Frequency tables showing descriptive results for each survey question are provided in a separate Technical Appendix. The statistics presented in the

report exclude “do not know” and “refused” responses. Percentages shown in most figures and tables are rounded to the nearest whole number; therefore, percentages may not add up to 100 percent.

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

Table A2. Survey Quota Weighting Strategy

MCO	Population of eligible members (N)	Number of completed surveys (n)	Weight
AMERIGROUP	4,579	313	14.63
Evercare	3,848	308	12.49
Molina	781	66	11.83
Superior	3,876	306	12.67

Analysis of differences in frequencies used the Pearson Chi-square test of independence, and analysis of differences in means used t-tests and analysis of variance (ANOVA). To prevent overestimation of statistical significance, all tests were performed without weighting. These tests allowed comparison of frequencies and means among the four MCOs and other demographic sub-groups within the sample.

Body mass index (BMI) was calculated by dividing the member’s weight in kilograms by their height in meters squared. BMI could be calculated for 964 members in the sample (97 percent) for whom height and weight data were complete. Height data were missing for 9 members (0.91 percent), and weight data were missing for 22 members (2.21 percent).

Survey respondents were classified into one of four clinically relevant BMI categories, which are recognized by the Centers for Disease Control and Prevention.²⁵

- 1) Underweight – less than 18.5
- 2) Healthy weight – 18.5 to 24.9
- 3) Overweight – 25.0 to 29.9
- 4) Obese – 30.0 or greater

In addition, researchers conducted a multivariate analysis to examine the effects of demographic, health status, and health delivery factors on members' perceived improvement in their behavioral health. A more detailed description of this analysis is presented in **Appendix C**

Appendix B. Supplementary Tables

Table B1. Primary Mental Health Diagnoses for Sampling

Adjustment Disorders (i.e., a stress-related disturbance marked by emotional distress and impaired functioning that does not meet criteria for another DSM-IV-TR Axis I disorder)	Adjustment Disorder with ... Anxiety Depressed Mood Disturbance of Conduct Mixed Anxiety and Depressed Mood Mixed Disturbance of Emotions and Conduct Separation Anxiety Disorder Adjustment Reaction, <i>Not Otherwise Specified</i> (NOS)
Anxiety Disorders	Generalized Anxiety Disorder Panic Disorder without Agoraphobia Posttraumatic Stress Disorder Anxiety Disorder NOS
Attention-Deficit/Hyperactivity Disorders (ADHD)	ADHD Combined Type ADHD Predominantly Inattentive Type ADHD Predominantly Hyperactive-Impulsive Type
Bipolar Disorders	Bipolar I Disorder Bipolar II Disorder Bipolar Disorder NOS
Depressive Disorders	Dysthymic Disorder Major Depressive Disorder Depressive Disorder NOS
Pain Disorders Related to Psychological Factors	Psychogenic Pain Tension Headache
Schizophrenia and Other Psychotic Disorders	Schizophrenia... Simple Type Disorganized Type Paranoid Type Residual Type Latent Schizophrenia Schizoaffective Disorder Schizophreniform Disorder Schizophrenia NOS Delusional Disorder
Substance Abuse and Dependence Disorders	Alcohol Abuse Alcohol Dependence Alcohol Withdrawal Alcohol Related Disorder NOS Cannabis Abuse Cannabis Dependence

	Cocaine Dependence Opioid Dependence Sedative, Hypnotic, or Anxiolytic Abuse Tobacco Use Disorder Combinations of Drug Dependence Drug Abuse NOS Drug Dependence NOS
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Appendix C. Multivariate Analysis

Many of the ECHO[®] Survey questions included in the fiscal year 2011 STAR+PLUS Behavioral Health Survey could be combined to form composite scores in general domains of behavioral health care. The ECHO[®] composite domains presented in this report include: *Getting Treatment Quickly, How Well Clinicians Communicate, Information About Treatment Options, and Perceived Improvement*. Among these, *Perceived Improvement* functions as a member-reported outcome measure, combining members' responses to questions about their behavioral health improvement in the past year. Specifically, the *Perceived Improvement* domain assesses improvement in a member's ability to: 1) deal with daily problems, 2) deal with social situations, 3) accomplish things, and 4) deal with symptoms or problems.

