



Texas Medicaid Managed Care: STAR Child and STAR+PLUS Adult Behavioral Health Survey Report

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The Institute for Child Health Policy

University of Florida

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

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Executive Summary

Introduction

Ensuring a high quality of behavioral health care in Medicaid managed care is an important priority for state Medicaid programs.^{1,2} In the Texas STAR program, members receive behavioral health services depending on their managed care organization and service area. In most service areas, behavioral health services are either part of a managed care organization's integrated benefits package or delivered through a sub-contracted behavioral health organization. In the Dallas service area, STAR and STAR+PLUS members receive behavioral health care through the NorthSTAR program, which contracts with ValueOptions, a behavioral health organization.

In 2009, the Texas Legislative Budget Board (LBB) recommended improving the transparency and accountability of behavioral health services in Texas Medicaid and the Children's Health Insurance Program (CHIP).³ Specifically, the LBB called for an assessment of member satisfaction and experience with the behavioral health services delivered through the Texas Medicaid managed care organizations, behavioral health organizations, and NorthSTAR. Patients' rating of satisfaction with health care is an indicator of quality of care, and has been associated with positive health-related behaviors, such as compliance with treatment.^{4, 5}

In fiscal year 2013, as part of the external quality review activities for the State of Texas, the Institute for Child Health Policy (IHP) conducted a set of behavioral health member surveys, including surveys with: (a) parents and caregivers of children enrolled in STAR who were diagnosed with a behavioral health condition in the past 12 months; and (b) adult STAR+PLUS members who had been diagnosed with a behavioral health condition in the past 12 months. The purpose of these surveys is to:

- Describe the demographic and household characteristics, health status, and overall well-being of: (a) child members in STAR with behavioral health conditions; and (b) adult members in STAR+PLUS with behavioral health conditions.
- Describe caregiver and adult member experience and satisfaction with behavioral health services across five domains of care: (1) utilization of behavioral health counseling and treatment; (2) access to and timeliness of behavioral health care; (3) managed care organization or behavioral health organization benefits, information, and assistance; (4) experiences with clinicians and the managed care organization; and (5) perceived outcomes of counseling and treatment.

Methodology

The Institute for Child Health Policy contracted with the National Opinion Research Center at the University of Chicago to conduct the surveys using computer-assisted telephone interviewing between May 2013 and August 2013.

For the STAR Child Survey, participants were selected from a stratified random sample of children continuously enrolled in the same STAR managed care organization between April 2012 and March 2013 (with one allowable one-month enrollment gap during the 12-month

period). The sample included only caregivers of children younger than 18 years of age, with a record of one or more behavioral health or chemical dependency diagnosis (ICD-9-CM code) and procedural (CPT code) combinations during the enrollment period (see **Table A1** in Appendix A). The sample was stratified by age and program into four quota groups: (1) STAR children: ≤ 12 years old; (2) STAR adolescents: 13 to 17 years old; (3) NorthSTAR children: ≤ 12 years old; and (4) NorthSTAR adolescents: 13 to 17 years old. The external quality review organization set a target sample of 1,200 completed telephone interviews with caregivers, representing 300 respondents for each of the quotas. The response rate for this survey was 59 percent and the cooperation rate was 88 percent.

For the STAR+PLUS survey, participants were selected from a stratified random sample of adults in STAR+PLUS who were continuously enrolled in the same STAR+PLUS managed care organization between April 2012 and March 2013 (with one allowable one-month enrollment gap during the 12-month period). The sample included only members 18 years of age and older with a record of one or more behavioral health or chemical dependency diagnosis (ICD-9-CM code) and procedural (CPT code) combinations during the enrollment period (see **Table A1** in Appendix A). The sample was stratified into eight quota groups according to the member's managed care organization, with separate quotas for dual-eligible members (statewide) and NorthSTAR members (by managed care organization). The external quality review organization set a target sample of 2,400 completed telephone interviews with members, representing 300 respondents for each of the quotas. The response rate for this survey was 63 percent and the cooperation rate was 79 percent.

The fiscal year 2013 STAR Child and STAR+PLUS Behavioral Health Surveys included:

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

To test for participation bias, the distributions of members' age, sex, and race/ethnicity were collected from the enrollment data and compared between members who responded to the survey and members who did not participate. In general, among members who could be contacted by the National Opinion Research Center, the participation rate was highest among members who identified as Hispanic, followed by members identifying as non-Hispanic white, non-Hispanic other, and non-Hispanic black. To facilitate inferences from the survey results to the STAR and STAR+PLUS member behavioral health populations, results were weighted to the full set of eligible beneficiaries in the enrollment dataset. A separate weight was calculated for each of the sampling groups by multiplying frequencies by the inverse probability of inclusion in the final sample (the total number of eligible members in the enrollment file divided by the number of members in the final sample).⁶ **Table A2** provides the weights for each survey quota for the STAR Child Survey. **Table A3** provides the weights for each survey quota for the STAR+PLUS Survey. The frequencies and means presented in this report and the technical appendix that accompanies this report incorporate survey weights.

Summary of Findings

Characteristics of Members Sampled for the Surveys

<u>Children in STAR</u>		<u>Adults in STAR+PLUS</u>	
Mean age	11 years	Mean age	51 years
Gender		Gender	
	% members		% members
Female	40%	Female	71%
Male	60%	Male	29%
Race/ethnicity		Race/ethnicity	
	% members		% members
Black	11%	Black	26%
Hispanic	64%	Hispanic	32%
White	21%	White	37%
Other	4%	Other	5%
Overweight or Obese		Obese	
	% members		% members
Boys	45%	Men	44%
Girls	53%	Women	60%
Top 3 Primary Behavioral Health Diagnosis Groups (% members)		Top 3 Primary Behavioral Health Diagnosis Groups (% members)	
Disruptive behavior disorders	44%	Mood disorders	56%
Adjustment disorders	19%	Psychotic disorders	21%
Mood disorders	19%	Substance-related	10%
Behavioral Health Service Utilization (past 12 months)		Behavioral Health Service Utilization (past 12 months)	
Home, office, or clinic	70%	Home, office, or clinic	84%
Prescription medicine	65%	Prescription medicine	86%
Emergency room/crisis center	17%	Emergency room/crisis center	37%
Telephone counseling	11%	Telephone counseling	12%

2013 STAR Child Behavioral Health Survey

Positive Findings

- *Access to and Timeliness of Behavioral Health Care.* The majority of caregivers (74 percent) reported that they were able to “usually” or “always” obtain a routine appointment as soon as they wanted, and 70 percent reported that they were able to get immediate counseling or treatment for their child as soon as they wanted. A majority of members (59 percent) indicated that their child was “usually” or “always” seen within 15 minutes of their scheduled appointment.
- *Experiences with Clinicians and Managed Care Organizations.* In the past 12 months, the majority of caregivers reported positive experiences with their child's clinician. Caregivers reported that clinicians completely discussed goals of their child's counseling or treatment (87 percent) and 84 percent of caregivers were informed about medication side effects.
- *Perceived Outcomes of Behavioral Health Counseling and Treatment.* More than three-quarters of caregivers reported some level of improvement in their child's symptoms compared to 12 months ago (78 percent).

Improvement Areas

- *Behavioral Health Treatment Benefits and Assistance.* About one-third of caregivers reported their child had used up all of his or her benefits for counseling or treatment (36 percent). Within this group, 47 percent said their child still needed counseling or treatment at the time benefits were used up. Among those who still needed counseling or treatment, only 43 percent of caregivers were told about other ways to get counseling, treatment, or medicine for their child. Caregivers had the most trouble with: receiving help from managed care organization or behavioral health organization customer service, experiencing delays in their child's counseling or treatment while waiting for approval from their managed care organization or behavioral health organization, finding a clinician with whom they were satisfied, and obtaining information about counseling or treatment from their child's managed care organization or on the Internet.
- *Perceived Outcomes of Behavioral Health Counseling and Treatment.* A little over half of caregivers (56 percent) believed their child had been helped a lot by the counseling or treatment he or she received in the past 12 months.

2013 STAR+PLUS Adult Behavioral Health Survey

Positive Findings

- *Access to and Timeliness of Behavioral Health Care.* The majority of members (75 percent) reported that they “usually” or “always” were able to obtain a routine appointment as soon as they wanted, and 65 percent reported that they were able to get immediate counseling or treatment as soon as they wanted. Fifty-one percent of members indicated they were “usually” or “always” seen within 15 minutes of their scheduled appointment.

- *Experiences with Clinicians and Managed Care Organizations.* The majority of members were satisfied with their provider’s communication skills and ability to make them feel comfortable and safe during the clinical encounter.

Improvement Areas

- *Access to and Timeliness of Behavioral Health Care.* Forty percent of members were able to obtain phone counseling or treatment when needed.
- *Behavioral Health Treatment Benefits and Assistance.* Nineteen percent of members said they had used up all of their benefits for counseling or treatment. Within this group, 70 percent said they still needed counseling or treatment at the time benefits were used up. Among those who still needed counseling or treatment, 42 percent of members were told about other ways to get counseling, treatment, or medicine. STAR+PLUS members had the most trouble with: finding a clinician with whom they were satisfied, waiting for approval from their managed care organization or behavioral health organization, and obtaining information about counseling or treatment from their managed care organization or on the Internet.
- *Experiences with Clinicians and Managed Care Organizations.* Among members who had to seek a new clinician after joining their managed care organization, about 3 in 10 members (33 percent) expressed some level of dissatisfaction with their clinician.
- *Perceived Outcomes of Behavioral Health Counseling and Treatment.* Less than two-thirds of members felt they had benefited “a lot” from the behavioral health counseling or treatment they received in the past 12 months (61 percent). Compared to members in the survey without substance-related disorders, a significantly lower percentage of members with substance-related disorders reported they had benefited “a lot” from counseling and treatment (62 percent vs. 52 percent).

ECHO Composites

The ECHO Composite measures include *Getting Treatment Quickly, How Well Clinicians Communicate, Getting Treatment and Information from the Plan or Behavioral Health Organization, Information About Treatment Options, and Perceived Improvement.* The ECHO survey also contains a number of items allowing respondents to rate their care based on a scale of zero to ten, zero being the lowest possible rating and ten being the highest. Results for the composites are presented in **Tables 1 and 2**, below.

Global Ratings

The two global rating items include respondents’ overall rating of counseling or treatment, as well as the respondents’ overall rating of the managed care organization. Results are presented in **Tables 3 and 4**, below.

