



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

The Texas Primary Care Case Management Child Member Survey Report

Fiscal Year 2011

**Institute for Child Health Policy
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**The External Quality Review Organization
For Texas Medicaid Managed Care and CHIP**

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Executive Summary

Purpose

This report provides results from the fiscal year 2011 Primary Care Case Management (PCCM) Child Member Survey for the State of Texas, prepared by the Institute for Child Health Policy (IHP) at the University of Florida, the External Quality Review Organization (EQRO) for Texas Medicaid Managed Care and the Children's Health Insurance Program. The purpose of this survey is to provide a demographic and health profile of children enrolled in the Texas PCCM program, and to assess caregivers' experiences and satisfaction with their children's healthcare.

Methods

Participants were selected from a random sample of 1,385 families with children enrolled in PCCM in Texas. Between May and July 2011, 400 caregivers of child PCCM members were surveyed by telephone.

The response rate for the PCCM Child Member Survey was 58 percent and the cooperation rate was 79 percent.

The PCCM Child Member Survey instrument included the following questionnaires and items:

- The Consumer Assessment of Healthcare Providers and Systems (CAHPS[®]) Health Plan Survey 4.0 (Medicaid core and supplemental modules)
- The Children With Special Health Care Needs (CSHCN) Screener[®]
- Items from the National Survey of CSHCN (NS-CSHCN), addressing transition to adult care for CSHCN
- Items developed by IHP to assess caregiver and member demographic and household characteristics.

Descriptive analyses were performed on all survey items, with a focus on the Health and Human Services Commission (HHSC) Performance Indicator Dashboard for fiscal year 2010 and the CAHPS[®] Health Plan Survey composite measures. CAHPS[®] composite measures assess caregivers' experiences and satisfaction with ten different health care 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

Statistical tests were conducted to determine if there were differences in the results based on caregiver/member characteristics.

Summary of Findings

Profile of PCCM survey participants (caregivers):

- The majority were the biological mothers of PCCM members.
- The average age was 35 years old.
- The majority were Hispanic (67 percent), primarily of Mexican descent.
- Approximately 34 percent did not complete high school.
- Forty percent spoke mainly Spanish at home.
- Approximately 42 percent were married.

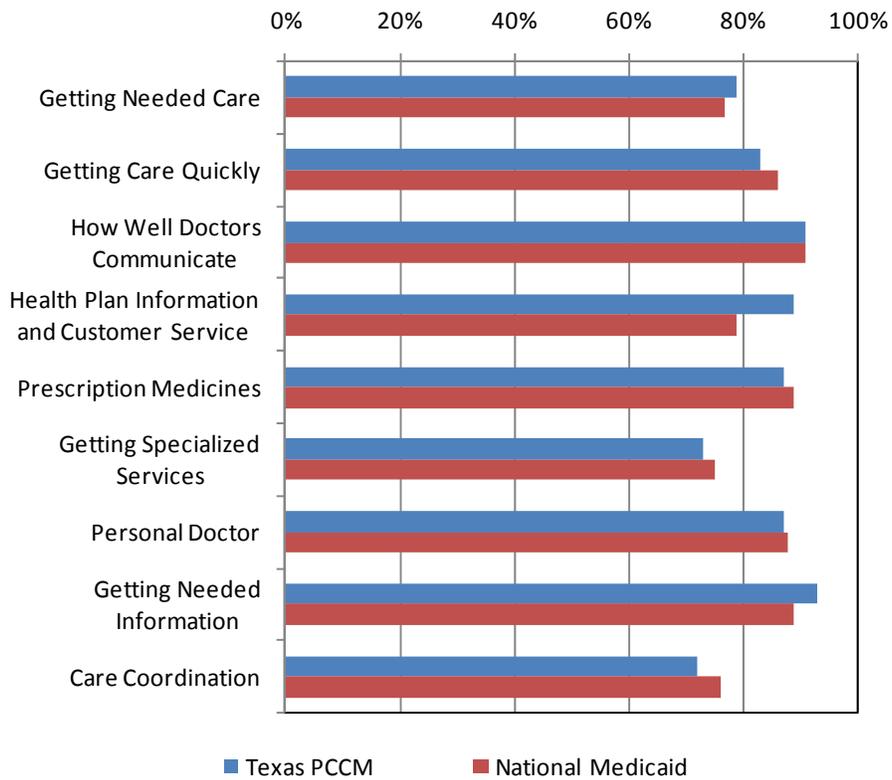
Profile of PCCM survey child members:

- Fifty-one percent were male and 48 percent were female.
- The average age was 9 years old.
- The majority were Hispanic (67 percent), primarily of Mexican descent
- Forty-seven percent lived in a single-parent household.
- Twenty-three percent had at least one special health care need.
- Thirty-one percent of members were obese.

Positive Findings

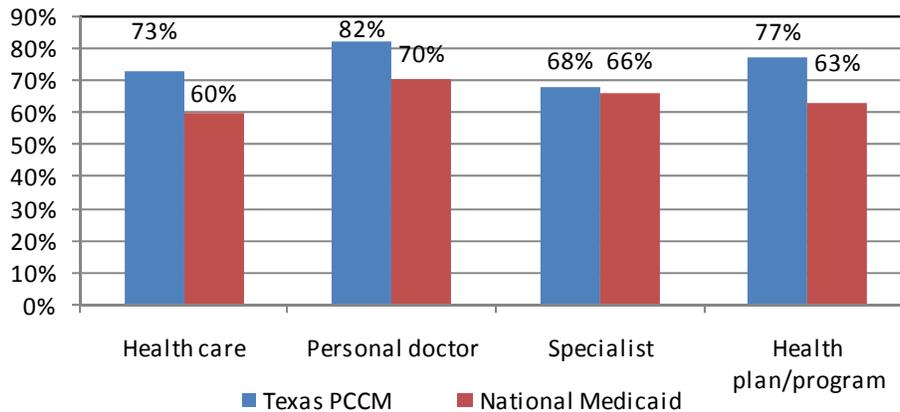
- *Personal doctors.* Eighty-four percent of PCCM child members had a personal doctor. Caregivers reported good access to help or advice when calling their child's personal doctor during normal office hours (89 percent) and slightly lower access when calling after normal office hours (73 percent). Most personal doctors addressed the health literacy of caregivers and their children in positive ways during the office visit.
- *Preventive care.* Among caregivers of children less than three years old, 84 percent received reminders to bring their child in for check-ups or immunizations. Nearly all caregivers had good access to appointments for check-ups or immunizations.
- *Specialist care.* Access to specialist referrals for children in PCCM was particularly good, with 77 percent of caregivers saying they "usually" or "always" were able to get a specialist referral for their child when they needed it. This is higher than the HHSC Dashboard standard of 59 percent for STAR MCOs.
- *CAHPS® composite scores.* Texas PCCM performed well for most child CAHPS® composites, particularly for *How Well Doctors Communicate* (91 percent), *Health Plan Information and Customer Service* (89 percent), *Prescription Medicines* (87 percent), and *Getting Needed Information* (94 percent) – all of which were equal to or greater than the national Medicaid averages. Lower scores were observed for *Getting Specialized Services* and *Care Coordination*

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



- Caregiver ratings.* On a scale from 0 to 10, caregivers provided high mean ratings of their child’s health care (8.97), personal doctor (9.33), specialist (8.98), and the PCCM Program (9.18). When expressed as the percentage of caregivers who indicated a rating of 9 or 10, all ratings in Texas PCCM were equal to or greater than the averages for Medicaid plans nationally.

Percent of caregivers rating their child’s health services a “9” or “10”



Negative Findings

- *Urgent care.* Among caregivers whose child had gone to the emergency room, nearly half said their child had at least one emergency room visit because they could not get an appointment for routine care. However, one-quarter said they would “never” have taken their child to the doctor’s office or clinic instead of the emergency room, even if they were able to get a timely appointment.
- *Timeliness of care.* Approximately 42 percent of caregivers reported having some delays in their child’s treatment while waiting for approval from the PCCM Program. Among caregivers whose child was seen in a doctor’s office or clinic, only 26 percent reported waiting 15 minutes or less for their child to be taken to the exam room. Both percentages indicated lower performance in PCCM than their corresponding HHSC Dashboard standards for STAR MCOs.
- *Preparing CSHCN for transition.* Among caregivers of adolescent CSHCN who saw doctors that treated only children, 35 percent said their child’s doctors had discussed with them their child’s transition to adult care. Only one in four caregivers of adolescent CSHCN said their child’s doctors had discussed how to obtain or keep health insurance coverage for their child after the transition.
- *Care coordination.* The CAHPS® composite *Care Coordination* score in PCCM was only slightly lower than the national Medicaid average (73 percent vs. 76 percent). However, among caregivers whose child received health care from a health provider besides their personal doctor, only 59 percent said that someone from the PCCM program or their child’s doctor’s office or clinic helped them coordinate their child’s care.

EQRO Recommendations

Effective March 2012, the Texas PCCM Program will complete its transition to Medicaid managed care through the STAR and STAR+PLUS programs.¹ The EQRO recommends that STAR and STAR+PLUS MCOs moving into PCCM counties focus on areas where caregiver experiences and satisfaction were low for this population under the PCCM Program, and where the population’s demographic and health status require focused efforts.

Domain	Recommendations	Rationale	HHSC Response
Child obesity	<ul style="list-style-type: none"> • Develop or improve upon existing child obesity disease management (DM) programs, and prioritize their implementation in former PCCM counties. • Consider implementation of Performance Improvement Projects (PIPs) to evaluate the 	The rate of obesity among children and adolescents in PCCM was 31 percent, which is considerably higher than national and state averages.	<p>MCOs must provide or arrange for the provision of disease management health home services for persons with chronic conditions such as being overweight, as evidenced by having a Body Mass Index (BMI) over 25.</p> <p>Two of the quality measures included in the 2012 HHSC Performance Dashboard are:</p>

	<p>short- and long-term effects of health plan exercise and nutrition programs, using weight, BMI, and measures of body fat composition as outcomes.</p> <ul style="list-style-type: none"> • Work with network providers in former PCCM counties to ensure they are following U.S. Preventive Services Task Force (UPSTF) guidelines for child obesity screening and referrals to weight management programs.² 		<ol style="list-style-type: none"> 1. Adult BMI Assessment in STAR+PLUS Program 2. Weight Assessment and Counseling for Nutrition & Physical Activity for Children/Adolescents in STAR. <p>HHSC has not established a standard for these indicators, so these reports will help establish the baselines for these measures.</p>
<p>Emergency room (ER) utilization</p>	<ul style="list-style-type: none"> • Prioritize implementation of health plan systems for monitoring inappropriate ER use in former PCCM counties. • Consider developing member education programs, using recent strategies found to be successful at reducing ER use in low-income populations: <ul style="list-style-type: none"> ○ Training caregivers in the use of a low-literacy health book to respond to common childhood illnesses.³ ○ Distribution of a low-literacy health 	<p>Among caregivers whose child visited the ER, half reported visiting the ER because they could not get a timely appointment for routine care.</p> <p>However, one-quarter said they would “never” have taken their child to a doctor’s office or clinic instead of the ER, even if they got a timely appointment.</p>	<p>One of HHSC’s 2012 overarching goals in STAR and CHIP is to improve treatment for ambulatory care sensitive conditions (ACSCs) through reduction of emergency department visits.</p> <p>Ambulatory care, both outpatient and emergency department, is included in the 2012 Quality Challenge Award measures.</p>

	booklet on pediatric non-urgent care to caregivers who bring their child to an outpatient clinic. ⁴		
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Introduction and Purpose

The Texas Primary Care Case Management (PCCM) Program is a managed fee-for-service arrangement, utilizing a network of primary care and other health care providers that provide a medical home and health care services to individuals with Medicaid in 202 Texas counties. In its role as the External Quality Review Organization (EQRO) for the State of Texas Medicaid Managed Care, the Institute for Child Health Policy (IHP) collects satisfaction data from caregivers of child PCCM members through a biennial telephone survey. Caregivers' satisfaction with their children's health care is associated with length of well-child visits, time spent waiting for appointments, and overall expectations of their children's care, and is an important indicator of health care quality.^{5, 6,7}

The purpose of the fiscal year 2011 PCCM Child Member Survey Report is to:

- Describe the demographic characteristics of children enrolled in PCCM and their families.
- Document the health status of the PCCM child member population.
- Document caregivers' experiences and general satisfaction with the care their children receive under PCCM.
- Assess PCCM Program performance across four domains of care:
 - Access
 - Timeliness
 - Patient-centered care
 - Care coordination
- Identify disparities in caregiver experiences and satisfaction across population groups.

