



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

# **Texas Medicaid Managed Care STAR Adult Behavioral Health Survey Report**

**Fiscal Year 2012**

**Measurement Period:**

**September 1, 2011 through August 31, 2012**

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

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

## Table of Contents

Executive Summary.....	1
Introduction and Purpose.....	5
Methodology.....	7
Sample Selection Procedures.....	7
Survey Instruments.....	7
Survey Data Collection Techniques.....	8
Data Analysis.....	8
Survey Results.....	8
Demographic Characteristics.....	8
Health Status.....	9
Mental Health Diagnosis.....	9
Body Mass Index.....	10
Utilization of Behavioral Health Care.....	12
Access to and Timeliness of Behavioral Health Care.....	13
Getting Treatment Quickly.....	13
Office Wait.....	14
Members' Rating of Counseling or Treatment.....	15
Patient-Centered Care.....	15
Clinician Communication and Shared Decision-Making.....	15
Patient Information about Treatment and Management of their Condition.....	17
Patient Rights and Privacy.....	19
Cultural Competence.....	19
Members' Ratings of Their Clinician and Counseling.....	19
Perceived Outcomes of Behavioral Health Care.....	19
Behavioral Health Treatment Benefits and Assistance.....	22
Benefits.....	22
Getting Treatment, Information, and Assistance.....	23
Members' Rating of Their Health Plan or BHO.....	25
Behavioral Health Delivery Model Comparison.....	25
Summary Points and Recommendations.....	26
Appendix A. Detailed Methodology.....	32
Appendix B. Supplementary Tables.....	36
Endnotes.....	40

## List of Tables

Table 1. Reasons Why Members Visited the Emergency Room or Crisis Center.....	12
Table 2. ECHO® Composites and Ratings, by BH Delivery Model .....	25
Table A1. STAR Adult Behavioral Health Survey Sampling Strategy .....	32
Table A2. Survey Weighting Strategy .....	35
Table B1. Primary Mental Health Diagnoses for Sampling.....	37
Table B2. ECHO® Composite Scores, by Member Demographics .....	38
Table B3. ECHO® Ratings, by Member Demographics .....	39

## List of Figures

Figure 1. Member Reports of Overall Health and Mental Health .....	10
Figure 2. Mental Health Diagnostic Categories .....	10
Figure 3. BMI Classification of STAR Members .....	11
Figure 4. How Often Members Got Needed Counseling or Treatment Quickly.....	14
Figure 5. How Often Member Was Seen Within 15 Minutes of Appointment* .....	15
Figure 6. Percentage of Members Reporting Positive Communication with Their Clinician .....	16
Figure 7. Percentage of Members Provided Information to Better Manage Their Condition .....	17
Figure 8. Percent of Members Provided Information about Medication and Side Effects* .....	18
Figure 9. How Much Was the Member Helped by Counseling or Treatment? .....	20
Figure 10. Ratings of Recovery and Overall Mental Health.....	21
Figure 11. Members' Ratings of Improvement .....	22
Figure 12. STAR MCO Member Experiences Getting Treatment and Information.....	24

# Executive Summary

## Introduction

The Institute for Child Health Policy (ICHP) is the External Quality Review Organization (EQRO) contracted by the Texas Health and Human Services Commission to evaluate members' satisfaction with their behavioral health care services while enrolled in the STAR program. In fiscal year (FY) 2012, as part of external quality reviews for the state of Texas, ICHP conducted a set of satisfaction surveys of adult STAR and NorthSTAR members who received behavioral health services in the past six months.

The purpose of the FY 2012 STAR Adult Behavioral Health Survey is to:

- Describe the demographic and health profile of adult members with behavioral health conditions.
- Document member experiences and satisfaction with the behavioral health care they received through their STAR managed care organization (MCO) or behavioral health organization (BHO) across five domains of care:
  - Utilization of behavioral health care
  - Access to and timeliness of behavioral health care
  - Patient-centered care
  - Perceived outcomes of behavioral health care
  - Behavioral health treatment benefits and assistance
- Compare the performance of the three behavioral health delivery models (STAR MCO, STAR BHO, and NorthSTAR) on the Experience of Care and Health Outcomes (ECHO®) composites and member ratings.

## Methodology

Survey participants were selected from a stratified random sample of adults 18 to 64 years old who were enrolled in STAR or NorthSTAR between July 2011 and December 2011, and who had a record of one or more mental health/chemical dependency diagnoses and procedure combinations during the measurement period. The EQRO set a target sample of 900 completed telephone interviews, representing 300 respondents for each of three distinct behavioral health delivery models: (1) STAR MCO; (2) STAR BHO; and (3) NorthSTAR.

The FY 2012 STAR Adult Survey included:

- The ECHO® Survey 3.0.<sup>1</sup>
- Items developed by ICHP pertaining to member demographic and household characteristics.