Table 1. STAR Child ECHO® Composites

Composite	Mean (SD)	Range
<i>Getting Treatment Quickly</i>	2.18 (SD = 0.74)	1.00 – 3.00
<i>How Well Clinicians Communicate</i>	2.48 (SD = 0.65)	1.00 – 3.00
<i>Getting Treatment and Information from the Plan</i>	2.60 (SD = 0.53)	1.00 – 3.00
<i>Getting Treatment and Information from the Behavioral Health Organization</i>	2.43 (SD = 0.70)	1.00 – 3.00
<i>Information About Treatment Options</i>	0.67 (SD = 0.47)	0.00 – 1.00
<i>Perceived Improvement</i>	3.22 (SD = 0.75)	1.00 – 4.00

Table 2. STAR+PLUS Adult ECHO® Composites

Composite	Mean (SD)	Range
<i>Getting Treatment Quickly</i>	2.14 (SD = 0.78)	1.00 – 3.00
<i>How Well Clinicians Communicate</i>	2.39 (SD = 0.64)	1.00 – 3.00
<i>Getting Treatment and Information from the Plan</i>	2.33 (SD = 0.70)	1.00 – 3.00
<i>Getting Treatment and Information from the Behavioral Health Organization</i>	2.28 (SD = 0.76)	1.00 – 3.00
<i>Information About Treatment Options</i>	0.51 (SD = 0.44)	0.00 – 1.00
<i>Perceived Improvement</i>	2.66 (SD = 0.84)	1.00 – 4.00

Table 3. STAR Child Global Ratings

Global Ratings	Mean (SD)	Range
<i>Treatment</i>	8.30 (SD = 2.39)	0.00 – 10.00
<i>Health Plan - Managed Care Organization Only</i>	9.14 (SD = 1.65)	0.00 – 10.00

Table 4. STAR+PLUS Adult Global Ratings

Global Ratings	Mean (SD)	Range
<i>Treatment</i>	8.17 (SD = 2.46)	0.00 – 10.00
<i>Health Plan - Managed Care Organization Only</i>	8.02 (SD = 2.70)	0.00 – 10.00

Recommendations

The external quality review organization recommends the following strategies to Texas HHSC and the Medicaid managed care organizations for improving the delivery and quality of behavioral health care. Recommendations are focused on two domains: (1) health status and behavioral health of STAR child members, including the comorbidity of obesity and disruptive behaviors; and (2) access to behavioral counseling or treatment among STAR child and STAR+PLUS adult members, including communication between patients and clinicians and patients' access to emergency services.

Domain: Child Health Status and Mental Health – Obesity and Disruptive Behaviors	
Recommendations	Rationale
<ul style="list-style-type: none"> • Continue to maintain and improve efforts to identify children and adolescents with obesity and behavioral disorder co-morbidities. • Implement or improve upon prevention and treatment programs to meet the special needs of these members. • Continue treatment and prevention efforts to encourage and increase protective factors and healthy behaviors that can help prevent the onset of a diagnosable behavioral disorder and reduce risk factors that can lead to the development of a behavioral disorder.⁷ 	<p>Among children and adolescents with a behavioral health diagnosis in the STAR program, nearly half of boys and more than half of girls were overweight or obese. Among STAR child members, the primary diagnosis for behavioral health was disruptive behaviors (44 percent), followed by adjustment disorders (19 percent) and mood disorders (19 percent).</p> <p>Obesity affects a large proportion of child STAR members with behavioral health conditions, and weight-based stigmatization experienced by these members may be associated with more severe behavioral illness symptoms and a lower likelihood of seeking treatment.⁸</p> <p>Standardized programs of health risk monitoring for youths with psychiatric conditions have been successful at identifying overweight and obese patients in outpatient and day treatment settings.⁹</p> <p>The presence of problem behaviors during childhood is related to the development of many risk behaviors and clinical diagnosis (e.g. substance abuse and dependence, depression and anxiety, suicide, sexual risk behaviors) during adolescence and adulthood.¹⁰ The Department of Health and Human Services and the Institute of Medicine are calling on schools to enhance early identification methods to assess and connect students with behavioral health services.¹¹</p>

	<p>Also, the Substance Abuse and Mental Health Services Administration recommends promoting behavioral health among children, including: (1) early childhood interventions, (2) programs to increase social skills among children, (3) school-based activities to promote behavioral health, (4) violence prevention programming, and (5) structural and community development programs.¹²</p>
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Domain: Access to Behavioral Counseling or Treatment

Recommendations	Rationale
<ul style="list-style-type: none"> • Improve clinician communication skills, specifically targeting providers of members with more severe and persistent behavioral health symptoms. Web-based resources, such as those developed by the Agency for Healthcare Research and Quality (AHRQ), can be useful for encouraging better two-way communication between clinicians and patients.¹³ • Continue to provide members with easy access to local behavioral health services (e.g. crisis hotline). Provide STAR child caregivers and STAR+PLUS members with easier access to referral information and local services for emergency or crisis counseling or treatment services. 	<p>Caregivers of children and adolescents in the STAR program had the most trouble with: 1) getting help from customer service; 2) delays in their child’s counseling or treatment while waiting for managed care organization or behavioral health organization approval; 3) finding a clinician with whom they are satisfied; and 4) obtaining information about counseling or treatment from their child’s managed care organization or on the Internet.</p> <p>Among STAR+PLUS members, 36 percent reported they needed emergency counseling or treatment in the past 12 months, but 47 percent of those members “always” saw someone as soon as they wanted.</p> <p>Among caregivers of a child or adolescent in the STAR program, 24 percent reported their child needed emergency counseling or treatment, but 53 percent “always” saw someone as soon as they wanted.</p> <p>Successful strategies for improving clinicians’ communication and providing access to local behavioral health services are important for ensuring improvement in behavioral health conditions, including access to emergency or crisis counseling or treatment.</p>

- Members can contact the crisis hotline of the Local Mental Health Authority (LMHA) for their county.¹⁴ For behavioral health services for children and adolescents, professionals can utilize an intensive-based approach to service delivery, where services are provided based on the continuum of behavioral health. For example, Levels of Care (LOCs) have been designed to make services available that correspond to the intensity and complexity of the identified needs of the youth.¹⁵

Introduction

The quality of behavioral health care in Medicaid managed care is an important priority.¹⁶ In the Texas STAR program, members receive behavioral health services depending on their managed care organization and service area. Behavioral health services can be part of the managed care organization's integrated benefits package or delivered through a sub-contracted behavioral health organization. STAR members living in the Dallas service area receive behavioral health care through the NorthSTAR program, which contracts with ValueOptions, a behavioral health organization.

The STAR+PLUS program is a Texas Medicaid Managed Care program designed to integrate the delivery of acute and long-term services and support for members with chronic and complex conditions.¹⁷ Members in STAR+PLUS receive acute primary and specialist care, long-term services such as attendant care and adult day health care, and service coordination to address complex medical conditions. Members receive behavioral health services through their STAR+PLUS managed care organization, either directly through the managed care organization as part of its integrated benefits package, or through a sub-contracted behavioral health organization. In state fiscal year 2013, the STAR+PLUS program operated in counties located in the Bexar, Dallas, El Paso, Harris, Hidalgo, Jefferson, Lubbock, Nueces, Tarrant, and Travis service areas.¹⁸

In the 2009 report titled *Texas State Government Effectiveness and Efficiency: Selected Issues and Recommendations*, the Texas Legislative Budget Board (LBB) recommended improving the transparency and accountability of behavioral health services in Texas Medicaid and CHIP.¹⁹ Specifically, the LBB recommended the assessment of members' satisfaction and experiences with the behavioral health services they receive through their Medicaid managed care organization, behavioral health organization, or NorthSTAR. Patients' rating of satisfaction with health care is an indicator of quality of care, and has been associated with positive health-related behaviors, such as compliance with treatment.^{20, 21}

In fiscal year 2013, as part of external quality review activities for the State of Texas, the Institute for Child Health Policy conducted a set of behavioral health member surveys to assess members' experiences and satisfaction with behavioral health services received between May 2012 and August 2013. This report presents findings from surveys conducted with: (a) parents of children enrolled in STAR who were diagnosed with and treated for a behavioral health condition in the past 12 months; and (b) adult STAR+PLUS members who were diagnosed with and treated for a behavioral health condition in the past 12 months. The purpose of this report is to:

- Describe the demographic and household characteristics of child and adult members with behavioral health conditions.
- Assess the health status of the population, including overall health ratings and obesity.
- Describe caregivers' experiences and satisfaction with the behavioral health services their children receive in STAR across five domains of care: (1) utilization of behavioral health counseling and treatment; (2) access to and timeliness of behavioral healthcare; (3)

managed care organization or behavioral health organization benefits, information, and assistance; (4) experiences in clinician offices; and (5) perceived outcomes of counseling and treatment.

- Describe adult members' experiences and general satisfaction with the behavioral health care they receive through STAR+PLUS managed care organizations and behavioral health organizations across six domains of care: (1) utilization of behavioral health counseling and treatment; (2) access to and timeliness of behavioral health care, (3) managed care organization or behavioral health organization benefits, information, and assistance, (4) experiences in clinician offices, (5) presence of a usual source of behavioral health care, and (6) perceived outcomes of counseling and treatment.

Methodology

Sample Selection

STAR Child Behavioral Health Survey

Survey participants were selected from a stratified random sample of children continuously enrolled in the same STAR managed care organization between April 2012 and March 2013 (with one allowable one-month gap in enrollment during the 12-month period). The sample included only children younger than 18 years of age with a record of one or more behavioral health or chemical dependency diagnosis (ICD-9-CM code) and procedural (CPT code) combinations during the enrollment period (see **Table A1** in Appendix A). The sample was stratified by age and program into four groups: (1) children enrolled in STAR: ≤ 12 years old; (2) adolescents enrolled in STAR: 13 to 17 years old; (3) children enrolled in NorthSTAR: ≤ 12 years old; and (4) adolescents enrolled in NorthSTAR: 13 to 17 years old.

These criteria are based on the technical specifications for the Experience of Care and Health Outcomes (ECHO[®]) survey (described below), and ensure that children in the sample received behavioral health services and that families had sufficient experience with the program to respond to the survey questions.

A target sample of 1,200 completed telephone interviews was set, representing 300 respondents per quota. Target samples were met for all sampling groups, with a total of 1,223 completed interviews collected (see **Table 5**). The number of completes exceeded the target in all quotas because the survey fielding protocol allows multiple interviewers to call on the same quotas simultaneously.²² The response rate for this survey was 59 percent and the cooperation rate was 88 percent.²³ **Table A2** provides the weights for each survey quota for the STAR Child Survey.

Table 5. STAR Child Behavioral Health Survey – Targeted and Completed Surveys

Survey quota	Targeted surveys	Completed surveys
STAR child (< 13 years old)	300	310
STAR adolescent (13 to 17 years old)	300	302
NorthSTAR child (< 13 years old)	300	301
NorthSTAR adolescent (13 to 17 years old)	300	310

STAR+PLUS Behavioral Health Survey

Survey participants were selected from a stratified random sample of adults continuously enrolled in the same STAR+PLUS managed care organization between April 2012 and March 2013 (with one allowable one-month gap in enrollment during the 12-month period). The sample included only adults 18 years of age and older with a record of one or more behavioral health or chemical dependency diagnosis (ICD-9-CM code) and procedural (CPT code) combinations during the enrollment period (see **Table A1** in Appendix A). The sample was stratified into eight groups according to the member's STAR+PLUS managed care organization, service area, and Medicare eligibility: (1) Amerigroup Medicaid-only; (2) Cigna-HealthSpring Medicaid-only; (3) Molina Medicaid-only (all service areas except Dallas); (4) Superior Medicaid-only (all service areas except Dallas); (5) UnitedHealthcare Medicaid-only; (6) Statewide dual-eligible members (any managed care organization); (7) Molina Medicaid-only in Dallas service area; (8) Superior Medicaid-only in Dallas service area. The Molina and Superior members in the Dallas service area were separated into their own quotas because these members receive behavioral health services through NorthSTAR. Members who participated in the fiscal year 2011 STAR+PLUS Adult Behavioral Health Member Survey were excluded.

A target sample of 2,400 completed telephone interviews was set, representing 300 respondents per quota. Target samples were met for all sampling groups except Cigna-HealthSpring Medicaid-only (N = 183), with a total of 2,340 completed interviews collected (see **Table 6**). Due to discrepancies between the recorded managed care organization (from enrollment data) and the members' self-reported managed care organization, five survey responses were excluded from the analysis – two from Amerigroup, one from Cigna-HealthSpring, and two from individuals who were dually-eligible – resulting in 2,335 total surveys included in the analysis. The lower completion rate in Cigna-HealthSpring was largely due to the small number of eligible members in the managed care organization population (N = 3,945). A number of quotas exceeded the target because the survey fielding protocol allows multiple interviewers to call on the same project simultaneously.²⁴ The response rate for this survey was 63 percent and the cooperation rate was 79 percent.²⁵ **Table A3** provides the weights for each survey quota for the STAR+PLUS Survey.