Beginning on September 1, 2011, the PCCM Program will be phased out as part of the Medicaid 1115 Waiver Managed Care Expansion.⁸ STAR and STAR+PLUS managed care delivery systems will be expanded into areas that currently serve PCCM clients. The contents of this report provide valuable information to the Texas Medicaid Programs and Managed Care Organizations on improving health care quality as clients are transitioned from PCCM into managed care.

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

Survey participants were selected from a simple random sample of children enrolled in PCCM in Texas for six continuous months between September 2010 and February 2011. These criteria ensured that families would have sufficient experience with the program to respond to the survey questions. Members whose caregivers had participated in the prior year's survey (fiscal year 2009) were excluded from the sample. A target sample of 400 completed telephone interviews was set.

Survey Instruments

The fiscal year 2011 PCCM Child Member Survey instrument was comprised of:

- The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 4.0 (Medicaid core and supplemental modules) ⁹
- The Children With Special Health Care Needs (CSHCN) Screener® ¹⁰
- Items from the National Survey of CSHCN (NS-CSHCN), addressing transition to adult care for CSHCN ¹¹
- Items developed by ICHP to assess caregiver and member demographic and household characteristics.

The CAHPS® Health Plan Survey (Version 4.0) is a widely used instrument for measuring and reporting consumer experiences with their or their child's health plan and providers. The survey allows for the calculation and reporting of ten 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. **Table B1** in **Appendix B** lists the individual survey items that comprise each of the ten composite measures. 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* ¹²
- *Prescription Medicines*
- *Getting Specialized Services*
- *Shared Decision-Making*
- *Personal Doctor*
- *Getting Needed Information*
- *Care Coordination*

CAHPS® composite measures were scored using two methods, following National Committee for Quality Assurance (NCQA) specifications: (1) Calculation of global proportions, and (2) Calculation of 3-point means. ¹³ The EQRO has discontinued use of the 100-point scoring system used in survey reports of prior years. However, for purposes of prior-year comparison, the 100-point equivalents are presented alongside the new scores in **Table B2** in **Appendix B**.

The CAHPS® Health Plan Survey also includes questions that function as indicators of health plan performance, as listed on the HHSC Performance Indicator Dashboard for fiscal year 2010. ¹⁴ While the HHSC Dashboard indicators were not developed for quality improvement in the PCCM Program, they are relevant for this year's PCCM Child Member Survey because of the upcoming transition of PCCM members to STAR and STAR+PLUS. Texas Medicaid Managed Care Organizations (MCOs) moving into former PCCM areas in the coming year will be held to HHSC Dashboard standards for this population. Therefore, this report will set a baseline for tracking survey-based HHSC Dashboard indicators in former PCCM areas.

The survey-based HHSC Dashboard indicators for child members include:¹⁵

- *Good access to urgent care*
- *Good access to specialist referral*
- *Good access to routine care*
- *No delays for an approval*
- *No exam room wait greater than 15 minutes*
- *Good access to behavioral health treatment or counseling*

Most CAHPS® composite measures and items have national data available for comparison, which are submitted to the NCQA by State Medicaid agencies and individual health plans.¹⁶ This report includes national comparisons for CAHPS® composite global proportions (when available), as well as national comparisons for caregiver ratings of their child's personal doctor, specialist, health care, and health plan.

Survey Data Collection Techniques

The EQRO sent letters written in English and Spanish to caregivers of 1,385 randomly sampled PCCM members, requesting their participation in the survey. Of the advance letters sent, one was returned undeliverable.

The Survey Research Center (SRC) at the University of Florida conducted the survey using computer-assisted telephone interviewing (CATI) between May and July 2011. The SRC telephoned caregivers of PCCM members seven days a week between 10 a.m. and 9 p.m. Central Time. Up to 30 attempts were made to reach a family, and if the family was not reached after that time, the software selected the next individual on the list. If a respondent was unable to complete the interview in English, SRC rescheduled the interview at a later date and time with a Spanish-speaking interviewer. Of 400 completed interviews, 39 (10 percent) were conducted in Spanish. On average, 8.2 calls per phone number were made in the PCCM child member sample.

Thirty-seven percent of families could not be located. Among those located, 11 percent were not eligible to complete the survey, six percent indicated that their child was not enrolled in PCCM, and 12 percent refused to participate. The response rate was 58 percent and the cooperation rate was 79 percent.

Data Analysis

Descriptive statistics and statistical tests were performed using the statistical software package SAS 9.1 (Cary, NC: SAS Institute Inc.). The statistics presented in this report exclude "do not know" and "refused" responses. Percentages shown in figures and tables are rounded to the nearest whole number; therefore, percentages may not add up to 100 percent.

Analysis of differences in frequencies used the Pearson Chi-square test of independence and Fisher's exact test, and analysis of differences in means used t-tests, analysis of variance (ANOVA), and Pearson's correlation. These tests allowed for comparison of frequencies and means between 2009 and 2011 results, and among demographic sub-groups within the survey sample.¹⁷ **Tables B3 and B4 in Appendix B** shows scaled CAHPS® composite means by child's gender, race/ethnicity, and CSHCN status.

Survey Results

This section details survey findings regarding PCCM member demographics, health status, caregiver experiences and satisfaction with their child's usual source of care, access and timeliness of care, patient-centered care, and care coordination. Frequency tables showing descriptive results for each survey question are provided in a separate Technical Appendix.¹⁸

Demographic Information

Parent and household characteristics

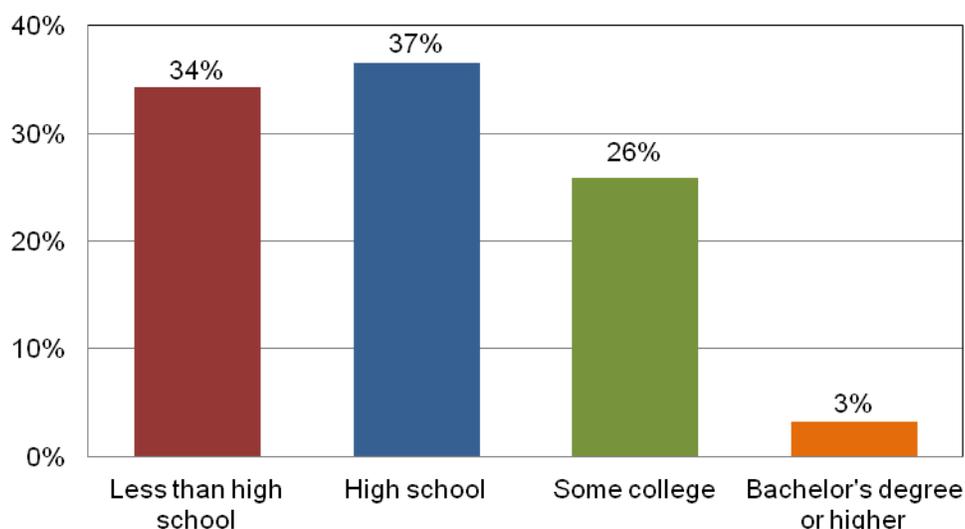
The average age of survey respondents was 34.9 years (SD = 11.0), with a range of 18 to 78 years of age.

The majority of respondents were Hispanic (67 percent), followed by White, non-Hispanic (22 percent), Black, non-Hispanic (nine percent), and Other, non-Hispanic ethnicity (three percent).

- Among Hispanic respondents, 91 percent identified themselves as Mexican, Mexican-American, or Chicano, one percent as Central American, and five percent as "Other."
- Forty percent of respondents stated that they mainly spoke Spanish at home.

Figure 1 presents the educational level of caregivers of PCCM members. Thirty-four percent of caregivers reported not completing high school. This is greater than the percentage of the Texas population (25 years or older) with less than a high school education, which was estimated at 21 percent from 2005 to 2007 by the U.S. Census.¹⁹ The lower educational status of caregivers highlights the importance of efforts to improve health literacy among members living in PCCM areas and their families. Thirty-seven percent of caregivers had a high school diploma or GED, 26 percent had taken some college courses, and three percent had a Bachelor's degree or higher.

Figure 1. Parent's Level of Education



The vast majority of respondents were the biological mothers of members.

- Female caregivers comprised 96 percent of all survey respondents.
- Ninety percent of survey respondents reported that they were the biological parent of the PCCM member.

In PCCM, 47 percent of children lived in a single-parent household, while 52 percent lived in a two-parent household. Forty-two percent of caregivers were married, 35 percent were single or unmarried, 20 percent were divorced or separated from their spouse, and four percent were widowed.

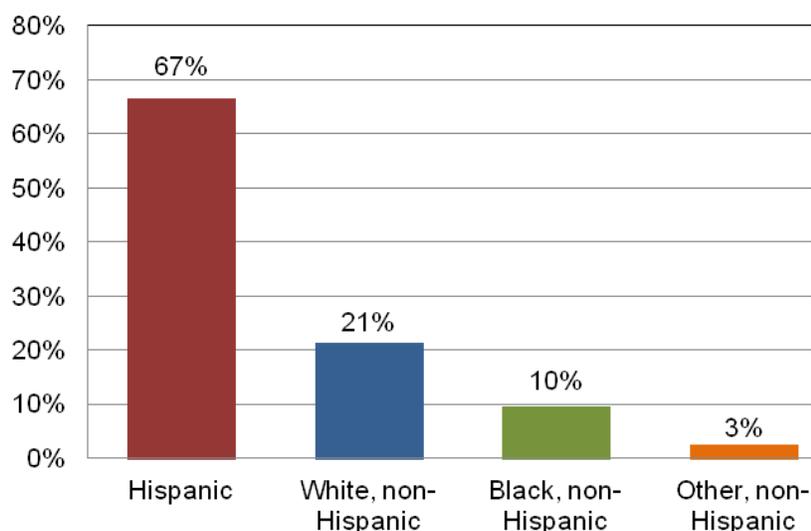
Child member characteristics

Child members in the PCCM program ranged in age from zero to 18 years old, with an average age of 8.6 years old (SD = 5.4). Fifty-two percent of children were male, and 49 percent of children were female.

Figure 2 shows the racial/ethnic breakdown of members in the fiscal year 2011 PCCM Child Member Survey. About 67 percent of child members were of Hispanic ethnicity. The percentage of Hispanic members in PCCM nearly doubles that in the Texas population, estimated at 38 percent in 2010 by the U.S. Census.²⁰

These findings emphasize the importance of culturally appropriate care for Hispanics, who have been shown to have poorer health status and lower levels of trust and satisfaction with their providers than the general population.²¹ Among all PCCM child members whose caregivers were surveyed, 21 percent were White, non-Hispanic and 10 percent were Black, non-Hispanic. Children classified as “Other, non-Hispanic” race/ethnicity included those of Asian or Pacific Islander, and American Indian or Alaska Native origin, as well as those whose caregivers specified their children were of mixed race/ethnicity or did not specify.