Most questions in the ECHO[®] Adult Survey address members' experiences with their behavioral health care, which indicate the quality of MCO/BHO *processes*. Thus, having a survey-based measure of improvement provides a unique opportunity to assess the role of health care factors on subjective *outcomes*. For this reason, ICHP conducted a multivariate analysis to test the influence of demographic factors and health care factors on the *Perceived Improvement* score.

Methodology

The multivariate analysis was conducted using unconditional logistic regression, with the outcome dichotomized (0 or 1) to permit calculation of the likelihood of high perceived improvement. In the absence of national standards for what represents "high" *Perceived Improvement* on the ECHO[®] survey, a threshold was selected based on the quartiles of distribution of responses within the study data. *Perceived Improvement* scores range from 1.00 (lowest) to 4.00 (highest). For the multivariate analysis, high *Perceived Improvement* was defined as any score equal to or greater than the 4th quartile of the distribution of responses (3.25). Thus, scores ranging from 1.00 to 3.24 were re-coded as "0," and scores ranging from 3.25 to 4.00 were re-coded as "1."

The EQRO tested a model to predict the odds of a member having high *Perceived Improvement*, controlling for member age, sex, race/ethnicity, obesity, STAR+PLUS MCO, and two test factors focusing on members' experiences with their behavioral health experiences – ECHO[®] *How Well Clinicians Communicate* and ECHO[®] *Information About Treatment Options*. The two ECHO[®] composites tested in this analysis were each dichotomized according to their quartiles of distribution in the dataset, with members in the upper quartile coded as "1"

(representing the best health delivery experiences) and members in the lower three quartiles coded as “0.” Members in the lower three quartiles in each composite were the reference group:

- ***How Well Clinicians Communicate.*** Scores for this composite range from 1.00 to 3.00. The upper quartile included all scores of 3.00.
- ***Information About Treatment Options.*** Scores for this composite range from 0.00 to 1.00. The upper quartile included all scores of 1.00.

The EQRO used the following covariates in the logistic regression model:

- Age – categorized into five age cohorts: 18 to 30 years old, 31 to 40 years old, 41 to 50 years old, 51 to 60 years old, and 61 years and older. The reference group was members 18 to 30 years old.
- Sex, with male members as the reference group.
- Race/ethnicity – categorized as White, non-Hispanic; Hispanic; or Black, non-Hispanic. The reference group was White, non-Hispanic members.
- Obesity, with non-obese members as the reference group.
- MCO – among the four STAR+PLUS MCOs, the reference group was Evercare, chosen because it had the highest percentage of members with *Perceived Improvement* scores of 3.25 or greater (28 percent). Molina was not included in the model due to the small number of members eligible for the analysis (n = 48).

Results

Results of the multivariate analysis are presented in **Table C1** as odds ratios. The odds ratios represent the likelihood of a member in a particular category having a high *Perceived Improvement* score, compared to members in the reference category. For any particular test variable or covariate, an odds ratio above 1.0 suggests that members in the specified category were more likely to have reported high *Perceived Improvement*. Conversely, an odds ratio below 1.0 suggests that members in the specified category were less likely to have reported high *Perceived Improvement* than members 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 $p < 0.05$.

Member’s age was significantly associated with the likelihood of high *Perceived Improvement*, with older members generally having lower odds of high *Perceived Improvement* than members in the youngest age category (18 to 30 years old). In particular, members 41 to 50 years old were about half as likely as those in the youngest age category to have reported high *Perceived Improvement*. Members 51 to 60 years old were about 60 percent less likely to have reported high *Perceived Improvement*.

Obesity was also moderately associated with high *Perceived Improvement* – at 30 percent for non-obese members and 25 percent for obese members. The likelihood of high scores was about 30 percent lower for obese members than for non-obese members. The member’s STAR+PLUS MCO was not associated with the likelihood of high *Perceived Improvement*.

Of the two test factors, *How Well Clinicians Communicate* was found to be significantly associated with high *Perceived Improvement*, controlling for the demographic and MCO factors. Members with high scores on *How Well Clinicians Communicate* were 2.3 times more likely than those with lower scores to have had reported high scores for *Perceived Improvement*.