Table 6. STAR+PLUS Behavioral Health Survey – Targeted and Completed Surveys

Survey quota	Targeted surveys	Completed surveys
Amerigroup (Medicaid-only)	300	311
Cigna-HealthSpring (Medicaid-only)	300	183
Molina (Medicaid-only, excluding Dallas SA)	300	305
Superior (Medicaid-only, excluding Dallas SA)	300	310
UnitedHealthcare (Medicaid-only)	300	301
Statewide dually eligible individuals	300	310
Molina (Medicaid-only, Dallas SA)	300	316
Superior (Medicaid-only, Dallas SA)	300	304

Survey Data Collection

The external quality review organization contracted with the National Opinion Research Center at the University of Chicago to conduct the surveys using computer-assisted telephone interviewing (CATI) between May 2013 and August 2013. The National Opinion Research Center telephoned parents and caregivers of STAR members, and adult STAR+PLUS members, seven days a week between 9 a.m. and 9 p.m. Central Time. Up to 25 attempts were made to reach a family before a member's phone number was removed from the calling circuit. If a respondent was unable to complete the interview in English, the National Opinion Research Center referred the respondent to a Spanish-speaking interviewer for a later time.

The external quality review organization sent advance notification letters written in English and Spanish to caregivers of sampled children in STAR, and to sampled adult members in STAR+PLUS, requesting their participation in the survey.

Attempts were made to contact caregivers of 5,941 children who were enrolled in STAR. Forty-eight percent of families could not be located. Among those located, two percent indicated that their child was not enrolled in STAR, and seven percent refused to participate.

Attempts were made to contact 18,465 STAR+PLUS members sampled for the survey. Sixty percent of members could not be located. Among those located, less than one percent indicated that they were not enrolled in STAR+PLUS, and 11 percent refused to participate.

Survey Instruments

The 2013 STAR Child Behavioral Health Survey and the 2013 STAR+PLUS Behavioral Health Survey included: (1) The Experience of Care and Health Outcomes (ECHO[®]) Survey 3.0;²⁶ and (2) Items developed by ICHP pertaining to parent and member demographic and household characteristics.

Questions regarding the demographic and household characteristics of members were developed by ICHP and have been used in surveys with more than 25,000 Medicaid and CHIP members in Texas and Florida. The items were adapted from questions used in the National Health Interview Survey, the Current Population Survey and the National Survey of America's Families.^{27,28,29} Respondents were also asked to report their height and weight. These questions allow calculation of the body mass index (BMI), a common population-level indicator of overweight and obesity.

The ECHO[®] Survey is part of the Consumer Assessment of Healthcare Providers and Systems (CAHPS[®]) family of surveys. The child version assesses parents' experiences and satisfaction with various aspects of their child's behavioral health care. The adult version assesses patients' experiences and satisfaction with various aspects of their behavioral health care. The survey allows for calculation and reporting of behavioral health care composites, which are scores that combine results for closely related survey items. ECHO[®] composite scores were calculated in the following domains: *Getting Treatment Quickly*, *How Well Clinicians Communicate*, *Getting Treatment and Information from the Plan or Behavioral Health Organization*, *Information About Treatment Options*, and *Perceived Improvement*. Researchers at ICHP scored the composites following ECHO[®] specifications. Values for *Getting Treatment Quickly*, *How Well Clinicians Communicate*, and *Getting Treatment and Information from the Plan or Behavioral Health Organization* range from 1.00 to 3.00 (from low to high quality/satisfaction). Values for *Information About Treatment Options* range from 0.00 to 1.00. Values for *Perceived Improvement* range from 1.00 to 4.00. For each of the five domains, a respondent's composite score was not calculated or considered in analysis if the respondent answered fewer than half of the questions in the composite.

For children and adults, behavioral health diagnoses were grouped based on the AHRQ *Mapping ICD-9-CM Codes Into Mental Health and Substance Abuse Clinical Classification Software Table*: (1) Adjustment Disorders, (2) Anxiety Disorders, (3) Disruptive Behavior Disorders, (4) Cognitive Disorders, (5) Developmental Disorders, (6) Childhood Disorders, (7) Impulse Control Disorders, (8) Mood Disorders, (9) Personality Disorders, (10) Psychotic Disorders, (11) Substance-Related Disorders, and (12) Miscellaneous Mental Disorders. **Table A1** contains a list of specific behavioral health diagnoses included in each of the above categories.³⁰

Data Analysis

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

To test for participation bias, the distributions of members' age, sex, and race/ethnicity were collected from the enrollment data and compared between members who responded to the survey and members who did not participate. Among child members in STAR whose caregivers

could be contacted by the National Opinion Research Center, 60 percent of respondents were listed as Hispanic, 21 percent as white, non-Hispanic, 16 percent as black, non-Hispanic, and 3 percent as other, non-Hispanic.³¹ The difference between the racial/ethnic distribution of caregivers who participated and the racial/ethnic distribution of members who did not participate was statistically significant. Therefore, to correct for potential response bias in the STAR Child survey data, the external quality review organization weighted the survey results to account for these differences. No significant differences were observed between respondents and non-respondents in STAR+PLUS for any of the demographic factors assessed.

To facilitate inferences from the survey results to the STAR and STAR+PLUS member behavioral health populations, results were also weighted to the full set of eligible beneficiaries in the enrollment dataset. A separate weight was calculated for each of the sampling groups by multiplying frequencies by the inverse probability of inclusion in the final sample (the total number of eligible members in the enrollment file divided by the number of members in the final sample)³². **Table A2** provides the weights for each survey quota for the STAR Child Survey. **Table A3** provides the weights for each survey quota for the STAR+PLUS Survey. The frequencies and means presented in this report and the technical appendix that accompanies this report incorporate survey weights.

Survey Results Part I: STAR Child Behavioral Health Survey

This section presents survey findings regarding: (1) demographic characteristics, (2) health status, (3) utilization of behavioral health counseling and treatment, (4) access to and timeliness of behavioral health care, (5) behavioral health benefits, (6) experiences with clinicians and managed care organizations, and (7) perceived outcomes of behavioral health care.

Characteristics of Survey Participants and Child Members

Profile of survey participants (parents/caregivers)

- 76 percent were the biological parent of the member.
- The majority of respondents were female (95 percent).
- The mean age was 41 years old.
- 40 percent had not completed high school.
- 65 percent described their household as a single-parent household.

Profile of sampled child members

- 60 percent were male and 40 percent were female.
- The mean age was 11 years old.
- 64 percent of child members were Hispanic.

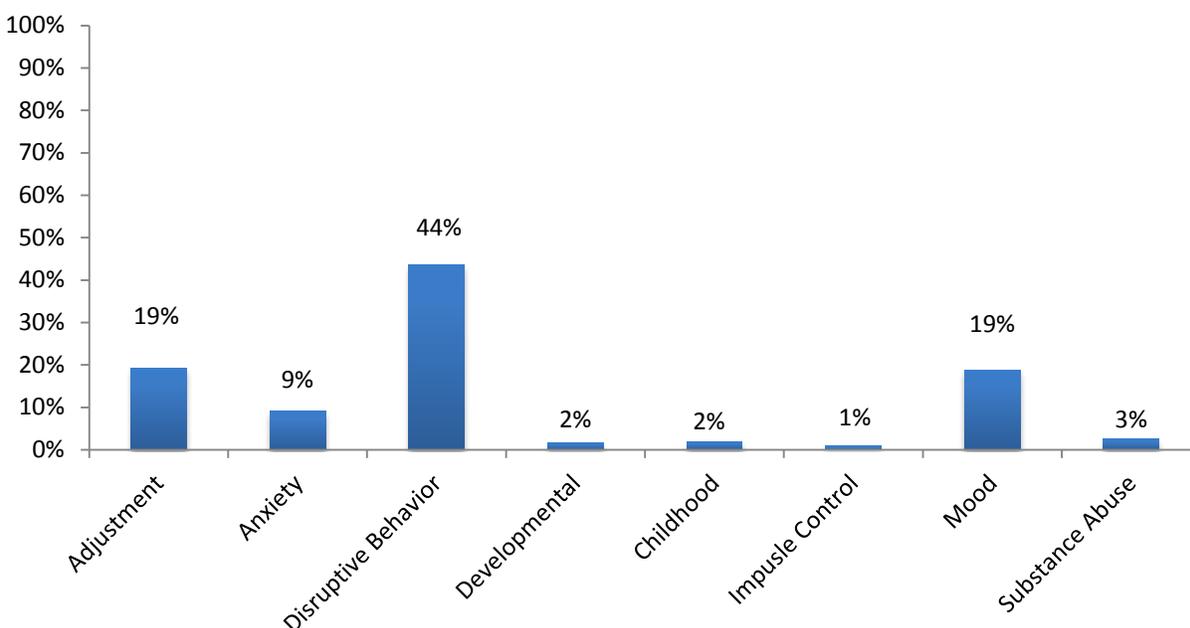
Health Status

Mental Health Diagnosis

The external quality review organization obtained all behavioral health diagnosis codes from claims data during the sampling enrollment period for children in the STAR Behavioral Health survey sample. Primary diagnosis codes (the first to appear in the member's claims) were grouped into behavioral health categories, following the AHRQ ICD-9-CM classification system for behavioral health and substance abuse (**Figure 1**).³³

The most common primary behavioral health diagnosis category was disruptive behavior disorders (44 percent), including diagnoses of Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (31 percent).

Figure 1. Primary Mental Health Diagnoses for STAR Child Behavioral Health Survey Members



The primary behavioral health diagnosis groups represented in Figure 1 account for 98 percent of the sample population. The remaining two percent of the sample population fell into one of the following disorder groups: cognitive disorders, personality disorders, psychotic disorders, or miscellaneous mental disorders.³⁴

Overall Health and Mental Health

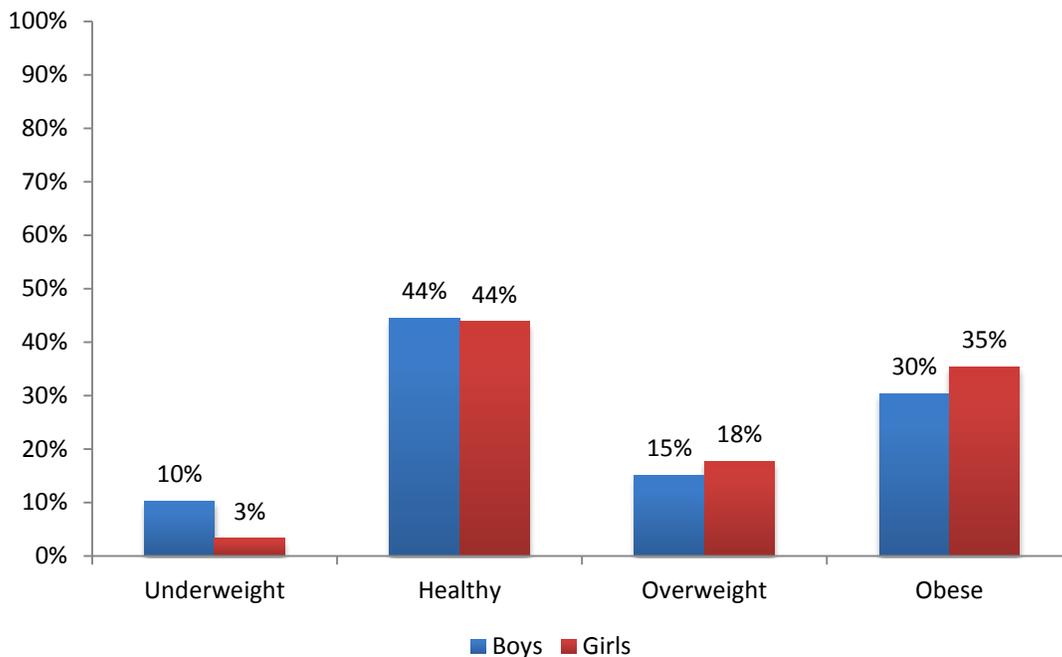
Caregivers provided more favorable ratings of their child's overall health than behavioral health, with more caregivers reporting "fair" and "poor" behavioral health of their children. Fifty-three percent of caregivers rated their child's overall health as "very good" or "excellent", compared to 45 percent who rated their child's behavioral health as "very good" or "excellent". In contrast, 23 percent of caregivers indicated that their child had "fair" or "poor" behavioral health, compared to 14 percent of caregivers indicating "fair" or "poor" overall health of their child.