Figure 2. PCCM Child Member Race/Ethnicity

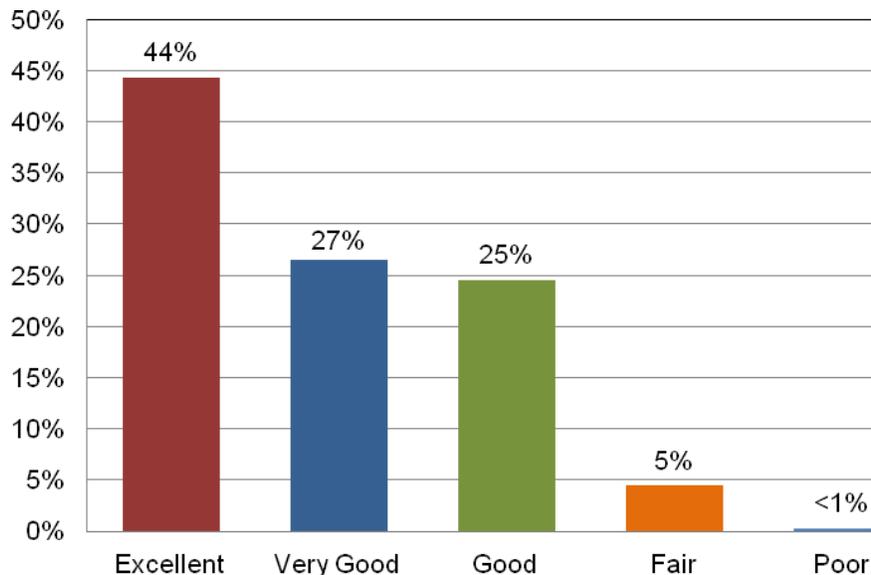


Child's Health Status

Caregivers' Ratings of Their Child's Health

Figure 3 provides caregivers' ratings of their child's overall health. Nearly half of caregivers surveyed (44 percent) rated their child's health as excellent. Only five percent rated their child's health as fair or poor.

Figure 3. Parents' Rating of Their Child's Overall Health



Caregivers were also asked to rate their child's mental or emotional health. The majority of parents rated their child's mental health as excellent or very good (73 percent). Only six percent of parents rated their child's mental health as fair or poor.

Children with Special Health Care Needs (CSHCN)

Children with special health care needs (CSHCN) comprise a unique group who may be more susceptible than healthy children to adverse outcomes from variations in the quality of their health care, and for whom close monitoring of access to care is an important component of quality assessment. The 2011 PCCM Child Member Survey used the CSHCN Screener[®] to evaluate the proportion of child members who had special health care needs.²² The screener identifies children as having special health care needs if they meet one or more of the following criteria:

- 1) Dependency on prescription medication
- 2) Above average use of health and educational services
- 3) Functional limitations (an inability to do things most children of the same age can do)
- 4) Need or use of specialized therapies
- 5) Need or use of treatment or counseling for emotional, developmental, or behavioral problems

Combining the above categories, 23 percent of PCCM child members were identified by caregivers as having special health care needs that have persisted for more than one year in at least one of the above criteria. As **Figure 4** shows, this marked the second consecutive survey year in which CSHCN rates have risen in PCCM, from 17 percent in 2007.

Figure 4. PCCM Child Members with at Least One Special Health Care Need: 2005-2011

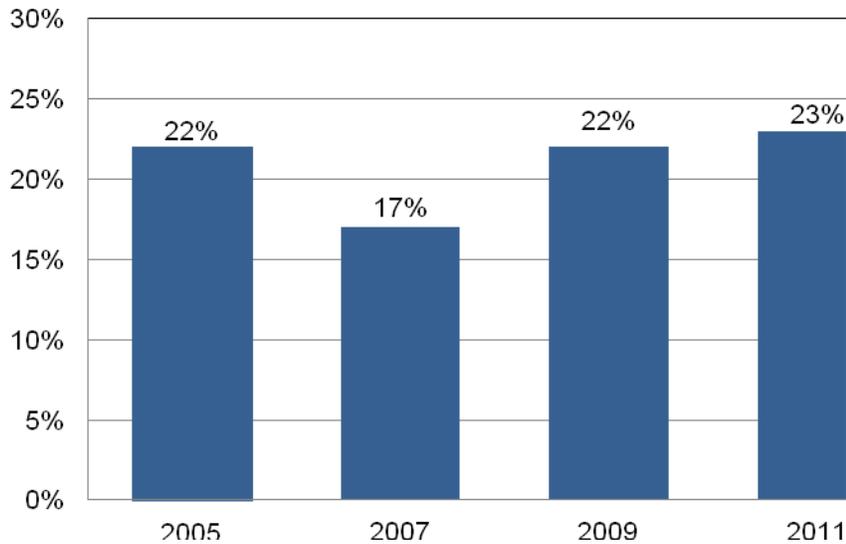


Figure 5 shows the prevalence of each of the five types of special health care needs in the PCCM sample. The most common special health care need among PCCM members was dependence on medications (18 percent), followed by above average use of services (10 percent), need for counseling (9 percent), and activity limitations (6 percent). Five percent reported that their child needed or received special therapy, such as physical, occupational, or speech therapy.

Figure 5. Prevalence of Special Health Care Needs among PCCM Child Members

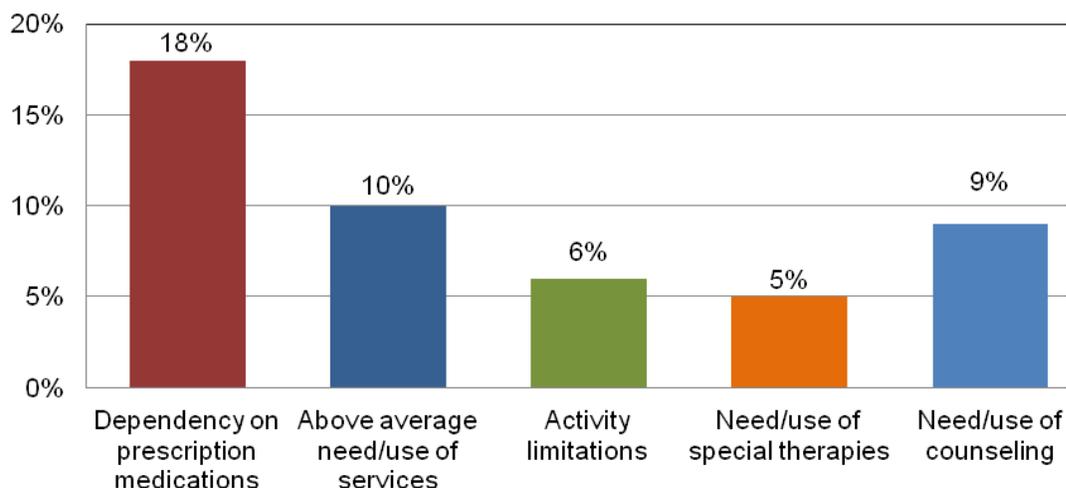


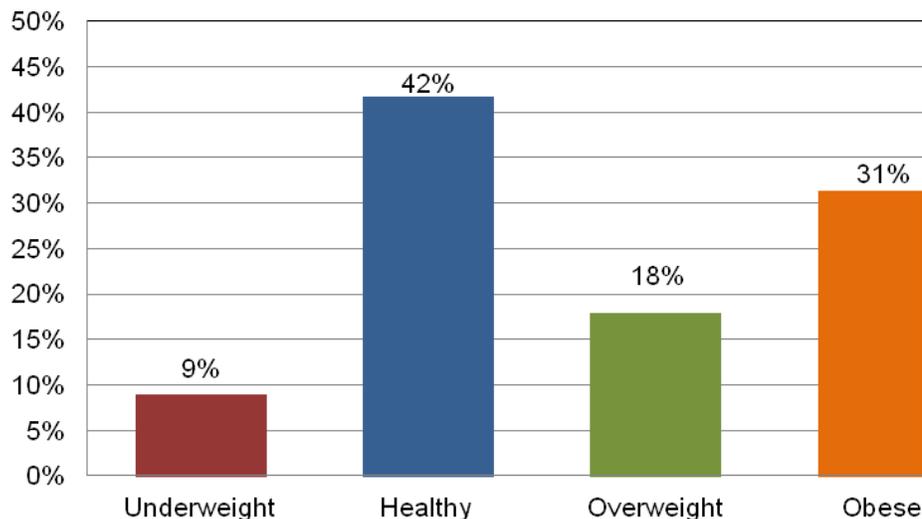
Figure B1 in Appendix B shows trends in the prevalence of each of the five types of special health care needs over the past four administrations of the PCCM Child Member Survey, from 2005 to 2011. Following a slight drop in prevalence for all five types in 2007, the prevalence of dependence on prescription medications increased in each following year, up to 18 percent in 2011. Prevalence of the other four types of special health care needs remained the same or decreased between 2009 and 2011.

Child overweight and obesity

BMI values were calculated using height and weight data for children enrolled in PCCM. For individuals between the ages of two and 19 years old, standards for the clinical relevance of BMI values vary by age and gender. Thus, when studying children and adolescents, classification into one of four clinically relevant BMI categories is more instructive than the BMI value itself.

Figure 6 shows the BMI classification of children and adolescents in the PCCM survey sample. Thirty-one percent of members in PCCM were obese. This figure is considerably higher than prevalence estimates of child obesity reported in national data (17 percent), as well as in data collected from Texas school children in 4th grade (22 percent), 8th grade (19 percent), and 11th grade (16 percent).^{23, 24} Reducing rates of overweight and obesity among children should be considered a priority for future quality improvement efforts as STAR and STAR+PLUS MCOs move into former PCCM areas.

Figure 6. BMI Classification



Access and Timeliness of Care

The following section examines access to and timeliness of care for PCCM child members. Specifically, results are presented for access to a personal doctor or usual source of care, preventive care, access to urgent and routine care, specialist care, specialized services, and prescription medications.

Personal doctor / usual source of care

Overall, 84 percent of child members in PCCM had a personal doctor. Greater than half of children in PCCM (58 percent) had been going to their personal doctor for three years or longer. However, approximately 18 percent of caregivers said their child had been going to his or her personal doctor for less than one year.

Caregivers were also asked whether their child had the same personal doctor before joining the PCCM Program – indicating their level of continuity of care.

- Sixty-six percent of caregivers reported that their child had the same personal doctor before joining PCCM. Among those who did not have the same personal doctor before joining, 72 percent it was “usually or “always” easy to get a personal doctor for their child that they were happy with.

Overall, 85 percent of caregivers reported their child had seen their personal doctor in the six months prior to the survey. Nearly one-quarter (24 percent) saw their personal doctor only once in the past six months. High utilization was observed among 16 percent of children in the sample, who saw their personal doctors five or more times in the past six months.

Caregivers generally rated their child's personal doctor highly, with a mean of 9.33 on a scale of 0 to 10. Eighty-two percent of caregivers gave their child's personal doctor a rating of 9 or 10, which compares favorably with the 70 percent who gave their child's personal doctor a rating of 9 or 10 in Medicaid plans nationally.

A number of survey items assessed caregivers' experiences with their child's personal doctor in the clinical setting, for which the CAHPS[®] *Personal Doctor* composite provides an overall score. (see **Table B1** in **Appendix B**). This composite uses three CAHPS[®] survey questions to assess whether personal doctors discussed developmental issues with caregivers and were able to understand how medical or behavioral health conditions affect the child's and family's day-to-day life. The composite score for positive experiences with personal doctors in PCCM was 87 percent, which is comparable to the Medicaid national rate of 88 percent. The NCQA mean for *Personal Doctor* was 0.87 on a scale from 0 to 1.