The EQRO used the likelihood-ratio test to determine the relative fit of the model, compared to simpler versions of the model with fewer covariates. This test permits a determination of the predictive value gained by adding certain factors to the model.

- First, a model including the demographic and MCO factors was compared to a simpler model including only the demographic factors. The addition of MCO to the model did not result in a significantly better fit.
- Second, the full model (including demographics, MCO, and the two ECHO[®] test variables) was compared to the model including only demographics and MCO. The addition of *How Well Clinicians Communicate* and *Information About Treatment Options* to the model resulted in a significantly better fit.

Model	Model Type			p-value
	Full (χ^2 , df)	Simple (χ^2 , df)	Difference (χ^2 , df)	
Demographics + MCO ^a	25.14, df = 10	24.47, df = 8	0.67, df = 2	= 0.715
Demographics + MCO + ECHO [®] ^b	36.14, df = 12	14.68, df = 10	21.46, df = 2	< 0.001

^a The simple model in this test included only demographics.

^b The simple model in this test included demographics and MCO.

The findings of the multivariate analysis suggest that members' experiences communicating with their clinicians is associated with perceived improvement of their behavioral health symptoms, independent of demographic factors and MCO membership. The EQRO conducted chi-square tests to determine whether any of the six individual items of the *How Well Clinicians Communicate* composite were more influential than the others on *Perceived Improvement*. Among the individual items, the most important predictor of high perceived improvement was the amount of time clinicians spent with the member. Members who said their clinicians always showed respect for what they had to say, involved them in treatment decisions, and made them feel safe were also significantly more likely to have had high *Perceived Improvement* scores.

Good communication is important for clinicians in establishing a rapport with members, and likely plays a role in establishing regular, continuous care. If a behavioral health provider gives members less time in the clinical encounter to voice their concerns, seems disrespectful or abrupt, or does not share in clinical decision-making, members may be less likely to return to that provider. Without regular, continuous care from a provider they can trust, these members are in turn less likely to show improvement in their behavioral health symptoms. Furthermore, research has found that the amount of time spent in consultations for mental health problems is associated with more accurate diagnosis of psychological problems, and that time pressure in the clinical encounter is a major barrier in treating conditions such as depression.²⁶

Table C1. Multivariate Analysis – Influence of Clinicians’ Communication and Information about Treatment Options on Perceived Improvement

Factor	Percent with high Perceived Improvement	Odds Ratio	95% CI
Age (years)			
18 to 30	39%	REF	-
31 to 40	34%	0.86	(0.41 – 1.80)
41 to 50	26%	0.51	(0.26 – 1.00)
51 to 60	21%	0.39	(0.20 – 0.75)
61 and older	31%	0.63	(0.27 – 1.47)
Sex			
Male	31%	REF	-
Female	25%	0.82	(0.53 – 1.25)
Race/Ethnicity			
White, non-Hispanic	25%	REF	-
Hispanic	27%	1.09	(0.69 – 1.72)
Black, non-Hispanic	29%	1.13	(0.70 – 1.83)
Obesity			
Non-obese	30%	REF	-
Obese	25%	0.68	(0.46 – 1.01)
MCO			
AMERIGROUP	27%	0.90	(0.57 – 1.44)
Evercare	28%	REF	-
Superior	26%	0.88	(0.55 – 1.42)
How Well Clinicians Communicate			
Lower score (1.00 – 2.99)	21%	REF	-
High score (3.00)	36%	2.33	(1.59 – 3.42)
Information About Treatment Options			
Lower score (0.00 – 0.99)	23%	REF	-
High score (1.00)	30%	1.28	(0.88 – 1.86)

Table C2. Individual Clinician Communication Items and *Perceived Improvement*

Percent of members saying their clinicians “always”...	ECHO® Perceived Improvement Score	
	1.00 – 3.24	3.25 – 4.00
Listened carefully to them ^a	64%	74%
Explained things in a way they could understand	65%	69%
Showed respect for what they had to say ^b	67%	78%
Spent enough time with them ^c	58%	77%
Involved them in their treatment as much as they wanted ^b	57%	74%
Made them feel safe ^b	73%	85%

^a Difference significant at $p < 0.100$

^b Difference significant at $p < 0.050$

^c Difference significant at $p < 0.001$

Endnotes

¹ AHRQ (Agency for Healthcare Research and Quality). 2011. "AHRQ Initiative Encourages Better Two-way Communication Between Clinicians and Patients." Available at: <http://www.ahrq.gov/news/press/pr2011/questionspr.htm>.