Body Mass Index

Body mass index (BMI) was calculated by dividing the child's weight in kilograms by their height in meters squared. BMI could be calculated only for children in the sample for whom height and weight data were complete (61 percent).³⁵ 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:³⁶ (1) Underweight (less than 5th percentile); (2) Healthy (5th percentile to less than 85th percentile); (3) Overweight (85th percentile to less than 95th percentile); and (4) Obese (95th percentile or greater). 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 children whose BMI deviated considerably from child growth standards provided by the World Health Organization.³⁷ By these standards, any BMI value that exceeded five standard deviations below or above the median BMI was considered biologically implausible and likely the result of errors in data collection.

Figure 2 provides the BMI results for boys and girls in the sample. Based on height and weight data, 53 percent of girls and 45 percent of boys were classified as overweight or obese. For comparison, among high school students in Texas, 16 percent self-reported being overweight and 14 percent being obese.³⁸

Figure 2. Body Mass Index Classification for STAR Child Boys and Girls



Utilization of Behavioral Health Counseling and Treatment

This section provides results for caregivers' self-report of their child's utilization of behavioral health services in the STAR Program.

In the past 12 months, caregivers reported whether:

- Their child received counseling, treatment, or medicine at home, or in an office, clinic, or other treatment program one or more times (70 percent).
- Their child took prescription medicine as part of his or her treatment (65 percent).
- Their child visited an emergency room or crisis center to get counseling or treatment one or more times (17 percent).
- They called someone to get professional telephone counseling for their child (11 percent).

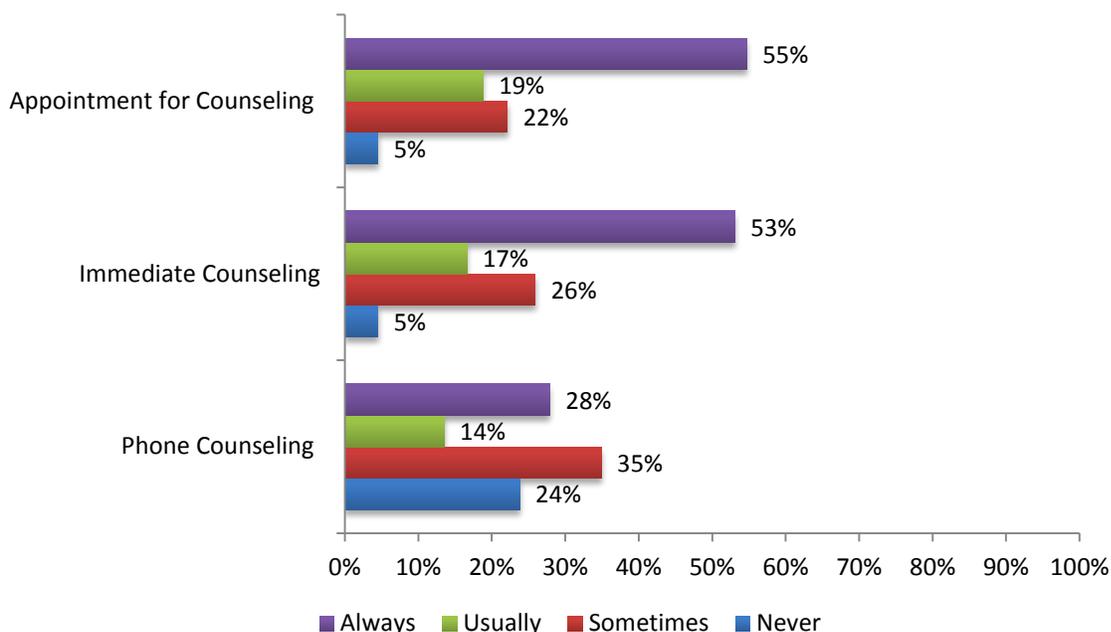
Access to and Timeliness of Behavioral Health Care

Getting Treatment Quickly

Three ECHO[®] survey questions comprise the composite *Getting Treatment Quickly*, including questions that assess how often caregivers were able to get routine and urgent treatment or counseling and treatment or counseling for their child over the telephone.

Figure 3 displays caregiver responses regarding how well they were able to obtain routine, immediate, and phone counseling and treatment services for their child when they were needed.

Figure 3. How Often STAR Child Caregivers Reported Getting Routine, Immediate, and Telephone Counseling or Treatment



Office Wait

Caregivers were asked how often their child was seen within 15 minutes of his or her appointment in the past 12 months. A majority of members indicated that their child was “usually” or “always” seen within 15 minutes of their scheduled appointment (59 percent). However, 18 percent said their child was never seen within 15 minutes, and 23 percent said they were only sometimes seen within 15 minutes.

Rating of Counseling or Treatment

When asked to rate their overall perceptions of their child’s behavioral health counseling and treatment on a scale of 0 to 10, zero indicating low quality and 10 indicating high quality, 60 percent of caregivers gave a rating of 9 or 10. The mean rating for behavioral health counseling and treatment was 8.30 (SD = 2.39).

Behavioral Health Treatment Benefits and Assistance

This section provides results for caregivers’ experiences with their child’s managed care organization or the behavioral health organization that provides counseling or treatment.

Extended Benefits

Caregivers were asked about their child’s benefits for counseling or treatment under their managed care organization in the past 12 months. Specifically, caregivers were asked about whether their child had used up all of his or her benefits and were still in need of counseling or treatment, and whether they were informed about other ways to get counseling or treatment for their child.

- About one-third of caregivers reported their child had used up all of his or her benefits for counseling or treatment (36 percent). Within this group, nearly half reported their child still needed counseling or treatment at the time the benefits were used up (47 percent).
- Among caregivers who said their child still needed counseling or treatment, 43 percent reported they were told about other ways to get counseling, treatment, or medicine for their child.

Behavioral health benefits in Texas Medicaid are limited to 30 encounters/visits per calendar year, with prior authorization required for extended encounters/visits that are determined to be medically necessary.³⁹ Results of this survey suggest that some children in STAR may still be in need of behavioral health services after exhausting their counseling or treatment benefits. It is possible that parents do not understand the managed care organization’s behavioral benefits package. It is also possible that parents may disagree with their child’s providers and/or managed care organization regarding which extended benefits are “medically necessary.” If a clinician requests prior authorization for additional counseling or treatment visits and the managed care organization denies the request based on lack of medical necessity, the parent may still believe that their child is in need of additional treatment.

Among caregivers who reported their child had used up all of his or her behavioral health counseling or treatment, 57 percent said their child's behavioral health provider requested that the managed care organization approve additional treatment. Among those whose providers requested additional treatment, 82 percent said the managed care organization approved the request.⁴⁰

Getting Treatment Information and Assistance

Results suggest that caregivers had the most problems with: (1) getting help from customer service, (2) delays in their child's counseling or treatment while waiting for managed care organization or behavioral health organization approval, (3) finding a clinician with whom they are satisfied, and (4) obtaining information about counseling or treatment through managed care organization materials or on the Internet. Specifically:

- 78 percent said it was “not a problem” to get the counseling or treatment they thought their child needed.
- 32 percent looked for information about counseling or treatment from their child's managed care organization in written materials or over the Internet, among which 78 percent reported it was not a problem to find or understand managed care organization information.
- 22 percent of caregivers said they had to fill out paperwork for their child's managed care organization regarding counseling or treatment, among which 80 percent said it was “not a problem” to fill out and complete this paperwork.
- 22 percent said their child needed approval for counseling or treatment from the managed care organization. Among these caregivers, 54 percent indicated they experienced no problems with delays in counseling or treatment while waiting for approval from their child's managed care organization.
- 21 percent reported that after joining the managed care organization, their child got someone new for counseling or treatment. Among these caregivers, 64 percent reported it was not a problem to get a clinician for their child they were happy with, while 20 percent reported it was a big problem to get a clinician for their child they were happy with.
- 15 percent called the managed care organization's customer service to get information or help about counseling or treatment for their child, and 65 percent said it was not a problem to get the help they needed for their child when calling the managed care organization's customer service.

Caregivers' Rating of Their Child's Health Plan or Behavioral Health Organization

Respondents belonging to a managed care organization were asked to provide an overall rating of their child's managed care organization in relation to counseling or treatment on a scale from 0 to 10, with 0 indicating the worst plan possible and 10 indicating the best plan possible. Eighty-one percent of members gave a rating of 9 or 10 for their child's managed care organization. The mean rating for the managed care organization was 9.14 (SD=1.65). Respondents belonging to a behavioral health organization were asked to provide an overall

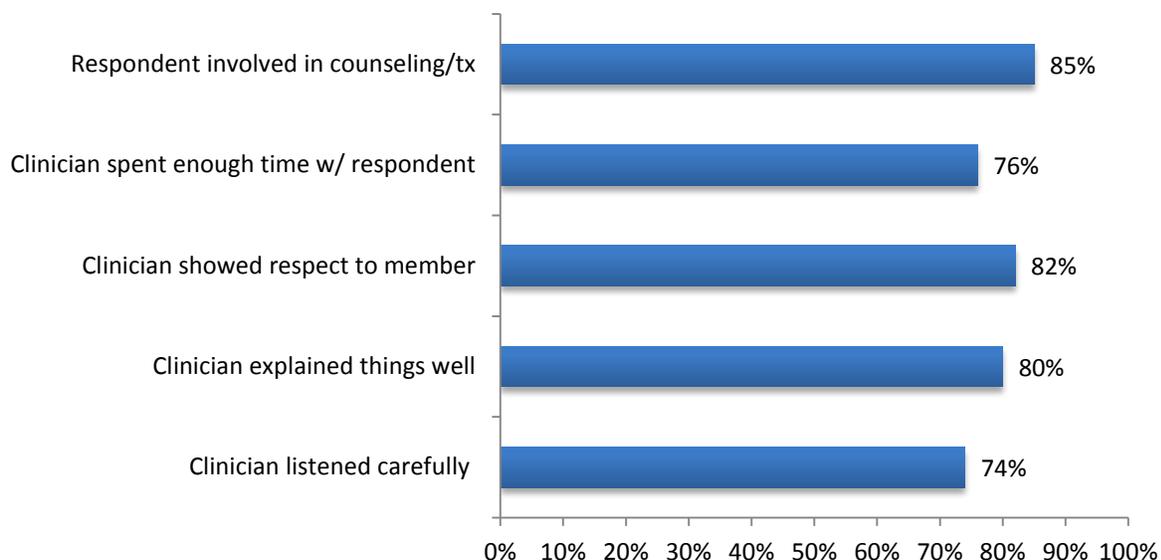
rating of the company that handles their child’s benefits for counseling or treatment on a scale from 0 to 10, with 0 indicating the worst company possible and 10 indicating the best company possible. Sixty-eight percent of these members gave a rating of 9 or 10 for the company that handles their child’s benefits. The mean rating for the company was 8.61 (SD=2.20).