For fiscal year 2011, the EQRO added a series of new CAHPS[®] supplemental questions to its caregiver surveys, which assess in more detail the extent to which personal doctors address developmental concerns for child members. **Table 1** lists nine of these developmental concerns, and the percentage of caregivers who said their child's personal doctor discussed these concerns with them in the past six months.

Table 1. Personal Doctors' Discussion of Child Development

The child's personal doctor discussed...	Percent of caregivers who answered "Yes"
The child's learning ability	71%
The kinds of behaviors that are normal for a child of the same age	77%
How the child's body is growing	81%
The child's moods and emotions	64%
How the child gets along with others	62%
Things the caregiver could do to keep the child from getting injured	68%
How much or what kind of food the child eats	74%
How much or what kind of exercise the child gets	68%
Any problems in the household that might affect the child	52%

Preventive care

Child members under the age of three years accounted for just under 20 percent of the PCCM survey sample. Caregivers who had children in that age bracket were asked a series of questions about preventive care.

- Eighty-four percent indicated they had received reminders by mail, telephone, or in-person to bring their child in for a checkup or immunization shots.
- Eighty-seven percent reported their child had been to a health provider for a check-up or immunization shots.
- Ninety-five percent of caregivers whose children had been to a health care provider for a check-up or immunization shots stated they had gotten the appointment as soon as they thought the child needed it.

Urgent and routine care

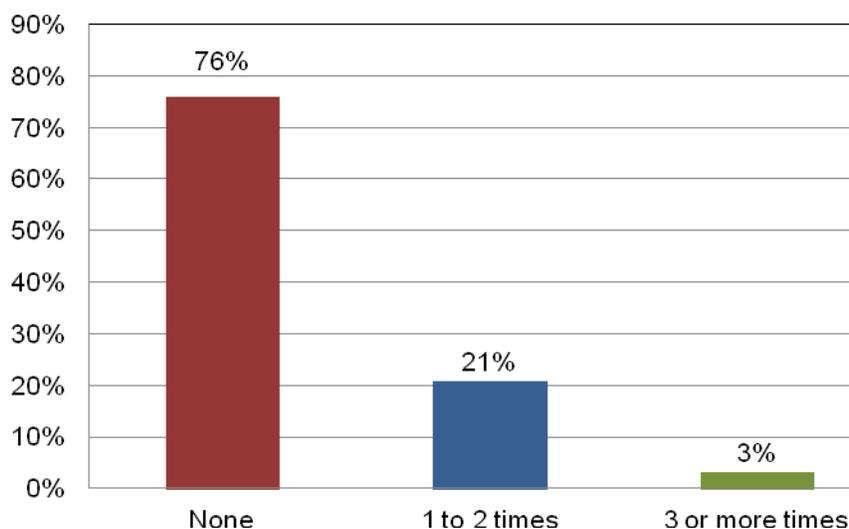
Twenty-nine percent of caregivers reported that their child had an illness, injury, or condition that needed care right away in a clinic, emergency room, or doctor's office during the six months prior to the survey.

- *Good access to urgent care.* Among caregivers of children in PCCM who needed urgent care, about 89 percent said their child "usually" or "always" received urgent care as soon as they thought it was needed. This compares favorably to the HHSC Dashboard standard of 86 percent, to which MCOs participating in the STAR Program are held.

Figure 7 presents the number of times caregivers reported their child went to the emergency room for care during the six months prior to the survey. Twenty-four percent of caregivers reported their child had visited the emergency room at least once. However, not all emergency room visits were necessarily made in response to urgent health care needs. Among caregivers who said their child had visited the emergency room:

- Fifty-two percent reported making *at least one* of these emergency room visits because they could not get an appointment for their child’s health care at a doctor’s office or clinic as soon as they thought it was needed.
- Twenty-five percent said that *even if they had gotten a timely appointment*, they would *never* have taken their child to a doctor’s office or clinic instead of the emergency room. While this response was based on a smaller number of respondents (n = 95), it suggests that the problem of inappropriate emergency room utilization may not completely be resolved through the adequate delivery of outpatient care.

Figure 7. Number of Times Child Went to the Emergency Room for Care



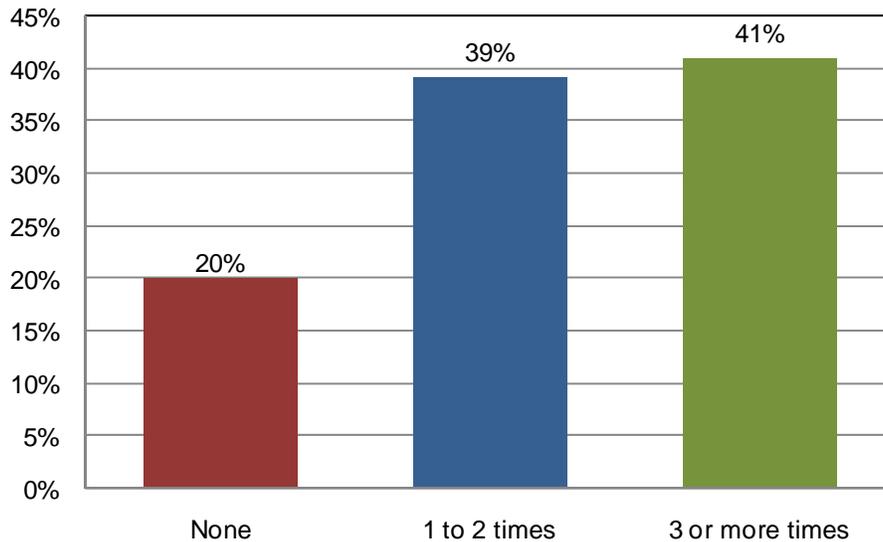
Approximately two-thirds of caregivers in PCCM (63 percent) reported that they had made routine appointments in the past six months for their child’s health care at a doctor’s office or clinic. Rates of seeking routine care were significantly lower among caregivers of Hispanic children (59 percent) than among caregivers of non-Hispanic children (71 percent).²⁵ This finding reinforces existing research suggesting that Hispanics are less likely to seek and receive health care services, especially preventive services.²⁶

- *Good access to routine care.* Among those caregivers who made routine appointments for their child, 78 percent in PCCM said they “usually” or “always” got an appointment for health care as soon as they thought their child needed. This is comparable to the HHSC Dashboard standard of 78 percent, to which MCOs participating in the STAR Program are held.

Figure 8 presents the number of times caregivers reported their child went to a doctor’s office or clinic to get health care during the six months prior to the survey. Eighty percent of caregivers reported their child had visited a doctor’s office or clinic at least once.

- *No exam room wait greater than 15 minutes.* Among caregivers whose child went to a doctor’s office or clinic in the six months prior to the survey, 26 percent reported their child was “always” taken in to the exam room within 15 minutes of their appointment. This important indicator of timeliness of care falls well below the HHSC Dashboard standard of 42 percent, to which MCOs participating in the STAR Program are held.

Figure 8. Number of Times Child Went to a Doctor’s Office or Clinic for Care



A final measure of the timeliness of care is the number of days caregivers had to wait between making an appointment for their child and actually seeing a health provider.

- Thirty-six percent reported being able to make a same-day appointment for their child.
- Fifty-five percent had to wait up to one week to see a health provider.
- Nine percent reported a wait time of greater than one week.

Twenty percent of caregivers stated that their child “usually” or “always” had to wait for an appointment because the provider they wanted worked limited hours or had few available appointments.

The mean score for the CAHPS® composite *Getting Care Quickly* was 2.57 out of 3.00, following NCQA specifications. This composite includes questions regarding the timely delivery of urgent care and the timeliness of making routine appointments. Overall, 83 percent of caregivers “usually” or “always” had positive experiences with *Getting Care Quickly*. This is comparable to the 86 percent reported for this composite measure in Medicaid plans nationally.

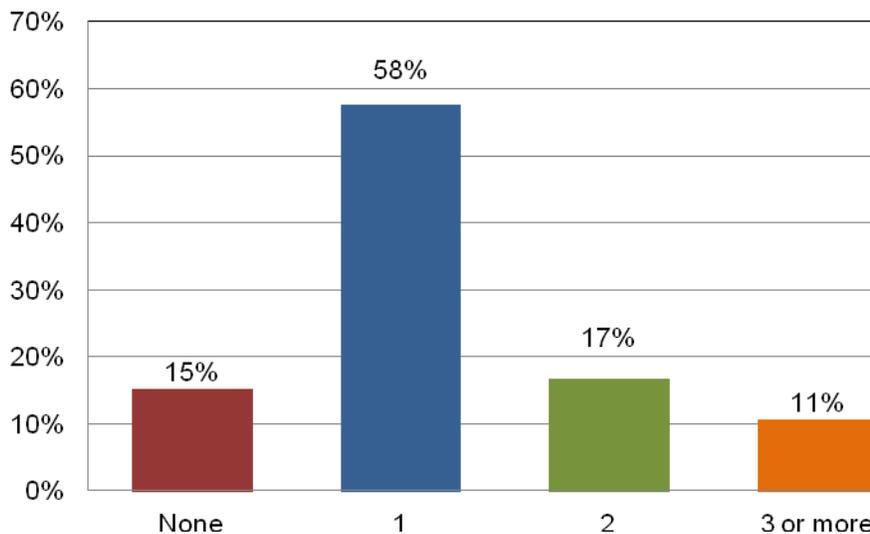
Specialist care

In the six months prior to the survey, 17 percent of caregivers of children in PCCM attempted to make an appointment for their child to see a specialist. Among these caregivers, 73 percent said it was “usually” or “always” easy to get specialist appointments for their children, which is comparable to the 74 percent reported for Medicaid plans nationally. About one-third of caregivers (34 percent) reported that the specialist their child saw most often was the same doctor as the child’s personal doctor.

- *Good access to specialist referral.* Seventy-seven percent of caregivers said it was “usually” or “always” easy to obtain a referral to a specialist that their child needed to see, which considerably exceeds the HHSC Dashboard standard of 59 percent to which MCOs participating in the STAR Program are held.

Figure 9 displays the number of specialists PCCM child members had seen during the six months prior to the survey. Among children and adolescents in the PCCM survey sample whose caregivers tried to make specialist appointments for them during the six months prior to the survey, 11 percent saw three or more specialists during that time period. However, 15 percent of children who needed specialist care never saw a specialist during that time period.

Figure 9. Number of Specialists Seen in Last 6 Months



Overall, on a scale of 0 to 10, caregivers of children in PCCM rated their child’s specialist a mean of 8.98. These ratings were significantly higher for CSHCN; caregivers of CSHCN rated their child’s specialist a mean of 9.52, compared to 8.58 among parents of non-CSHCN.²⁷ Sixty-eight percent of caregivers gave their child’s specialist a rating of 9 or 10, which is comparable to the 66 percent reported for Medicaid plans nationally.