² Mastal, M.F., M.E. Reardon, M. English. 2007. "Innovations in Disability Care Coordination Organizations: Integrating Primary Care and Behavioral Health Clinical Systems." *Professional Case Management*, 12(1): 27-36.

³ HHSC (Texas Health and Human Services Commission). 2011a. *Texas Medicaid in Perspective, Eighth Edition*. "Chapter 6: Medicaid Managed Care." Available at <http://www.hhsc.state.tx.us/Medicaid/reports/PB8/PinkBookTOC.html>.

⁴ U.S. Department of Health and Human Services. 1999. *Mental Health: A Report of the Surgeon General*. Rockville, MD.

⁵ The Legislative Budget Board Staff (LBBS). 2009. *Texas State Government Effectiveness and Efficiency: Selected Issues and Recommendations*. Available at: <http://www.lbb.state.tx.us/>.

⁶ Pascoe, G.C. 1983. "Patient Satisfaction in Primary Health Care: A Literature Review and Analysis." *Evaluation and Program Planning* 6: 185-210.

⁷ Hall, J.A., Roter, D.L., and Katz, N.R. 1988. "Meta-analysis of Correlates of Provider Behavior in Medical Encounters." *Medical Care* 26 (7): 657-675.

⁸ HHSC. 2011b. "STAR+PLUS Overview." Available at <http://www.hhsc.state.tx.us/starplus/Overview.htm>

⁹ Consumer Assessment of Healthcare Providers and Systems (CAHPS®). 2011. "ECHO® Survey and Reporting Kit." Available at: <http://www.cahps.ahrq.gov/Surveys-Guidance/ECHO.aspx>.

¹⁰ CDC (Centers for Disease Control and Prevention). 2011. U.S. Obesity Trends. Available at: <http://www.cdc.gov/obesity/data/trends.html>.

¹¹ Flegal, K.M., M.D. Carroll, C.L. Ogden, L.R. Curtin. 2010. "Prevalence and trends in obesity among U.S. adults, 1999 – 2008." *Journal of the American Medical Association* 303: 235-241.

¹² Chi-square = 38.36, p < 0.001.

¹³ Chi-square = 5.49, p = 0.064.

¹⁴ Chi-square = 19.88, p < 0.001.

¹⁵ Chi-square = 21.79, p < 0.001.

¹⁶ The coding scheme for the open-ended question was developed to parse out responses of mental health and non-mental health issues. Within the category of mental health, further categorization was developed. If a member only responded with a non-behavioral health reason (e.g., "I broke my arm.") they were discarded from the analysis. If a member responded with both a behavioral health issue and a non-

behavioral health related issue, only the behavioral health related issue was coded (e.g., “I had bad anxiety and a hysterectomy.”) Multiple behavioral health issues were each given a separate code (e.g., “My husband hit me and then I had a breakdown.”). The category “Family Issues” comprised responses relating to abusive family members or death of a loved one.

¹⁷ Texas Medicaid and Healthcare Partnership (TMHP). 2010. *Texas Medicaid Provider Procedures Manual. 7.4.1. Annual Encounters/Visits Limitations*. Available at: <http://www.tmhp.com/HTMLmanuals/TMPPM/2010/2010TMPPM-18-066.html>.

¹⁸ Chi-square = 13.83, p = 0.003.

¹⁹ Chi-square = 16.47, p = 0.011.

²⁰ T-test = 3.06; p = 0.002.

²¹ AHRQ (Agency for Healthcare Research and Quality). 2011.

²² Mastal, M.F., et al. 2007.

²³ CAHPS[®]. 2011.

²⁴ Chi-square = 13.70, p = 0.001.

²⁵ CDC. 2011

²⁶ Hutton, C. and J. Gunn. 2007. “Do longer consultations improve the management of psychological problems in general practice? A systematic literature review.” *BMC Health Services Research* 7: 71.