Experiences with Clinicians and Health Plan

How Well Clinicians Communicate

Five ECHO® survey questions comprise the composite *How Well Clinicians Communicate*. This composite assesses how often a child’s clinician or therapist involves the family in treatment as much as they wanted, spent enough time with the family, showed respect, explained things well, and listened carefully. **Figure 4** depicts caregivers’ experiences with each of the five aspects of provider communication. Most caregivers reported “usually” or “always” having positive communication experiences with their child’s clinician in the past 12 months.

Figure 4. Percentage of STAR Child Respondents Who Reported They “Usually” or “Always” Had Positive Communication Experiences with Their Child’s Clinician



Information from Clinicians

Caregivers were asked a series of questions about whether they were given information regarding their child's rights as a patient, the counseling or treatment options available to their child, the goals of treatment and how to manage their child's condition, and the side effects of medications. In the past 12 months, the majority of caregivers reported:

- Their provider completely discussed goals of their child's counseling or treatment (87 percent).
- They were informed about medication side effects (84 percent).
- They were given information about their child's rights as a patient (82 percent).

- They were given as much information as they wanted about how to manage their child's condition (76 percent).
- They were informed about the counseling or treatment options available to their child (67 percent).

One ECHO[®] survey item summarized the *Information about Treatment Options*. This item assesses whether the clinician or therapist informed caregivers about the different kinds of counseling or treatment available for their child. Results indicate that approximately one-third of caregivers are not receiving information about treatment options that might help them to better manage their child's condition (33 percent).

Patient Privacy

Caregivers were asked if anyone their child saw for treatment or counseling shared information with others that should have been kept private. The vast majority of caregivers reported that their child's clinician did not share information about their child's treatment or counseling with others (94 percent).

Cultural Competence

Caregivers were asked whether their child's race/ethnicity, culture, or religion made any difference in the kind of counseling or treatment he or she needed. The vast majority said no (96 percent), indicating that their child's race/ethnicity, culture or religion would not affect the kind of counseling or treatment he or she needed. Among caregivers who indicated their child's race/ethnicity, culture, or religion did make a difference, 91 percent reported the care their child received was responsive to those needs.

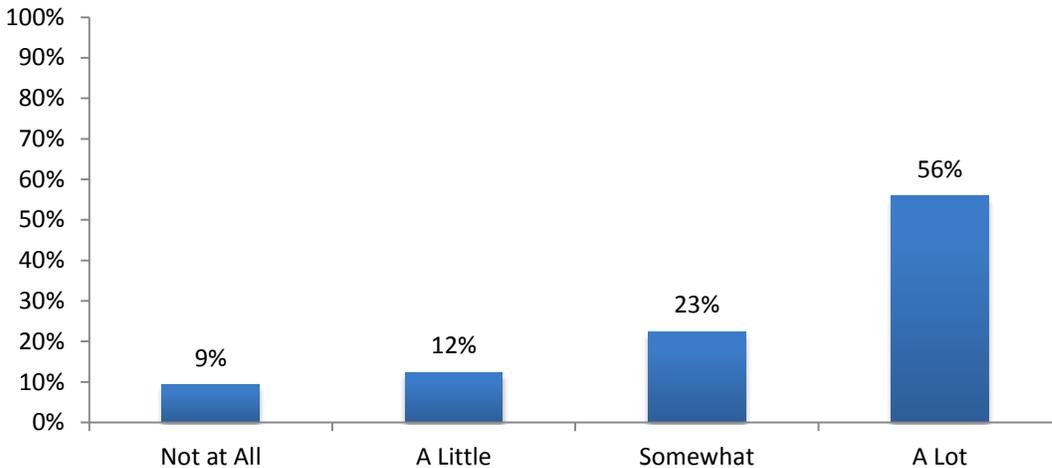
Perceived Outcomes of Behavioral Health Counseling and Treatment

How Much the Child Has Been Helped

To fully assess the quality of behavioral health counseling or treatment for children in STAR, caregivers were asked about the outcomes of counseling or treatment for their child in the past 12 months. Specifically, caregivers were asked to rate how much their child had been helped by the counseling or treatment he or she received in the past 12 months.

Figure 5 provides the percentage of caregivers reporting their child had been helped by counseling or treatment "a lot", "somewhat", "a little", or "not at all". Fifty-six percent of caregivers believed their child had been helped a lot by the counseling or treatment he or she received in the past 12 months. To examine whether responses to this question varied by the child's primary behavioral health diagnosis, the external quality review organization conducted an analysis of this item for each of the three most prevalent primary diagnostic groups in the STAR Child Behavioral Health Survey – disruptive behavior disorders, adjustment disorders, and mood disorders. Compared to children without these disorders, no significant differences were observed in the percentage of caregivers reporting their child was helped "a lot" by the counseling or treatment he or she received for children with disruptive behavior disorders (58 percent), adjustment disorders (55 percent), or mood disorders (55 percent).⁴¹

Figure 5. Caregiver Perception of How Much Their STAR Child Member Was Helped by Behavioral Health Treatment

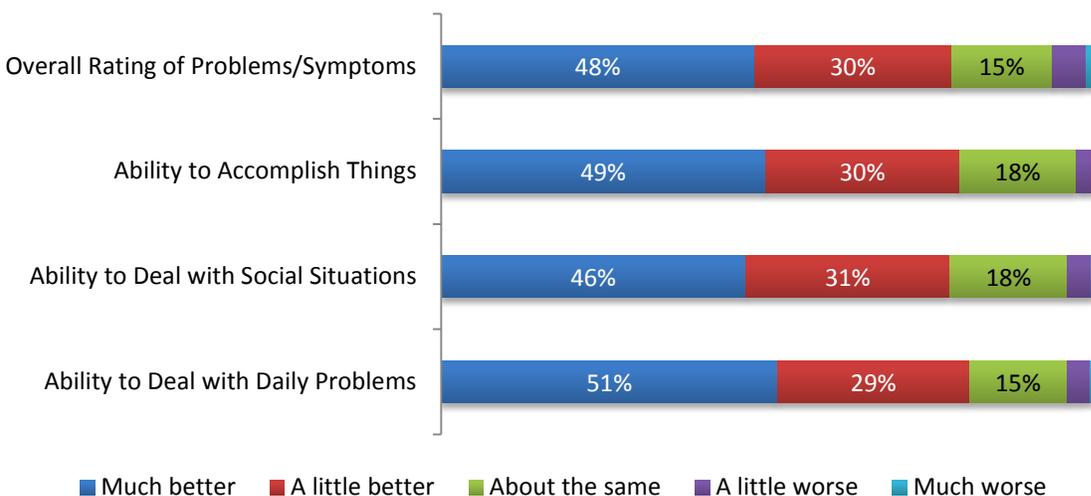


Perceived Improvement

Four ECHO[®] survey items comprise the composite *Perceived Improvement*. This composite assesses caregiver perceptions of their child's ability to deal with daily problems and social situations, to accomplish the things he or she wants, and the overall improvement in their child's problems or symptoms.

Figure 6 presents caregivers' ratings of their child's improvement compared to 12 months ago on each of the four *Perceived Improvement* items. The majority of caregivers reported some degree of improvement in their child's condition.

Figure 6. Ratings from Caregivers of STAR Child Members on Child's Improvement Compared to 12 Months Ago



Survey Results Part II: STAR+PLUS Behavioral Health Survey

This section presents survey findings for adults with behavioral health conditions in STAR+PLUS regarding: (1) demographic characteristics, (2) health status, (3) utilization of behavioral health counseling and treatment, (4) access to and timeliness of behavioral health care, (5) behavioral health benefits, (6) experiences with clinicians and managed care organizations, and (7) perceived outcomes of behavioral health care.

Characteristics of Survey Participants

The majority of survey respondents were female (71 percent), and the mean age among all respondents was 51 years old. White, non-Hispanic members represented 37 percent of members, followed by Hispanic members (32 percent), and Black, non-Hispanic members (26 percent). Five percent of surveyed members were of “Other, non-Hispanic” race/ethnicity, which included American Indian/Alaskan Native and Asian/Pacific Islander. In addition, 87 percent of respondents stated the language spoken in their home was English. In regard to employment, educational, and household characteristics:

- The vast majority of respondents were not employed at the time of the survey (97 percent).
- Half of respondents lived in a single-parent household (50 percent). Thirty-eight percent reported they were not a parent, indicating that no children lived in the household. Thirty-eight percent reported living alone.
- Thirty-eight percent of respondents had not attained a high school diploma or GED, 34 percent had obtained a high school diploma or GED, and 28 percent of respondents had attained a college degree.
- Thirty-nine percent of respondents reported they were single, which was the most common marital status in the sample. Divorced individuals represented 30 percent of the sample, and married individuals represented 12 percent of the sample.

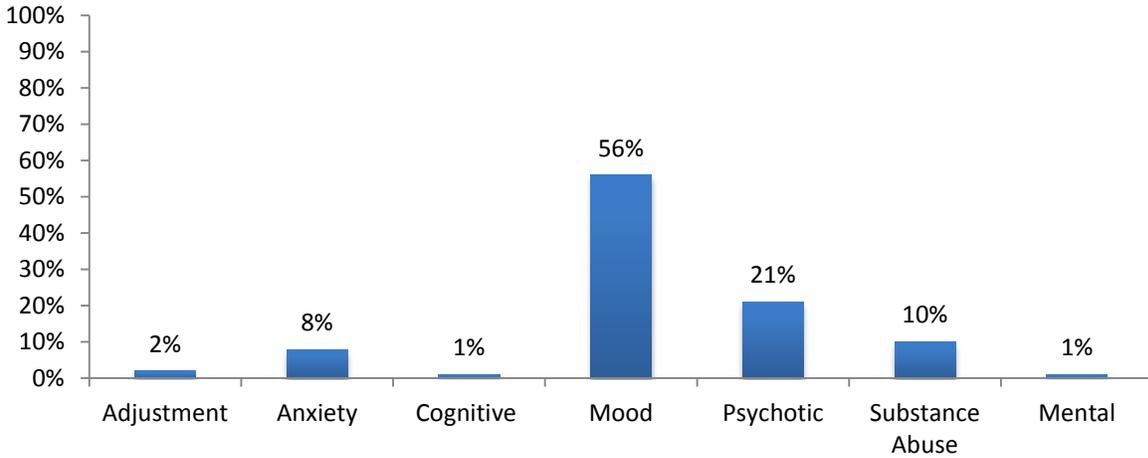
Health Status

Mental Health Diagnosis

The external quality review organization obtained all behavioral health diagnosis codes from claims data during the sampling enrollment period for adults in the STAR+PLUS Behavioral Health survey sample. Primary diagnosis codes (the first to appear in the member’s claims) were grouped into behavioral health diagnosis categories, following the AHRQ ICD-9-CM classification system for behavioral health and substance abuse disorders (**Figure 7**).⁴² These behavioral health diagnosis groupings accounted for 99 percent of the sample population. The remaining one percent of the sample population was grouped into a “Less Common Disorders” category, which includes disruptive behavior and personality disorders.

The most common behavioral health diagnosis category was mood disorders (56 percent). The two subcategories within the mood disorder category are bipolar disorders and depressive disorders, which made up 26 percent and 30 percent of the survey respondent diagnoses, respectively.