Specialized services

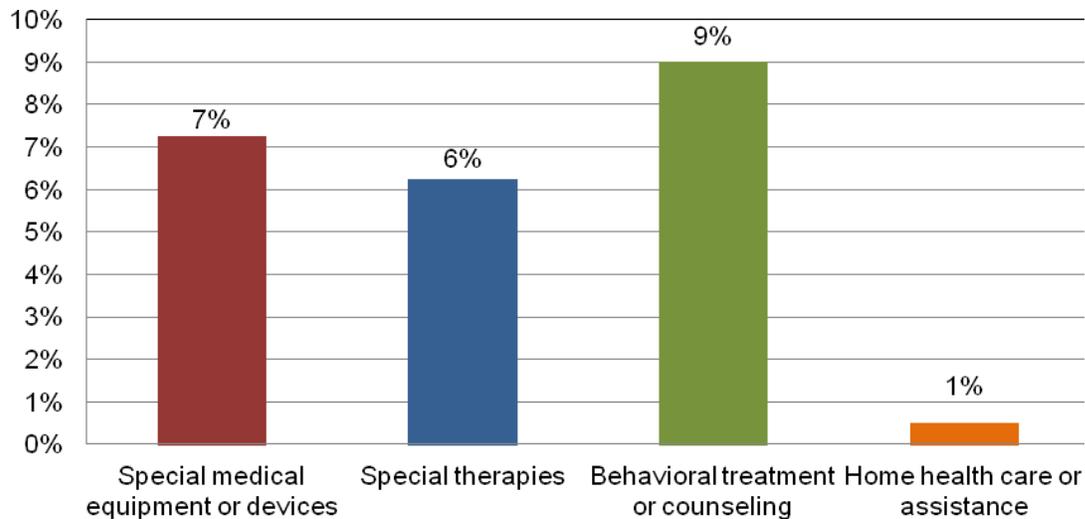
The PCCM Child Member Survey assessed the need for and access to specialized services in the following areas:

- special medical equipment or devices (such as a walker, wheelchair, nebulizer, feeding tubes, or oxygen equipment)
- special therapies (such as physical, occupational, or speech therapy)
- treatment or counseling for emotional, developmental, or behavioral problems
- home health care or assistance (such as home nursing or help with feeding, bathing, or dressing their child)

Figure 10 presents the percentage of children in PCCM who needed each of the four types of specialized services. Of these services, the need was greatest for behavioral, emotional, or

developmental counseling (nine percent), followed by special medical equipment (seven percent), and special therapies (six percent). Less than one percent of caregivers reported seeking home health care services for their children. Male members were significantly more likely than female members to need special therapies (nine percent vs. four percent).²⁸

Figure 10. Need for Specialized Services

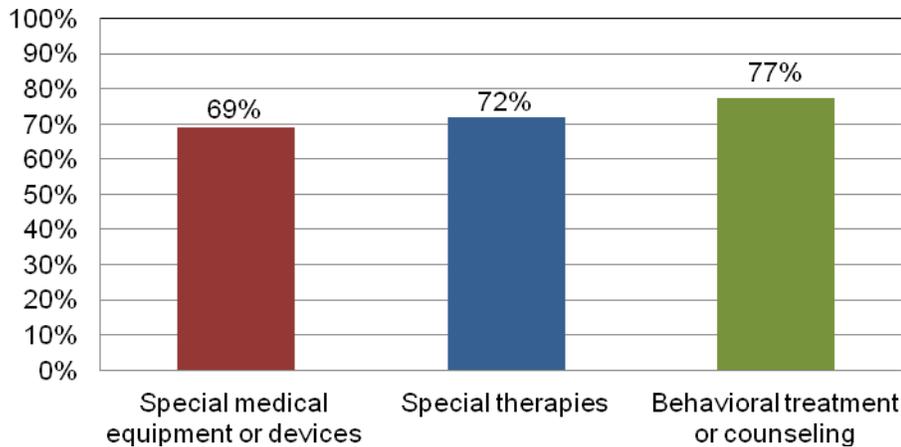


Caregivers of PCCM child members who needed specialized services were also asked how easy it was to obtain the necessary services.

Those who responded that it was “usually” or “always” easy to get specialized services were considered to have good access (**Figure 11**). Access was best for children who needed behavioral health treatment or counseling (77 percent) followed by special therapies (72 percent), and special medical equipment or devices (69 percent).

- *Good access to behavioral health treatment or counseling.* Seventy-seven percent of caregivers whose children needed behavioral health treatment or counseling reported that it was “usually” or “always” easy to get these services. While this HHSC Dashboard indicator has no set standard for MCOs participating in the STAR Program, this was the highest rate of access among the different types of specialty care, and may be considered a good baseline for quality improvement.

Figure 11. Good Access to Specialized Services²⁹



The CAHPS[®] composite, *Getting Specialized Services* assesses how often it was easy for caregivers to get special medical equipment or devices, special therapies, and behavioral health treatment or counseling for their child. The mean score for *Getting Specialized Services* following NCQA specifications was 2.35 out of 3.00. Overall, 73 percent of caregivers “usually” or “always” had positive experiences with *Getting Specialized Services* for their child. This rate is comparable to the 75 percent reported for Medicaid plans nationally.

Prescription medicines

The CAHPS[®] composite *Prescription Medicines* consists of a single item assessing how often it was easy for parents to get prescription medicines for their child. In the six months prior to the survey, 43 percent of PCCM caregivers filled or refilled a prescription for their child. PCCM caregivers’ experiences with getting prescription medicine for their child were fairly similar to the nation as a whole. Eighty-seven percent of caregivers reported that it was either “usually” or “always” easy to get prescription medicines for their child through PCCM, compared to the national Medicaid mean of 89 percent.

Medicaid PCCM program satisfaction

This section describes caregivers’ experiences and satisfaction with various aspects of PCCM program administration, including approval for care, tests, or treatment, and the provision of information.

The CAHPS[®] composite *Getting Needed Care* is based on two survey items that assess: (1) how often it was easy for parents to get appointments for their child with specialists, and (2) how often it was easy for parents to get care, tests, and treatment for their child through their child’s health plan. Based on these two items, 79 percent of caregivers “usually” or “always” had positive experiences with *Getting Needed Care* for their child. This rate is comparable to the 77 percent reported for Medicaid plans nationally. The mean score for *Getting Needed Care* following NCQA specifications was 2.41 out of 3.00.

- *No delays for approval.* Among caregivers who tried to get care, tests, or treatment for their child through the PCCM program, 58 percent reported “never” having problems with delays in getting approval for their child’s health care. This percentage is slightly lower

than the HHSC Dashboard standard of 65 percent to which MCOs participating in the STAR Program are held.

Few caregivers reported looking for information in written materials or on the Internet about how the PCCM Program works (13 percent). Among these caregivers, 75 percent said these written materials “usually” or “always” provided them the information they needed.

Overall, on a scale of 0 to 10, caregivers of children in PCCM rated the PCCM Program a mean of 9.18. Seventy-seven percent of caregivers gave the PCCM Program a rating of 9 or 10, which is higher than the 63 percent reported for Medicaid plans nationally.³⁰

Patient-Centered Care

This section provides results regarding caregivers’ evaluation of the quality of communication with their child’s doctor, doctor’s office staff, and customer service, and whether those interactions were mostly informative, positive, and respectful. Good patient-centered care also includes an acceptable and consistent level of shared decision-making between providers and parents regarding treatment decisions for children.

Seeking help/advice from doctors

Four CAHPS® survey items ask caregivers about phoning their child’s personal doctor both *during* and *after* regular office hours to get help or advice for their child, and the extent to which they were able to get the help or advice they needed.

- Thirty-nine percent of caregivers telephoned their child’s personal doctor *during* regular office hours to seek help or advice for their child. Among these caregivers, the vast majority (89 percent) said they “usually” or “always” got the help or advice they needed regarding their child’s care.
- Fifteen percent of caregivers telephoned their child’s personal doctor *after* regular office hours to seek help or advice for their child. Among these caregivers, 73 percent reported that they “usually” or “always” got the help or advice they needed for their child.

The CAHPS® composite *Getting Needed Information* assesses how often caregivers had their questions answered by their child’s doctors or other health care providers. Ninety-four percent of caregivers stated that they “usually” or “always” had their questions answered by their child’s doctors or other health care providers. This percentage is slightly higher than the 89 percent reported for Medicaid plans nationally. The mean score for *Getting Needed Information* following NCQA specifications was 2.83 out of 3.00.

Doctors’ communication

Five CAHPS® survey questions comprise the composite *How Well Doctors Communicate*. This composite assesses how often a child’s personal doctor explains things well, listens carefully, shows respect, and spends enough time with the family. Combining responses to all five questions, 91 percent of caregivers “usually” or “always” had positive experiences with *How Well Doctors Communicate*. This percentage is comparable to the 91 percent reported for Medicaid plans nationally. The mean score for *How Well Doctors Communicate* following NCQA specifications was 2.73 out of 3.00.

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

Table 2. Health Literacy Promotion by Personal Doctors

The child’s personal doctor...	Percent of caregivers who answered “usually” or “always”
Used pictures, drawings, or models to explain things	15%
Showed interest in the caregiver’s questions and concerns	96%
Seemed to “really care” about the caregiver and the caregiver’s child	94%
Gave the caregiver easy-to-understand instructions about how the caregiver’s child should take his/her medication	92%
Explained the possible side effects of the child’s medicines in a way that was easy to understand	96%
Gave the caregiver written information that was easy to understand	93%
Suggested ways to help the caregiver and child remember to take the child’s medicine	63%

Caregivers were also asked about their experiences with personal doctor practices that can adversely affect the doctor-patient relationship and the promotion of health literacy. These included “usually” or “always”:

- Using medical words the caregiver did not understand (12 percent)
- Interrupting caregivers while they were talking (1 percent)
- Using condescending, sarcastic, or rude tone or manner with the caregiver (2 percent)

Office staff and customer service

Two CAHPS® survey questions comprise the composite *Health Plan Information and Customer Service*, assessing how often customer service at the child’s health plan: (1) gave caregivers the information or help they needed; and (2) treated caregivers with courtesy and respect. Combining responses to both questions, 89 percent of caregivers “usually” or “always” had positive experiences with *Health Plan Information and Customer Service* administered through the PCCM Program. This percentage is higher than the 79 percent reported for Medicaid plans nationally. The mean score for *Health Plan Information and Customer Service* following NCQA specifications was 2.71 out of 3.00

Fifty-seven caregivers (14 percent) stated they tried to get information or help from customer service through the PCCM Program. Among these caregivers:

- Eighty-four percent said that PCCM Program customer service “usually” or “always” gave them the information or help they needed.
- Fifty-one percent were able to get the information or help they needed in a single call.
- Twenty-seven percent made two calls to get the information or help they needed.
- Eighteen percent made three or more calls to get the information or help they needed.
- Four percent were still waiting for information or help.

Shared decision-making

Over half of the caregivers (55 percent) said their child’s provider informed them there was more than one choice for their child’s treatment or health care. Among these caregivers:

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

Together, these CAHPS® survey items comprise the composite *Shared Decision-Making*, for which 93 percent of caregivers had positive experiences. However, the response sets used in NCQA specifications for this composite differ from those used in the CAHPS® Health Plan Survey 4.0 Medicaid version. Therefore, an NCQA mean score could not be calculated for the *Shared Decision-Making* composite for comparative purposes.

Caregivers of CSHCN were significantly more likely than caregivers of children without special health care needs to report their child’s provider asked them which choice they thought was best for their child (98 percent vs. 89 percent.)³¹

Preparing CSHCN for transition to adult care

Caregivers were asked a series of questions about how their child’s doctors and other health care providers were preparing him or her for the transition from pediatric to adult care. Issues surrounding the transition from adolescence to adulthood are especially salient for those with chronic conditions, who report lower utilization rates of recommended care and difficulty finding adult-oriented providers who can meet their health care needs.³²

These questions were only asked of caregivers if their child: (a) was 11 years of age or older; and (b) had at least one special health care need, as identified by the CSHCN Screener®. In the fiscal year 2011 survey sample, only 11 percent of respondents met both of these criteria.

Among these respondents:

- Sixty-four percent said their child’s doctors or other health care providers treated only children. Among those whose child’s doctors treated only children, 35 percent said their child’s doctors spoke with them about their child eventually seeing health care providers who treat adults.

- Fifty-two percent indicated that their child’s doctors or other health care providers had spoken with them or their child about their child’s health care needs as he/she becomes an adult.
- Eighty-two percent reported that their child’s doctors “usually” or “always” encouraged their child to take responsibility for his/her own health care needs, such as taking medication, understanding his/her health, or following medical advice.

Another potential challenge that accompanies one’s transitions into young adulthood involves the need to find insurance coverage. Retaining insurance coverage after reaching adulthood can be difficult. Title V public funding typically ends at age 21; eligibility for Supplemental Security Income becomes more stringent, resulting in the loss of Medicaid coverage, and Medicaid benefits may change even if eligibility is retained.³³ Less than one in four caregivers of adolescents with special health care needs (24 percent) reported that someone had spoken with them about how to obtain or keep some form of health insurance coverage as their child becomes an adult.

In many instances where doctors and/or healthcare providers failed to convey certain information to caregivers, caregivers often acknowledged that such information would have been beneficial to them and/or their children. These included:

- Forty-seven percent of caregivers who were not counseled about having their child see doctors or other health care providers who treat adults.
- Ninety-one percent of caregivers who were not counseled about their child’s health care needs as he/she becomes an adult.
- Eighty-six percent of caregivers who were not counseled about how to obtain or keep health insurance coverage as their child becomes an adult.

Care Coordination

One-third of caregivers (34 percent) stated their child received care from another doctor or provider who was not their child’s personal doctor. Among these caregivers:

- Seventy-four percent said their child’s personal doctor seemed informed and up-to-date about the care their child received through these other providers.
- Fifty-nine percent said that someone from the PCCM Program or their child’s doctor’s office or clinic helped them coordinate their child’s care among these other health providers.

Two CAHPS® survey questions comprise the composite *Care Coordination*, assessing whether caregivers received help: (1) from their child’s health plan (the PCCM Program), doctor’s office, or clinic in coordinating care among different providers and services; and (2) from doctors or providers in contacting their child’s school or daycare. Combining responses to both questions, 73 percent of caregivers had positive experiences with *Care Coordination*. This percentage is slightly lower than the 76 percent reported for Medicaid plans nationally. The NCQA mean for *Care Coordination* was 0.73 on a scale of 0 to 1.

Fourteen percent of caregivers reported receiving help from a case manager or care coordinator who was not from the PCCM Program or their child’s doctor’s office or clinic.

The vast majority of respondents (96 percent) stated they were “satisfied” or “very satisfied” with the care coordination their children received.

Summary and Recommendations

This report provides results from the fiscal year 2011 PCCM Child Member Survey regarding: (1) demographic and household characteristics of PCCM members and their caregivers; (2) the health status of PCCM members, including special health care needs and body mass index; and (3) caregiver experiences and satisfaction with the access and timeliness of their child's routine, urgent, and specialized care; elements of patient-centered care such as doctor's communication, customer service, and shared decision-making; transition of CSHCN to adult care; and care coordination. The following summary highlights areas of relevance for maintaining and improving the quality of care for PCCM members following the transition of PCCM to STAR and STAR+PLUS in the coming year.

Demographic and household characteristics

- **Caregiver characteristics.** Survey respondents were predominantly female and Hispanic, with an average age of 35 years old. Approximately one-third of respondents had less than a high school education. One-third of respondents were single or unmarried.
- **Member characteristics.** Approximately half of PCCM members were male, and half were female. The average age of members was 9 years old. Hispanic members represented the largest racial/ethnic group in PCCM (67 percent), followed by white, non-Hispanics (21 percent) and black, non-Hispanics (10 percent).

Child's health status

- **Physical and mental health.** Nearly half of caregivers reported that their child was in “excellent” health. Approximately one-third of children were obese. Three-quarters of caregivers rated their child's mental health as “excellent” or “very good.”
- **Special health care needs.** One-quarter of children in PCCM were identified as having at least one special health care need that persisted for more than one year. The most common special health care need was dependence on medications (18 percent), followed by above-routine need or use of services (10 percent) and need or use of behavioral health treatment or counseling (9 percent).

Access to and timeliness of care

- **Personal doctor / usual source of care.** Eighty-four percent of PCCM members had a personal doctor. Among these members, 85 percent had seen their personal doctor in the past six months. The percentage of caregivers who rated their child's personal doctor a 9 or 10 was greater than the national average (82 percent vs. 70 percent). The CAHPS® *Personal Doctor* composite result was comparable to the national average (87 percent vs. 88 percent). The majority of personal doctors discussed child development concerns with caregivers.
- **Preventive care.** Among caregivers of children less than three years old, 84 percent said they received reminders to bring their child in for check-ups or immunizations.

Nearly all caregivers whose child was seen for check-ups or immunizations said they got an appointment as soon as they needed it.

- **Urgent care.** Nearly one-third of caregivers said their child needed urgent care in the six months prior to the survey. *Good access to urgent care* was 89 percent, compared with the HHSC Dashboard standard of 86 percent for STAR. One-quarter of members visited the emergency room at least once, and nearly half of caregivers said their child had at least one emergency room visit because they could not get an appointment for routine care. However, among these caregivers, one-quarter said they would “never” take their child to the doctor’s office or clinic instead of the emergency room.
- **Routine care.** Nearly two-thirds of caregivers made appointments for routine care for their child during the six months prior to the survey. Rates were significantly lower among caregivers of Hispanic members (59 percent). *Good access to routine care* was 78 percent, compared with the HHSC Dashboard standard of 78 percent for STAR. Eighty percent of caregivers said their child went to the doctor’s office or clinic at least once. *No exam room wait greater than 15 minutes* was 26 percent, which is considerably lower than the HHSC Dashboard standard of 42 percent for STAR. One-third of caregivers who made an appointment for their child were seen within one day. The CAHPS® *Getting Care Quickly* composite result was 83 percent, compared with 86 percent nationally.
- **Specialist care.** Seventeen percent of caregivers tried to make a specialist appointment for their child. One-third said the specialist their child saw most often was also their child’s personal doctor. *Good access to specialist referral* was 77 percent, which is considerably higher than the HHSC Dashboard standard of 59 percent for STAR. The percentage of caregivers who rated their child’s specialist a 9 or 10 was 68 percent, compared to the national average of 66 percent.
- **Specialized services.** The most-needed specialized service in PCCM was treatment or counseling for an emotional, behavioral, or developmental problem (nine percent of members). *Good access to behavioral health treatment and counseling* was 77 percent, and was the highest performing access measure among the different types of specialized services. The CAHPS® *Getting Specialized Services* composite result was comparable to the national average (73 percent vs. 75 percent).
- **Prescription medicines.** Forty-three percent of caregivers reported having filled or refilled a prescription for their child during the six months prior to the survey. The CAHPS® *Prescription Medicines* composite result was comparable to the national average (87 percent vs. 89 percent).
- **PCCM program satisfaction.** The CAHPS® *Getting Needed Care* composite result was comparable to the national average (79 percent vs. 77 percent). The rate of *no delays for an approval* was 58 percent, which is slightly lower than the HHSC Dashboard standard of 65 percent for STAR. The percent of caregivers who rated the PCCM Program a 9 or 10 was 77 percent, compared with 63 percent for Medicaid plans nationally.

Patient-centered care

- **Seeking help or advice from personal doctors.** Caregivers of PCCM members reported good access to help or advice when calling their child’s personal doctor during

normal office hours (89 percent) and slightly lower access when calling after normal office hours (73 percent). The CAHPS® *Getting Needed Information* composite result was slightly higher than the national average (94 percent vs. 89 percent).

- **Doctors' communication.** The CAHPS® *How Well Doctors Communicate* composite result was comparable to the national average (both at 91 percent). Most personal doctors practiced good promotion of health literacy, although few caregivers reported their child's personal doctor used pictures, drawings, and models to explain things (15 percent).
- **Office staff and customer service.** The CAHPS® *Health Plan Information and Customer Service* composite result was 89 percent, which is higher than the national average of 79 percent. The majority of caregivers who called to get help or information from PCCM customer service "usually" or "always" got the help or information they needed (84 percent), with 51 percent getting the help or information they needed in one call.
- **Shared decision-making.** The CAHPS® *Shared Decision-Making* composite result was 93 percent. Although no national comparisons were available, this high percentage is an indication of good performance for shared decision-making in the PCCM Program. Caregivers of CSHCN were significantly more likely than caregivers of children without special health care needs to say that providers asked them which treatment choice they thought was best for their child (98 percent vs. 89 percent).
- **Preparing CSHCN for transition to adulthood.** Among parents of CSHCN 11 years of age or older, whose child saw doctors who treated only children, only 35 percent said their child's doctors had discussed their child's transition to adult care. Only one in four said their child's doctors had discussed how to obtain or keep health insurance coverage for their child after the transition. Among caregivers whose child's doctors had not discussed transition of health insurance coverage, 86 percent said this information would have been helpful.

Care coordination

- **Need for care coordination.** One-third of PCCM child members received care from a health provider besides their personal doctor. Among caregivers of these children, three-quarters said their child's personal doctor seemed informed and up-to-date about the care their child received from these other providers.
- **Getting care coordination.** Among caregivers whose child received care from a health provider besides their personal doctor, 58 percent said that someone from the PCCM program or their child's doctor's office or clinic helped them coordinate their child's care. The CAHPS® *Care Coordination* composite result was slightly lower than the national average (73 percent vs. 76 percent).

EQRO Recommendations

Effective September 1, 2011, PCCM members in 28 counties contiguous to existing STAR and STAR+PLUS service areas will transition to Medicaid managed care through the STAR and STAR+PLUS programs.³⁴ Furthermore, proposed HHSC initiatives for the coming year include the conversion of PCCM to STAR in the remaining Texas counties, effective March 2012.³⁵

Because the former PCCM Program population will be served through Medicaid managed care in the STAR and STAR+PLUS programs, recommendations based on the findings of this report focus on quality of care and caregiver satisfaction during this transition.

The EQRO recommends that STAR and STAR+PLUS MCOs moving into PCCM counties focus on areas where caregiver experiences and satisfaction were low for this population under the PCCM Program, and where the population’s demographic and health status require focused efforts.

Domain	Recommendations	Rationale	HHSC Reponse
Child obesity	<ul style="list-style-type: none"> • Develop or improve upon existing child obesity disease management (DM) programs, and prioritize their implementation in former PCCM counties. • Consider implementation of Performance Improvement Projects (PIPs) to evaluate the short- and long-term effects of health plan exercise and nutrition programs, using weight, BMI, and measures of body fat composition as outcomes. • Work with network providers in former PCCM counties to ensure they are following guidelines for child obesity screening and referrals to weight management programs.³⁶ 	<p>The rate of obesity among children and adolescents in PCCM was 31 percent, which is considerably higher than national and state averages.</p>	<p>MCOs must provide or arrange for the provision of disease management health home services for persons with chronic conditions such as being overweight, as evidenced by having a Body Mass Index (BMI) over 25.</p> <p>Two of the quality measures included in the 2012 HHSC Performance Dashboard are:</p> <ol style="list-style-type: none"> 3. Adult BMI Assessment in STAR+PLUS Program 4. Weight Assessment and Counseling for Nutrition & Physical Activity for Children/Adolescents in STAR. <p>HHSC has not established a standard for these indicators, so these reports will help establish the baselines for these measures.</p>
Emergency	<ul style="list-style-type: none"> • Prioritize 	Among caregivers whose	One of HHSC’s 2012

<p>room (ER) utilization</p>	<p>implementation of health plan systems for monitoring inappropriate ER use in former PCCM counties.</p> <ul style="list-style-type: none"> • Consider developing member education programs, using recent strategies found to be successful at reducing ER use in low-income populations: <ul style="list-style-type: none"> ○ Training caregivers in the use of a low-literacy health book to respond to common childhood illnesses.³⁷ ○ Distribution of a low-literacy health booklet on pediatric non-urgent care to caregivers who bring their child to an outpatient clinic.³⁸ 	<p>child visited the ER, half reported visiting the ER because they could not get a timely appointment for routine care.</p> <p>However, one-quarter said they would “never” have taken their child to a doctor’s office or clinic instead of the ER, even if they got a timely appointment.</p>	<p>overarching goals in STAR and CHIP is to improve treatment for ambulatory care sensitive conditions (ACSCs) through reduction of emergency department visits.</p> <p>Ambulatory care, both outpatient and emergency department, is included in the 2012 Quality Challenge Award measures.</p>
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Appendix A. Detailed Survey Methodology

Sample selection procedures

Survey participants were selected from a simple random sample of children, age 17 years and younger, who were enrolled in PCCM in Texas for at least six continuous months between September 2010 and February 2011. Following CAHPS[®] sampling specifications, members with a gap of no more than 30 days during this period were also eligible. These criteria ensured that families would have sufficient experience with the program to respond to the survey questions. Members whose caregivers had participated in the prior year's survey (fiscal year 2009) were excluded from the sample.