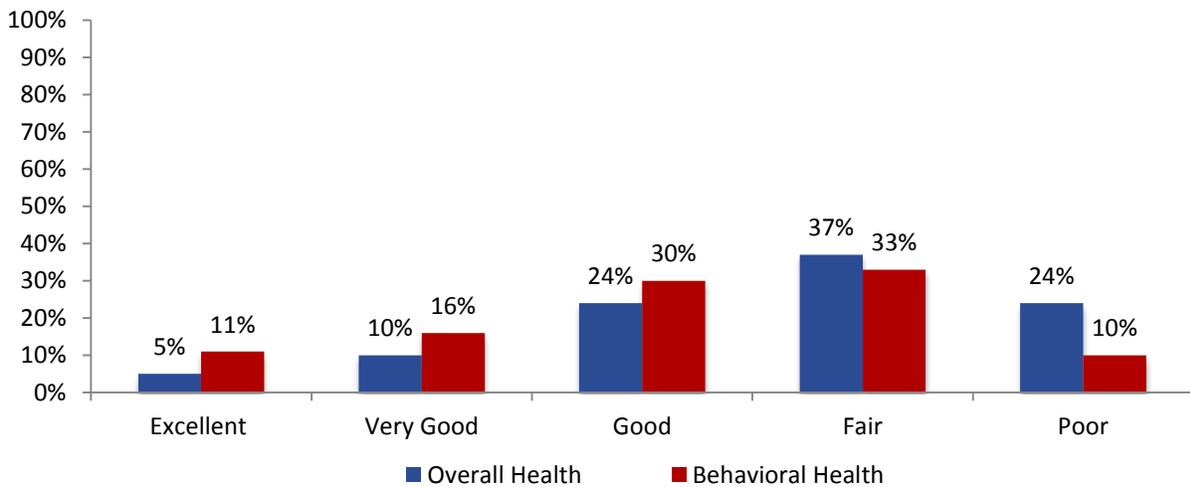
Figure 7. Primary Mental Health Diagnoses for STAR+PLUS Adult Behavioral Health Survey Members



Overall Health and Mental Health

Figure 8 presents member ratings of their overall health and behavioral health. Members provided slightly more favorable ratings of their behavioral health compared to their overall health.

Figure 8. STAR+PLUS Member Reports of Overall Health and Behavioral Health



Body Mass Index

Body mass index (BMI) was calculated by dividing the member’s weight in kilograms by their height in meters squared. Due to missing height or weight numbers, BMI could not be calculated for three percent of the sample. Survey respondents were classified into one of four clinically relevant BMI categories, which are recognized by the Centers for Disease Control and

Prevention⁴³: (1) underweight: less than 18.5; (2) healthy weight: 18.5 to 24.9; (3) overweight: 25.0 to 29.9; and (4) obese: 30.0 or greater. Based on their weight and height data, more than half of members were classified as obese (56 percent), and 26 percent were classified as overweight.

Utilization of Behavioral Health Counseling and Treatment

Members were asked about their utilization of behavioral health services in the STAR+PLUS program during the last 12 months. Members reported whether:

- They took prescription medicine as part of their behavioral health treatment (86 percent).
- They went to an office, clinic, or other treatment program one or more times to get counseling, treatment, or medicine (84 percent).
- They visited an emergency room or crisis center one or more times to get counseling or treatment (37 percent).
- They called someone to get professional telephone counseling (12 percent).

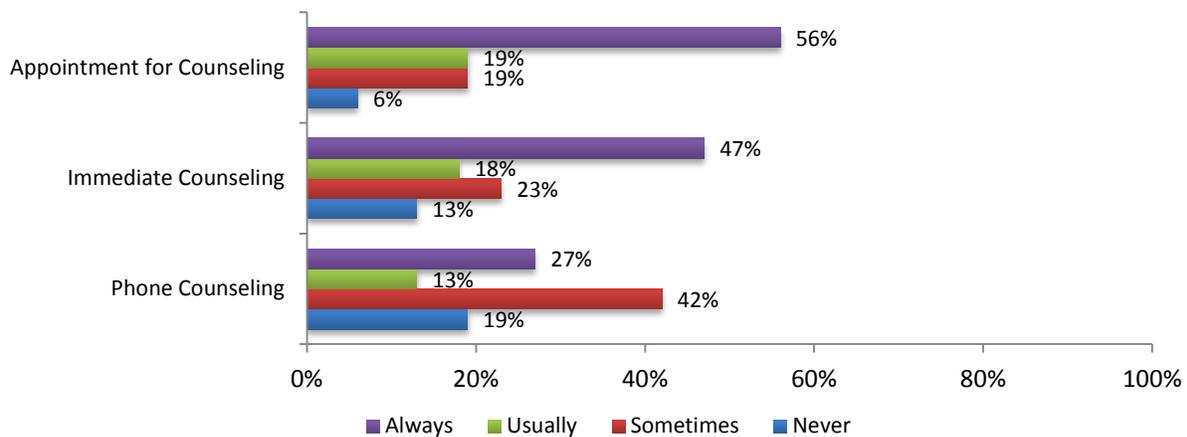
Access to and Timeliness of Behavioral Health Care

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

Getting Treatment Quickly

Three ECHO[®] survey questions comprise the composite *Getting Treatment Quickly* and assess how often members were able to get routine, immediate, or telephone counseling or treatment. Responses are described in **Figure 9**. The results reveal that the timeliness of receiving counseling or treatment depends on the type of care (e.g., routine appointment, urgent, and telephone) that members need. Members were more likely to “always” receive timely routine behavioral health care than telephone or immediate care. Less than half of members were able to “usually” or “always” get professional counseling over the telephone.

Figure 9. How Often STAR+PLUS Members Reported Getting Routine, Immediate, and Telephone Counseling or Treatment



Office Wait

Members were asked how often they were seen within 15 minutes of their appointment in the past 12 months. About half of members indicated they were “usually” or “always” seen within 15 minutes of their scheduled appointment (51 percent). However, 23 percent said they were never seen within 15 minutes, and 26 percent said they were only sometimes seen within 15 minutes.

Rating of Counseling or Treatment

When asked to rate their overall perceptions of their behavioral health counseling and treatment on a scale of 0 to 10, 55 percent of members gave a rating of 9 or 10. The mean rating for behavioral health counseling and treatment was 8.17 (SD = 2.46).

Behavioral Health Treatment Benefits and Assistance

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

Extended Benefits

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

- 19 percent said they had used up all of their benefits for counseling or treatment.
- Among those who used up their benefits, 70 percent said they still needed counseling or treatment.
- Among those who still needed counseling or treatment, 42 percent said they were told about other ways to get counseling, treatment, or medicine for themselves.

Behavioral health benefits in Texas Medicaid are limited to 30 encounters/visits per calendar year, with prior authorization required for extended encounters/visits that are determined to be medically necessary.⁴⁴ Results of this survey suggest that some members in STAR+PLUS may still be in need of behavioral health services after exhausting their counseling or treatment benefits. It is possible that members do not understand the managed care organization's behavioral benefits package. It is also possible that members may disagree with their provider and/or managed care organization regarding which extended benefits are "medically necessary." If a clinician requests prior authorization for additional counseling or treatment visits and the managed care organization denies the request based on lack of medical necessity, the member may still believe that they are in need of additional treatment.

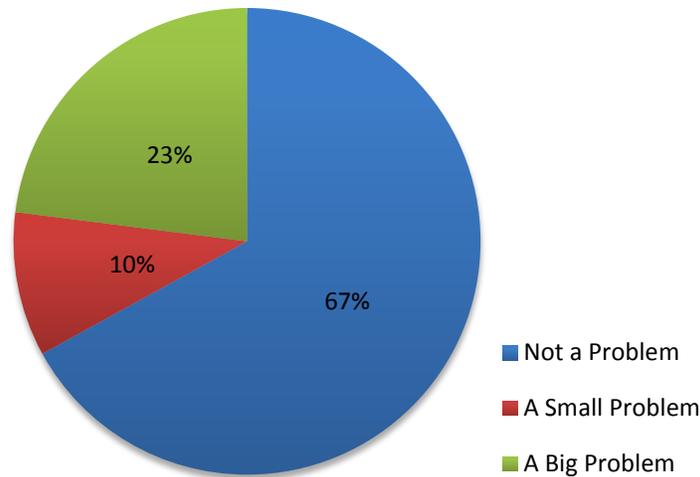
Getting Treatment Information and Assistance

The *Getting Treatment and Information from the Health Plan* composite was not calculated due to the small number of respondents answering the majority of these questions. Results suggest that members had the most problems with: 1) finding a clinician they were happy with; 2) waiting for managed care organization approval; and 3) obtaining information about counseling or treatment from their managed care organization or on the Internet.

- 68 percent of members reported it was not a problem to get the counseling or treatment they thought they needed.
- 27 percent said they looked for information about counseling or treatment from their managed care organization in written materials or over the Internet. Among these members, 30 percent said it was a “big problem” to find or understand this information.
- 23 percent said they needed approval for counseling or treatment from the managed care organization. Among members who needed approval, 28 percent reported having a “big problem” with delays in obtaining approval, 34 percent reported having a “small problem” with delays, and 38 percent said they had no problems with delays.
- 23 percent said they called the managed care organization's customer service to get information or help about counseling or treatment. Among these members, nearly half reported having either a “big problem” (22 percent) or a “small problem” (23 percent) getting the help they needed from customer service.
- 16 percent said they had to fill out paperwork for their managed care organization regarding counseling or treatment (16 percent). Among these members, 70 percent indicated that it was not a problem to fill out and complete this paperwork, compared to 25 percent who said it was a “small problem”, and 5 percent who said it was a “big problem” to fill out the paperwork.

One-quarter of members said that after joining their managed care organization, they got someone new for counseling or treatment. Among these members, 33 percent said they had problems finding a clinician they were happy with (**Figure 10**). This finding suggests that some members may have experienced discontinuity in their behavioral health care as a result of joining the managed care organization and being unable to immediately find a provider they were satisfied with.

Figure 10. The Percentage of STAR+PLUS Members Reporting Whether it was a Problem to Find a Clinician They Were Happy with after Joining the Health Plan



Members' Rating of Their Health Plan or Behavioral Health Organization

Members were asked to provide an overall rating of their managed care organization or company that handled their benefits (behavioral health organization) related to counseling and treatment on a scale from 0 to 10, with 0 indicating the worst plan and 10 indicating the best plan. Fifty-seven percent of members gave a rating of 9 or 10 for their managed care organization and 65 percent gave a rating of 9 or 10 for their behavioral health organization. Mean ratings were 8.02 for the managed care organization (SD=2.70) and 8.43 for the behavioral health organization (SD=2.37).