A target sample of 400 completed telephone interviews was set. Using a 95 percent confidence interval, the responses provided in the tables and figures are within ± 4.9 percentage points of the "true" responses in the PCCM caregiver population.

Enrollment data were provided to ICHP from a third party administrator for PCCM in Texas. These 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 1,385 eligible PCCM members were collected and provided to interviewers. For households with multiple children enrolled in PCCM, one child from the household was randomly chosen as the member for whom the caregiver would respond to the survey.

Survey instruments

The fiscal year 2011 PCCM Child Member Survey is comprised of:

- The Consumer Assessment of Healthcare Providers and Systems (CAHPS[®]) Health Plan Survey 4.0 (Medicaid care and supplemental modules)³⁹
- The Children With Special Health Care Needs (CSHCN) Screener^{® 40}
- Items from the National Survey of CSHCN (NS-CSHCN), addressing transition to adult care for CSHCN⁴¹
- Items developed by ICHP addressing caregiver and member demographic and household characteristics

The CAHPS[®] Health Plan Survey is a widely used instrument for measuring and reporting consumer experiences with their or their child's health plan and providers. The PCCM Child 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*

CAHPS® composite measures were scored using two methods, following NCQA specifications: (1) Calculation of global proportions, which typically represent the percentage of a sample who reported “usually” or “always” having positive experiences in a particular domain; and (2) Calculation of 3-point means, which are scaled and permit statistical comparisons of groups within a sample. The EQRO has discontinued the use of the 100-point scoring system used in survey reports of prior years. However, for purposes of prior-year comparison, the 100-point equivalents are presented alongside the new scores in **Table B2** in **Appendix B**.

Composite scores were calculated following NCQA specifications for all domains except *Shared Decision-Making*. One item in the specifications for *Shared Decision-Making*, which assesses whether the child’s doctor or provider told the caregiver there was more than one choice for their child’s treatment, was dropped from composite calculations for this survey. In many health care decisions, there may only be one choice for treatment. In these situations, neglecting to tell caregivers of other choices does not reflect poor shared decision-making on the part of providers. Furthermore, the response sets specified for these questions in the CAHPS® Health Plan Survey differ from those specified for composite calculation by the NCQA.

Most CAHPS® composite measures have national data available for comparison, which are submitted to the NCQA by State Medicaid agencies and individual health plans.⁴² In 2010, a total of 15 states submitted data for benchmarking. This report includes national comparisons for CAHPS® composite global proportions (when available), as well as national comparisons for caregiver ratings of their child’s personal doctor, specialist, health care, and health plan.

The CAHPS® Health Plan Survey also includes questions that function as indicators of health plan performance, as listed on the HHSC Performance Indicator Dashboard for fiscal year 2010.⁴³ While the HHSC Dashboard indicators were not developed for quality improvement in the PCCM Program, they are relevant for this year’s PCCM Child Member Survey because of the upcoming transition of PCCM members to STAR and STAR+PLUS. Texas Medicaid MCOs moving into former PCCM areas in the coming year will be held to HHSC Dashboard standards for this population. Therefore, this report will set a baseline for tracking survey-based HHSC Dashboard indicators in former PCCM areas.

The survey-based HHSC Dashboard indicators for child members include:⁴⁴

- *Good access to urgent care*
- *Good access to specialist referral*
- *Good access to routine care*
- *No delays for an approval*
- *No exam room wait greater than 15 minutes*
- *Good access to behavioral health treatment or counseling*

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 parents about five particular health consequences their child may experience:

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

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

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

The survey also includes questions regarding the demographic and household characteristics of caregivers and their children. These questions were developed by ICHP and have been used in surveys with more than 25,000 Medicaid and CHIP members in Texas and Florida. The items were adapted from questions used in the National Health Interview Survey, the Current Population Survey and the National Survey of America's Families.^{45, 46, 47}

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

Survey data collection

The EQRO sent letters written in English and Spanish to caregivers of 1,385 randomly sampled PCCM members, requesting their participation in the survey. Of the advance letters sent, one was returned undeliverable.

The Survey Research Center (SRC) at the University of Florida conducted the survey using computer-assisted telephone interviewing (CATI) between May and July 2011. The SRC telephoned caregivers of PCCM members seven days a week between 10 a.m. and 9 p.m. Central Time. The Sawtooth Software System was used to rotate calls in the morning, afternoon, and evening to maximize the likelihood of reaching potential survey respondents. Up to 30 attempts were made to reach a family, and if the family was not reached after that time, the software selected the next individual on the list. No financial incentives were offered to participate in the surveys. On average, 8.2 calls per phone number were made in the PCCM child member sample.

Thirty-seven percent of families could not be located. Among those located, 11 percent were not eligible to complete the survey, six percent indicated that their child was not enrolled in PCCM, and 12 percent refused to participate. The response rate was 58 percent and the cooperation rate was 79 percent.

The respondent was selected by asking to speak to the person in the household who was most knowledgeable about the child's health and health care. The respondent was also asked to confirm that the child was presently enrolled in PCCM in Texas. If a respondent was unable to complete the interview in English, SRC rescheduled the interview at a later date and time with a Spanish-speaking interviewer. Of 400 completed interviews, 39 (10 percent) were conducted in Spanish.

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

Data analysis

Descriptive statistics and statistical tests were performed using the statistical software package SAS 9.1 (Cary, NC: SAS Institute, Inc). Frequency tables showing descriptive results for each survey question are provided in a separate Technical Appendix.⁷⁴ The statistics presented in this report exclude "do not know" and "refused" responses. Percentages shown in figures and tables are rounded to the nearest whole number; therefore, percentages may not add up to 100 percent.

Analysis of differences in frequencies used the Pearson Chi-square test of independence and Fisher's exact test, and analysis of differences in means used t-tests, analysis of variance (ANOVA), and Pearson's correlation. These tests allowed comparison of frequencies and means between 2009 and 2011 results (none of which were significant), and among demographic sub-groups within the survey sample.

Body mass index (BMI) was calculated by dividing the child's weight in kilograms by their height in meters squared. BMI could be calculated for 241 children in the sample (60 percent) for whom height and weight data were complete.

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:⁴⁸

- Underweight (less than 5th percentile)
- Healthy (5th percentile to less than 85th percentile)
- Overweight (85th to less than 95th percentile)
- Obese (> 95th percentile)

These standardized BMI categories for children may be used for comparison with national and state averages. Analyses of child BMI excluded children younger than two years old, for whom data are not provided on NCHS BMI-for-age growth charts. Also excluded were 40 children whose BMI deviated considerably from age- and sex-specific child growth standards provided by the World Health Organization.^{49, 50} 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.

Appendix B. Supplementary Tables and Figures

Table B1. Survey Items Comprising the CAHPS® Composites

Getting Needed Care

- 1) How often was it easy to get appointments for your child with specialists?
- 2) How often was it easy to get the care, tests, or treatment you thought your child needed through his or her health plan?

Getting Care Quickly

- 1) When your child needed care right away for an illness, injury or condition, how often did you get care as soon as you needed?
- 2) Not counting the times your child needed care right away, how often did you get an appointment for health care as soon as you thought your child needed?

How Well Doctors Communicate

- 1) How often did your child's personal doctor explain things in a way that was easy to understand?
- 2) How often did your child's personal doctor listen carefully to you?
- 3) How often did your child's personal doctor show respect for you?
- 4) How often did your child's personal doctor explain things in a way that was easy for your child to understand?
- 5) How often did your child's personal doctor spend enough time with you?

Health Plan Information and Customer Service

- 1) How often did customer service at your child's health plan give you the information or help you needed?
- 2) How often did customer service staff at your child's health plan treat you with courtesy and respect?

Parents' Experience with Child's Personal Doctor

- 1) Did your child's personal doctor talk to you about how your child is feeling, growing, or behaving?
- 2) Does your child's personal doctor understand how these medical, behavioral, or other health conditions affect your child's day-to-day life?
- 3) Does your child's personal doctor understand how your child's medical, behavioral, or other health conditions affect your family's day-to-day life?

Parents' Experience with Shared Decision Making

- 1) Did your child's doctor or other health provider talk with you about the pros and cons of each choice for your child's treatment or health care?
- 2) When there was more than one choice for your child's treatment or health care, did your child's doctor or other health provider ask you which choice was best for your child?

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

- 1) How often did you have your questions answered by your child's doctors or other health care providers?

Parents' Experience with Coordination of Their Child's Care

- 1) Did anyone from your child's health plan, doctor's office, or clinic help coordinate your child's care among these different providers or services?
- 2) Did you get the help you needed from your child's doctors or other health providers in contacting your child's school or daycare?

Parents' Experience Getting Specialized Services for Their Child

- 1) How often was it easy to get special medical equipment or devices for your child?
- 2) How often was it easy to get special therapy for your child?
- 3) How often was it easy to get behavioral health treatment or counseling for your child?

Parents' Experience with Prescription Medicine

- 1) How often was it easy to get prescription medicines for your child through his or her health plan?

Table B2. Comparison of CAHPS® Composite Scoring Methods

CAHPS® Composite	Global proportion ^a	3-point mean ^b	100-point mean ^c
<i>Getting Needed Care</i>	79%	2.41	78.5
<i>Getting Care Quickly</i>	83%	2.57	81.0
<i>How Well Doctors Communicate</i>	91%	2.73	90.4
<i>Health Plan Information and Customer Service</i>	89%	2.71	89.5
<i>Personal Doctor</i>	87%	N/A ^d	87.3
<i>Prescription Medicines</i>	87%	2.65	87.5
<i>Getting Specialized Services</i>	73%	2.35	73.9
<i>Shared Decision-Making</i>	93%	N/A ^e	92.9
<i>Getting Needed Information</i>	94%	2.83	93.8
<i>Care Coordination</i>	73%	N/A ^d	67.2

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

^b Mean ranging from 0 to 3, following NCQA specifications.

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

^d NCQA specifications use a 0 to 1 scale for scoring *Personal Doctor* (PCCM mean = 0.87) and *Care Coordination* (PCCM mean = 0.73).

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

Table B3. Core CAHPS® Composite Scores by Child Demographics

Child Member Characteristics	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Health Plan Information and Customer Service
Gender				
Female	2.42	2.46	2.75	LD
Male	2.38	2.52	2.74	LD
Race/Ethnicity				
Hispanic	2.43	2.42 ^a	2.73	2.79
White, non-Hispanic	LD	2.75 ^a	2.79	LD
Black, non-Hispanic	LD	LD	LD	LD
Health Status				
CSHCN	2.62 ^a	2.54	2.79	LD
Non-CSHCN	2.26 ^a	2.45	2.72	2.71

Note: For statistical comparisons across sub-groups, composite scores were calculated using NCQA scoring methods at the member level. However, NCQA specifications require scores to be calculated in the aggregate. Therefore, some slight differences are to be expected between the scores presented here and those presented in Table B2.

Note: LD refers to “low denominator”. Results are not shown because the number of members in the denominator of these calculations was less than 30.

^a Differences in means were significant at $p < 0.05$.

Table B4. CAHPS® Composites for Chronic Conditions by Child Demographics

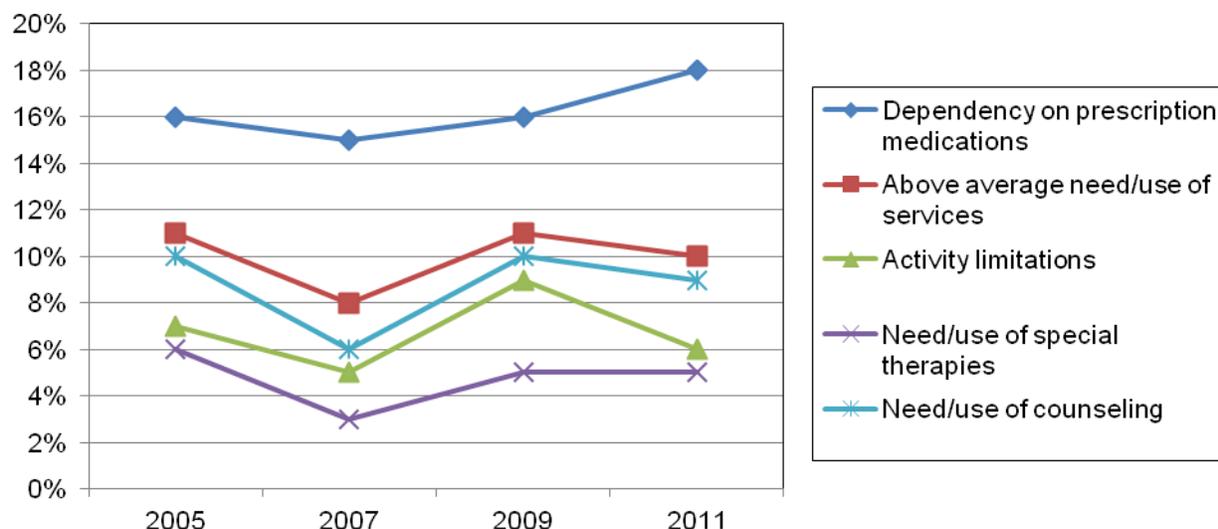
Child Member Characteristics	Personal Doctor	Prescription Medicines	Getting Specialized Services	Shared Decision-Making	Getting Needed Information	Care Coordination
Gender						
Female	0.89	2.54 ^a	2.20	0.93	2.86	0.63
Male	0.87	2.76 ^a	2.40	0.93	2.80	0.70
Race/Ethnicity						
Hispanic	0.87	2.57	2.23	0.93	2.85	0.70
White, non-Hispanic	0.88	2.78	LD	0.96	2.85	LD
Black, non-Hispanic	LD	LD	LD	LD	LD	LD
Health Status						
CSHCN	0.91	2.72	2.13	0.98 ^a	2.79	0.73
Non-CSHCN	0.86	2.59	2.44	0.90 ^a	2.84	0.62

Note: For statistical comparisons across sub-groups, composite scores were calculated using NCQA scoring methods at the member level. However, NCQA specifications require scores to be calculated in the aggregate. Therefore, some slight differences are to be expected between the scores presented here and those presented in Table B2.

Note: LD refers to “low denominator”. Results are not shown because the number of members in the denominator of these calculations was less than 30.

^a Differences in means were significant at $p < 0.05$.

Figure B1. Prevalence of Special Health Care Needs: 2005-2011 Trend



Endnotes

¹ Texas HHSC (Health and Human Services Commission). 2011. *Texas Healthcare Transformation and Quality Improvement Program, Medicaid Waiver 1115*. Austin, TX: HHSC.

² U.S. Preventive Services Task Force (USPSTF). 2010. "Screening for Obesity in Children and Adolescents: U.S. Preventive Service Task Force Recommendation Statement." *Pediatrics* 125(2): 361-367.

³ Herman, A. and P. Jackson. 2010. "Empowering Low-Income Parents with Skills to Reduce Excess Pediatric Emergency Room and Clinic Visits through a Tailored Low Literacy Training Intervention." *Journal of Health Communication* 15: 895-910.

⁴ Yoffe, S.J., R.W. Moore, J.O. Gibson, N.M. Dadfar, R.L. McKay, D.A. McClellan, T. Huang. 2011. "A Reduction in Emergency Department Use by Children From a Parent Educational Intervention." *Family Medicine* 43(2): 106-111.

⁵ Halfon, N., M. Inkelas, R. Mistry, and L.M. Olson. 2004. "Satisfaction With Health Care for Young Children." *Pediatrics* 113: 1965-1972.

⁶ Mangione-Smith, R., and E.A. McGlynn. 1998. "Assessing the Quality of Healthcare Provided to Children." *Health Services Research* 33(suppl.): 1059-1090.

⁷ Darby, C. 2002. "Patient/Parent Assessment of the Quality of Care." *Ambulatory Pediatrics* 2(suppl.): 345-348.

⁸ Texas HHSC. 2011.

⁹ Consumer Assessment of Healthcare Providers and Systems (CAHPS®). 2011. "CAHPS® Health Plan Survey 4.0, Child Medicaid Questionnaire." Available at <http://www.cahps.ahrq.gov/cahpskit/>.

¹⁰ The Child and Adolescent Health Measurement Initiative (CAHMI). 2008. "Children with Special Health Care Needs (CSHCN) Screener." Available at <http://cahmi.org>.

¹¹ National Survey of Children with Special Health Care Needs (NS-CSHCN). 2009/2010. Available at: <http://cshcndata.org>.

¹² For the EQRO's PCCM surveys, questions pertaining to the member's "health plan" are interpreted as pertaining to the PCCM Program overall.

¹³ NCQA specifications for scoring *Personal Doctor* and *Care Coordination* generate scores ranging from 0 to 1. The calculation of an NCQA mean for *Shared Decision-Making* was not possible because response sets used in NCQA specifications differ from those used in the CAHPS Health Plan Survey 4.0 Medicaid version.

¹⁴ Texas HHSC. 2010. *HHSC Uniform Managed Care Manual – Performance Indicator Dashboard for Administrative and Financial Measures*. Available at: http://www.hhsc.state.tx.us/Medicaid/UMCM/Chp10/10_1_1.pdf.

¹⁵ The HHSC Dashboard indicators *No Delays for an Approval* and *No Exam Room Wait Greater than 15 Minutes* were part of the CAHPS[®] Health Plan Survey Version 3.0 and are no longer assessed in Version 4.0. The EQRO continues to assess these indicators using modified wording of the CAHPS[®] 3.0 questions.

¹⁶ Agency for Healthcare Research and Quality (AHRQ). 2010. “The National CAHPS[®] Benchmarking Database.” Available at: https://www.cahps.ahrq.gov/content/ncbd/ncbd_intro.asp?p=105&s=5.

¹⁷ In statistical significance testing, the “p value” refers to the probability that the differences observed could have occurred by chance alone. For example, if a tested difference is found to have a p value of 0.03 (which is less than 0.05, and therefore statistically significant by the standards of this report), this means that there is only a 3 percent probability that the observed difference could have occurred by chance.

¹⁸ ICHP. 2011. *The Texas PCCM Child Member Survey Report: Technical Appendix*.

¹⁹ U.S. Census Bureau. 2007. “Texas: S1501. Education Attainment. Data Set: 2005-2007 American Community Survey 3-Year Estimates. Survey: American Community Survey.” Available at: <http://factfinder.census.gov/>.

²⁰ U.S. Census Bureau. 2010. “State and County QuickFacts.” Available at: <http://quickfacts.census.gov/qfd/states/48000.html>.

²¹ Hunt, K.A., A. Gaba, and R. Lavizzo-Mourey. 2005. “Racial and Ethnic Disparities and Perceptions of Health Care: Does Health Plan Type Matter?” *HSR: Health Services Research* 40(2): 551-576.

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²⁴ Hoelscher D.M., R. S. Day, E. S. Lee, R. F. Frankowski, S. H. Kelder, J. L. Ward, and M. E. Scheurer. 2004. “Measuring the Prevalence of Overweight in Texas Schoolchildren.” *American Journal of Public Health* 94(6): 1002-1008.

²⁵ Chi-square = 5.13, p = 0.02

²⁶ Balluz, L.S., C.A. Okoro, and T.W. Strine. 2004. “Access to Healthcare and Preventive Services Among Hispanics and Non-Hispanics – United States, 2001-2002.” *Morbidity and Mortality Weekly Report* 53(40): 937-941.

²⁷ T-test = -2.526, p = 0.008

²⁸ Chi-square = 4.48, p = 0.034

²⁹ Home health care assistance is omitted from this figure because it only had two valid cases.

³⁰ It should be noted that this question was originally intended for rating health plans / managed care organizations. For this report, it is being applied for rating the PCCM Program.

³¹ Chi-square = 3.96, p = 0.047

³² Lotstein, D.S., M. Inkelas, R.D. Hays, N. Halfon, and R. Brook. 2008. “Access to Care for Youth with Special Health Care Needs in the Transition to Adulthood.” *Journal of Adolescent Health* 43: 23-29.

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- ³³ Reiss, J.G., R.W. Gibson, and L.R. Walker. 2005. "Health Care Transition: Youth, Family, and Provider Perspectives." *Pediatrics* 115(1): 112-120.
- ³⁴ Texas HHSC, 2011.
- ³⁵ Texas HHSC, 2011.
- ³⁶ USPSTF. 2010.
- ³⁷ Herman, A. and P. Jackson. 2010.
- ³⁸ Yoffee, S.J., et al. 2011.
- ³⁹ CAHPS[®]. 2011.
- ⁴⁰ CAHMI. 2011.
- ⁴¹ NS-CSHCN. 2009/2010.
- ⁴² AHRQ. 2010.
- ⁴³ Texas HHSC. 2010.
- ⁴⁴ The HHSC Dashboard indicators *No Delays for an Approval* and *No Exam Room Wait Greater than 15 Minutes* were part of the CAHPS Health Plan Survey Version 3.0 and are no longer assessed in Version 4.0. The EQRO continues to assess these indicators using modified wording of the CAHPS 3.0 questions.
- ⁴⁵ National Center for Health Statistics. 2008. *National Health Interview Survey*. Available at <http://www.cdc.gov/nchs/nhis.htm>.
- ⁴⁶ U.S. Census Bureau. 2008. *Current Population Survey*. Available at <http://www.census.gov/cps>.
- ⁴⁷ Urban Institute. 2008. *National Survey of America's Families*. Available at <http://www.urban.org/center/anf/nsaf.cfm>.
- ⁴⁸ National Center for Health Statistics (NCHS). 2000. "Clinical Growth Charts: BMI-for-Age." Available at <http://www.cdc.gov/growthcharts/>.
- ⁴⁹ World Health Organization. 2008. "WHO Child Growth Standards." Available at <http://www.who.int/childgrowth/software/en/>.
- ⁵⁰ World Health Organization. 2008. "Growth Reference Data for 5 – 19 Years." Available at <http://www.who.int/growthref/en>.