Experiences with Clinicians and Health Plan

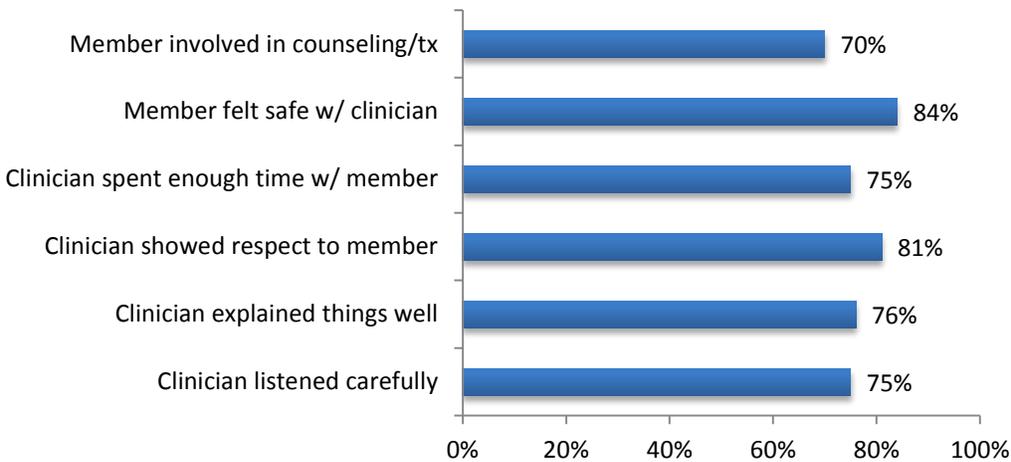
Presence of a Usual Source of Care

The majority of STAR+PLUS members had a usual source of behavioral health care. Seventy-four percent of members reported there was one person who provided most of their counseling and treatment in the past year.

How Well Clinicians Communicate

Six ECHO[®] survey questions comprise the composite *How Well Clinicians Communicate*. This composite assesses how often the clinician or therapist explained things well, listened carefully, showed respect for their patients, spent enough time with them, made them feel safe, and involved them in treatment. **Figure 11** provides members' responses to the six individual survey items that comprise the composite *How Well Clinicians Communicate*. The figure depicts the percentage of members that reported they "usually" or "always" had positive communication experiences with their clinician.

Figure 11. Percentage of STAR+PLUS Members Who Reported They “Usually” or “Always” Had Positive Communication Experiences with Their Clinician



The majority of members were satisfied with their provider’s communication skills and ability to make them feel comfortable and safe in the clinical encounter. In addition, 70 percent of members reported they were “usually” or “always” involved as much as they wanted in their counseling or treatment, which suggests that providers generally encouraged their patients to be active participants in their healing process. About three in ten members expressed some level of dissatisfaction with their clinicians, stating that they “never” or only “sometimes” had positive communication experiences.

Information from Clinicians

Two ECHO® survey items comprise the composite *Information about Treatment Options*. This composite assesses whether the clinician or therapist informed members about self-help or support groups and the different kinds of counseling or treatment available to them. Results indicate that many members are not receiving information about community resources and treatment options that might help them to better manage their condition.

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

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

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

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

- 76 percent said they were given as much information as they needed to manage their condition.
- 43 percent said their clinician discussed with them whether to include family and friends in their counseling or treatment.

In addition, 74 percent of members felt they could refuse a specific type of medicine or treatment, which suggests that most clinicians encouraged patient autonomy and were willing to share in treatment decision-making with their patients.

Patient Privacy

Members were asked if anyone they saw for treatment or counseling shared information with others that should have been kept private. The vast majority of respondents reported their clinician did not share information inappropriately about their treatment or counseling with others (92 percent).

Cultural Competence

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

Nine percent indicated that their race/ethnicity, language and culture, or religion was important to the type of counseling and treatment they received. Among these members, 72 percent reported their behavioral health care was responsive to those needs.

Members' Rating of Their Clinician

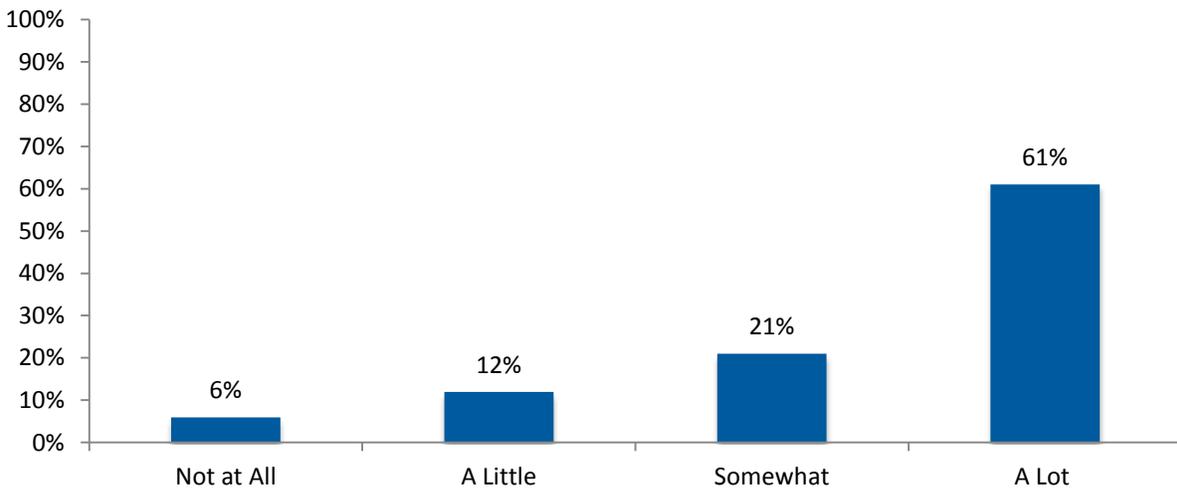
The survey also assessed members' overall satisfaction with their primary clinician who provided most of their counseling and treatment. Members were asked to rate the quality of their clinician on a 0- to 10-point scale (from worst to best). Seventy-two percent gave their clinician a high satisfaction rating (a 9 or 10). The mean clinician rating was 8.82 (SD = 2.05).

Perceived Outcomes of Behavioral Health Counseling and Treatment

Members were asked a series of questions about how behavioral health counseling or treatment has helped improve their quality of life and daily functioning. Most members felt they had benefited to some extent from the behavioral health counseling or treatment they received in the past 12 months. Sixty-one percent of members reported that, in the last 12 months, they had benefitted "a lot" from their counseling or treatment (**Figure 12**). To examine whether responses to this question varied by the member's primary behavioral health diagnosis, the external quality review organization conducted an analysis of this item for each of the three most prevalent primary diagnostic groups in the STAR+PLUS Behavioral Health Survey – mood disorders, psychotic disorders, and substance-related disorders. Compared to members in the survey

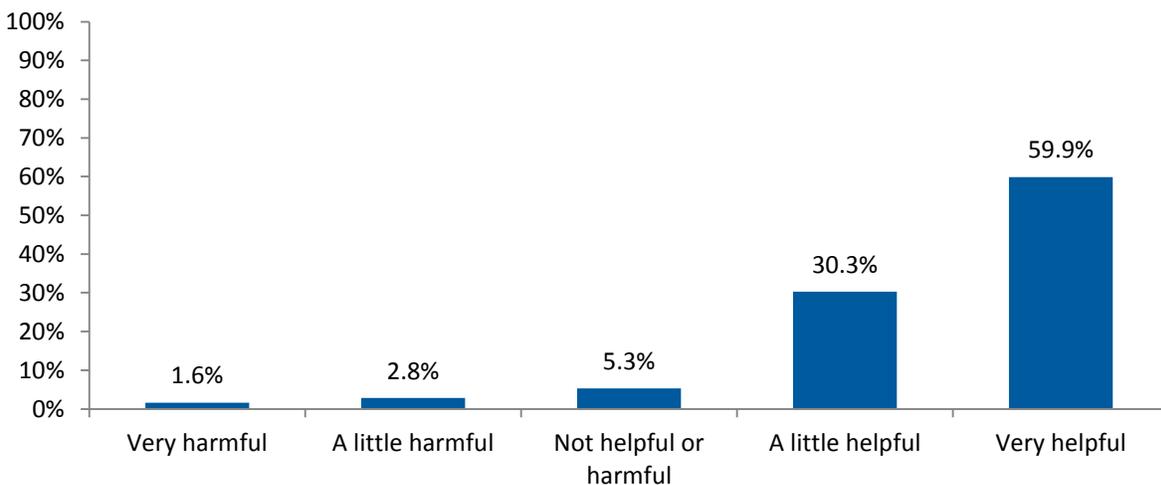
without substance-related disorders, a significantly lower percentage of members with substance-related disorders reported they were helped “a lot” by the counseling or treatment they had received (62 percent vs. 52 percent). There were no significant differences in the percentage who were helped “a lot” for members with mood disorders (60 percent) or psychotic disorders (67 percent).⁴⁵

Figure 12. How Much Was the STAR+PLUS Member Helped by Counseling or Treatment?



The impact of counseling or treatment on member’s quality of life was also assessed (**Figure 13**). Among members, 60 percent reported that counseling or treatment was “very helpful” in improving their quality of life, and 30 percent reported that counseling or treatment was “a little helpful” in improving their quality of life. A much smaller percentage of members (4 percent) reported that the counseling or treatment they received was “a little harmful” or “very harmful” to their quality of life.

Figure 13. Effect of Counseling or Treatment on STAR+PLUS Member’s Quality of Life



Perceived Improvement

Evaluating members' perceptions of their improvement provides a proxy for the quality and effectiveness of the behavioral health counseling and treatment they received in the past year. Four ECHO[®] survey items comprise the composite *Perceived Improvement*, which assesses respondents' perceptions of their ability to deal with daily problems and social situations, to accomplish the things they want to do, and the overall improvement in their problems or symptoms. The greatest area of improvement was in members' ability to deal with daily problems. Sixty-one percent said they were "a little better" or "much better" in their ability to deal with daily problems, compared to 12 months ago. In addition, half of respondents reported they were "a little better" or "much better" in their ability to deal with social situations (54 percent), and in their problems or symptoms (52 percent).

Thirty-one percent of members reported their problems, symptoms, and ability to manage their lives had not changed in the last year, and 17 percent reported that things had become "a little worse" or "much worse." These results indicate that certain members are not benefitting from their behavioral health counseling and treatment.

Recommendations

The external quality review organization recommends the following strategies to Texas HHSC and Medicaid managed care organizations for improving the delivery and quality of behavioral health care:

Child Health Status and Mental Health – Obesity and Disruptive Behaviors. STAR managed care organizations should continue to provide treatment and preventive efforts to reduce behavior problems among children and adolescents. Among STAR child members, the primary diagnosis for behavioral health was disruptive behaviors, followed by adjustment problems and mood disorders. The presence of problem behaviors during childhood is related to development of many risk behaviors and clinical diagnosis (e.g. abuse and dependence, depression and anxiety, suicide, sexual risk behaviors) during adolescence and adulthood.⁴⁶ It is also important to identify children and adolescents with obesity/behavioral disorder co-morbidities and devise prevention and treatment programs to meet the special needs of these members. It is critical to address obesity among children and adolescents because it affects a large proportion of child STAR members with behavioral health conditions. Moreover, weight-based stigmatization experienced by these members may be associated with more severe behavioral illness symptoms and a lower likelihood of seeking treatment.⁴⁷ In addition, the Substance Abuse and Mental Health Services Administration recommends the following initiatives to promote behavioral health among children: (1) early childhood interventions (e.g., home visits for pregnant women, pre-school psychosocial activities); (2) programs to increase social skills among children (e.g., skills building programs, child and youth development programs); (3) incorporation of school-based activities to promote behavioral health (e.g., programs supporting ecological changes in schools); (4) violence prevention programming; and (5) structural and community development programs. The Department of Health and Human Services and the Institute of Medicine are also calling on schools to enhance early identification methods to assess and connect students with behavioral health.⁴⁸

Access to Behavioral Counseling or Treatment. STAR+PLUS managed care organizations should maintain members' positive experiences with doctor's communication and continue efforts to maintain the quality of clinician-patient communication for members with behavioral health conditions. The AHRQ developed useful web-based resources for encouraging better two-way communication between clinicians and patients, including⁴⁹: (1) a series of videos featuring real patients and clinicians discussing the importance of asking questions and sharing information; (2) an interactive "Question Builder" tool that enables patients to create a personalized list of questions based on their health conditions; and (3) notepads designed for use in medical offices to help patients prioritize their questions for the clinician. In addition, it is important to provide access to local behavioral health services (e.g. crisis hotlines) and referral information to seek emergency or crisis counseling or treatment services. For instance, members can contact the crisis hotline of the Local Mental Health Authority (LMHA) for their county.⁵⁰ For behavioral health services for children and adolescents in STAR, professionals can utilize an intensive-based approach to service delivery, where services are provided based on the continuum of behavioral health. For instance, Levels of Care (LOCs) have been designed to make services available that correspond to the intensity and complexity of the identified needs of the youth.⁵¹

Appendix A. Supplementary Tables

Table A1. Primary Mental Health Diagnosis Categories

Primary Diagnosis/Disorder Categories	Examples of Diagnoses Within Category
Adjustment	Adjustment disorder with depressed mood Adjustment disorder with anxiety
Anxiety	Panic disorder Hysteria unspecified Identity disorder
Disruptive behavior	Attention-deficit disorder Attention-deficit/hyperactivity disorder Conduct disorder Oppositional defiant disorder
Cognitive	Delirium Dementia Amnesic and other cognitive disorders
Developmental	Communication disorders Developmental disabilities Intellectual disabilities Learning disorders Motor skills disorders
Disorders usually diagnosed in infancy, childhood, or adolescence	Elimination disorders Pervasive developmental disorders Tic disorders
Mood	Bipolar disorders Depressive disorders
Psychotic	Schizophrenia Other psychotic disorders
Substance-related	Alcohol-related disorders Drug-related disorders
Miscellaneous mental	Dissociative disorders Eating disorders Factitious disorders Mental disorders due to general medical conditions not elsewhere classified Other miscellaneous mental conditions Psychogenic disorders Sexual and gender identity disorders Sleep disorders Somatoform disorders

Table A2. Survey Quota Weighting Strategy, STAR Child Survey

Managed Care Organization / Behavioral Health Organization - Age group	Eligible members (N)	Completed surveys (n)	Weight
STAR - Child (< 13)	22,965	310	74.08
STAR - Adolescent (13-17)	14,356	302	47.54
NorthSTAR - Child (< 13)	2,638	301	8.76
NorthSTAR - Adolescent (13-17)	1,516	310	4.89
Member Race/Ethnicity	Members contacted (%)	Members participating (%)	Weight
White, non-Hispanic	21.8%	21.0%	1.04
Black, non-Hispanic	17.4%	15.8%	1.10
Hispanic	57.3%	59.9%	0.96
Other, non-Hispanic	3.6%	3.3%	1.09

Note: The final weight was calculated by multiplying the group weight by the weight modifier. Analyses were run to test for statistically significant participation differences in age, race/ethnicity, and sex variables. Participation varied significantly by race; therefore, race was included as a modifier.

Table A3. Survey Quota Weighting Strategy, STAR+PLUS Adult Survey

Managed Care Organization/ Behavioral Health Organization	Eligible members (N)	Completed surveys (n)	Weight
Amerigroup (Medicaid-only)	33,539	311	107.84
Cigna-HealthSpring (Medicaid-only)	3,945	183	21.56
Molina (Medicaid-only, excluding Dallas SA)	12,160	305	39.87
Superior (Medicaid-only, excluding Dallas SA)	20,864	310	67.30
UnitedHealthcare (Medicaid-only)	15,183	301	50.44
Statewide dually eligible individuals	125,619	310	405.22
Molina (Medicaid-only, Dallas SA)	10,084	316	31.91
Superior (Medicaid-only, Dallas SA)	7,282	304	23.95

Note: Analyses were run to test for statistically significant participation differences in age, race/ethnicity, and sex, but none were found. Therefore, no modifiers were needed.

Endnotes

¹ U.S. Department of Health and Human Services. 1999. *Mental Health: A Report of the Surgeon General*. Rockville, MD.

² U.S. Department of Health and Human Services. 2011. *National Prevention Council, National Prevention Strategy*. Washington, DC, Office of the Surgeon General, 2011. Available at: <http://www.surgeongeneral.gov/initiatives/prevention/strategy/report.pdf>

³ The Legislative Budget Board Staff (LBBS). 2009. *Texas State Government Effectiveness and Efficiency: Selected Issues and Recommendations*. Available at: <http://www.lbb.state.tx.us/>

⁴ Schoenfelder, T. 2012. "Patient satisfaction: A valid indicator for the quality of primary care?". *Primary Health Care*, 2(4). Retrieved from <http://dx.doi.org/10.4172/2167-1079.1000e106>

⁵ Gabel, S., M. Radigan, R. Wang, L.I. Sederer. 2011. "Health monitoring and promotion among youths with psychiatric disorders: program development and initial findings." *Psychiatric Services* 62(11): 1331-1337.

⁶ To correct for non-response bias, we used a sampling weight scheme based three steps: (1) calculate the base weight, (2) adjust for unit non-response, and (3) adjust to population size. This methodology is similar to national studies, such as the National Health and Nutrition Examination Survey. Available at: <http://www.cdc.gov/nchs/tutorials/dietary/surveyorientation/surveydesign/intro.htm>

⁷ Green, J.G., K.A. McLaughlin, M. Alegría, E.J. Costello, M.J. Gruber, K. Hoagwood, P.J., Leaf, S. Olin, N.A. Sampson, & R.C. Kessler. 2013. "School mental health resources and adolescent mental health service use". *Journal of the American Academy of Child & Adolescent Psychiatry* 52(5): 501-510.

⁸ Russell-Mayhew, S., G., Mc Vey, A. Bardick, & A. Ireland. 2012. "Mental Health, Wellness, and Childhood Overweight/Obesity." *Journal of Obesity*, doi: 10.1155/2012/281801.

⁹ Russell-Mayhew et al. 2012.

¹⁰ Jessor, R. 1991. "Risk behavior in adolescence: A psychosocial framework for understanding and action". *Journal of Adolescent Health*, 12, 597-605.

¹¹ Green et al. 2013.

¹² Green et al. 2013.

¹³ AHRQ (Agency for Healthcare Research and Quality). 2011. "AHRQ: Initiative Encourages Better Two-way Communication Between Clinicians and Patients." Available at: <http://www.ahrq.gov/news/press/pr2011/questionspr.htm>

¹⁴ Texas Department of State Health Services. 2013. How to Get Help – Mental Health. Available at: <http://www.dshs.state.tx.us/layouts/contentpage.aspx?pageid=35979&id=51143&terms=emergency+crisis+mental+health+services>

¹⁵ Texas Department of State Health Services. 2013. Child and Adolescent Mental Health Services. Available at: <http://www.dshs.state.tx.us/mhsa/cmh/>

¹⁶ U.S. Department of Health and Human Services. 1999.

¹⁷ HHSC (Texas Health and Human Services Commission). 2013a. *Texas Medicaid in Perspective, Ninth Edition*. "Chapter 7: Medicaid Managed Care." Available at <http://www.hhsc.state.tx.us/medicaid/reports/pb9/pinkbook.pdf>

¹⁸ HHSC (Texas Health and Human Services Commission). 2013b. "STAR+PLUS Overview." Available <http://www.hhsc.state.tx.us/starplus/overview.shtml>

¹⁹ The Legislative Budget Board Staff (LBBS). 2009. *Texas State Government Effectiveness and Efficiency: Selected Issues and Recommendations*. Available at: <http://www.lbb.state.tx.us/>.

²⁰ Schoenfelder. 2012.

²¹ Gabel et al. 2011.

²² The survey datasets include all unique cases. However, because multiple interviewers can call on the same quotas simultaneously, near the end of the study certain quotas can be exceeded.

²³ The response rate represents the number of completed or partially completed surveys divided by the number of verified, eligible households that could be contacted. The cooperation rate represents the number of completed or partially completed surveys divided by the number of members who either participated or refused.

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²⁶ Consumer Assessment of Healthcare Providers and Systems (CAHPS[®]). 2014. *Experience of Care & Health Outcomes (ECHO)*. Available at: <https://www.cahps.ahrq.gov/surveys-guidance/echo/index.html>.

²⁷ National Center for Health Statistics. 2008. *National Health Interview Survey*. Available at: <http://www.cdc.gov/nchs/nhis.htm>.

²⁸ U.S. Census Bureau. 2008. *Current Population Survey*. Available at: <http://www.census.gov/cps>.

²⁹ Urban Institute. 2008. *National Survey of America's Families*. Available at: <http://www.urban.org/center/anf/nsaf.cfm>

³⁰ Owens P, Myers M, Elixhauser A, Brach C. 2007. Care of Adults With Mental Health and Substance Abuse Disorders in U.S. Community Hospitals, 2004. Agency for Healthcare Research and Quality, HCUP Fact Book No.10. AHRQ Publication No. 07-0008. ISBN 1-58763-229-2. Available at: <http://archive.ahrq.gov/data/hcup/factbk10/>

³¹ This is the racial/ethnic distribution of members as determined from the enrollment data, which differs slightly from the distribution by self-report. Because self-report race/ethnicity is available only for members who participated, the enrollment data must be used for this analysis.

³² To correct for non-response bias, we used a sampling weight scheme based three steps: (1) calculate the base weight, (2) adjust for unit non-response, and (3) adjust to population size. This methodology is

similar to national studies, such as the National Health and Nutrition Examination Survey. Available at: <http://www.cdc.gov/nchs/tutorials/dietary/surveyorientation/surveydesign/intro.htm>.

³³ Owens et al. 2007

³⁴ The “miscellaneous disorders” category includes dissociative disorders, eating disorders, and other mental disorders as listed in Table A1 of Appendix A.

³⁵ Thirty percent of the STAR Child members were missing the height variable, and 10 percent were missing the weight variable. Therefore, BMI was not calculated for 39 percent of the sample.

³⁶ National Center for Health Statistics (NCHS). 2000. “Clinical Growth Charts: BMI-for-Age.” Available at: <http://www.cdc.gov/growthcharts/>

³⁷ World Health Organization. 2009. “WHO Child Growth Standards.” Available at: <http://www.who.int/childgrowth/software/en/>

³⁸ Texas Department of State Health Services. 2010. “Texas Overweight and Obesity Statistics.” *Texas Department of State Health Services*.

³⁹ Texas Medicaid and Healthcare Partnership (TMHP). 2010. *Texas Medicaid Provider Procedures Manual. 7.4.1. Annual Encounters/Visits Limitations*. Available at: <http://www.tmhp.com/HTMLmanuals/TMPPM/2010/2010TMPPM-18-066.html>

⁴⁰ A total of six caregivers in the sample reported that the request for additional treatment was denied.

⁴¹ Disruptive behavior disorders ($p = 0.08$); Adjustment disorders ($p = 0.43$); Mood disorders ($p = 0.95$).

⁴² Owens et al. 2007

⁴³ CDC (Centers for Disease Control and Prevention). 2011. U.S. Obesity Trends. Available at: <http://www.cdc.gov/obesity/data/trends.html>

⁴⁴ Texas Medicaid and Healthcare Partnership (TMHP). 2010

⁴⁵ Mood disorders ($p = 0.21$); Psychotic disorders ($p = 0.16$); Substance use disorders ($p < 0.001$).

⁴⁶ Jessor, R. 1991

⁴⁷ Russell et al. 2012

⁴⁸ Green et al., 2013

⁴⁹ AHRQ (Agency for Healthcare Research and Quality). 2013

⁵⁰ Texas Department of State Health Services. 2013. How to Get Help – Mental Health

⁵¹ Texas Department of State Health Services. 2013. Child and Adolescent Mental Health Services.