## Summary of Findings

### Demographic and Health Profile of STAR Behavioral Health Survey participants:

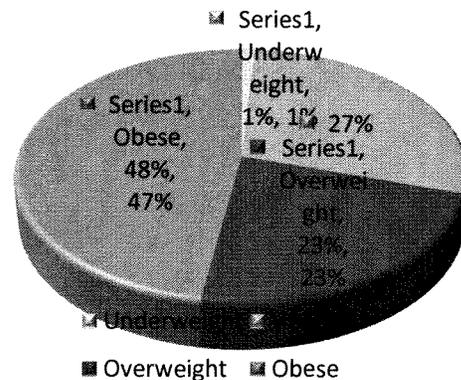
- The average age was 31 years old.
- Hispanic members were the most common racial/ethnic group (52 percent), followed by White, non-Hispanic members (24 percent), and Black, non-Hispanic members (19 percent).
- Thirty percent of members did not complete high school.
- Two-thirds of members were unemployed (67 percent).
- Most members were single (59 percent), one-quarter of members were divorced or separated (23 percent), and 10 percent were married.
- The vast majority of members lived with at least one other person (more than 99 percent), with an average of four people per household.
- One third of members rated their mental health as fair or poor.

### Positive findings

- **Patient Information about Treatment and Management of their Condition.** Seventy-six percent of members felt they could refuse a medicine or treatment suggested by their clinician.
- **Ratings of Clinician.** Members were satisfied with their primary clinicians, giving them a mean rating of 8.7 out of 10, with 68 percent of members giving a rating of 9 or 10.
- **Getting Treatment, Information, and Assistance.** The vast majority of members that talked with office staff said that they were treated with courtesy and respect.
- **Perceived Improvement.** About half of members said they were helped a lot by their care (44 percent).

### Improvement areas

- **Body mass index (BMI).** Over two-thirds of members were overweight or obese (72 percent); half of all members were obese (48 percent), and obesity rates were particularly high among women (50 percent).



- **Getting timely telephone counseling.** Timeliness of care for phone counseling was low. Among members who reported they tried to get counseling on the phone, only 37 percent said they usually or always got phone counseling in a timely manner, with a full 30 percent of members saying that they never got phone counseling when needed.
- **Benefits.** Twenty-one percent of members indicated that they used up all of their benefits; of this group, 68 percent said that they still needed counseling or treatment services, and less than half reported being told of other ways to receive counseling or treatment (41 percent).
- **Getting Treatment, Information, and Assistance.** Among members who reported they needed approval for counseling or treatment in the last six months, over a third said that they had a “big problem” with delays in treatment while they awaited approval (37 percent).

ECHO® Composite Scores

<b>Composite</b>	<b>Mean (SD)</b>	<b>Range</b>
<i>Getting Treatment Quickly</i>	1.96 (SD = 0.77)	1.00 – 3.00
<i>How Well Clinicians Communicate</i>	2.26 (SD = 0.72)	1.00 – 3.00
<i>Information About Treatment Options</i>	0.50 (SD = 0.43)	0.00 – 1.00
<i>Perceived Improvement</i>	2.78 (SD = 0.91)	1.00 – 4.00

## Recommendations

The EQRO recommends the following strategies for STAR and NorthSTAR, and their contracted MCOs and BHOs, to improve quality of care for adults receiving behavioral health services:

Domain	Recommendations	Rationale
Obesity among members with behavioral health conditions	<ul style="list-style-type: none"> <li>• Both STAR MCOs and BHOs should implement or improve upon efforts to measure and manage members' obesity. Potential strategies include:               <ul style="list-style-type: none"> <li>○ Standardized programs, such as those implemented by the New York State Office of Mental health to monitor weight of patients in outpatient settings;<sup>2</sup></li> <li>○ Behavior modification specifically targeting members with mental illness to reduce calorie intake, increase physical activity, and avoid medications with high weight gain risk.<sup>3</sup></li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Half of all STAR BH members were obese (48 percent), and women had a particularly high obesity rate (50 percent).</li> <li>• Research has shown that adults with mental disorders die, on average, 25 years earlier than adults in the general population, and obesity is a likely contributor. In addition, obesity is an obstacle to full participation in society, and can contribute to and/or exacerbate barriers present due to mental illness.<sup>4</sup></li> </ul>
Information about additional counseling options	<ul style="list-style-type: none"> <li>• For members needing additional counseling and treatment, beyond what is covered by the health plan, MCO and BHO network providers should be aware of and educate members about resources in their community, including:               <ul style="list-style-type: none"> <li>○ Self-help groups, which members can utilize at no cost.</li> <li>○ Other low-cost treatment options for anxiety and depression, such as therapy offered through federally funded health centers and</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• A substantial minority (about one-fifth) of members reported having used up all their BH benefits. Among these members, less than half said they were told of other ways to get counseling.</li> <li>• In addition, less than half (42 percent) of members were told about self-help or support groups, such as consumer-run groups or 12-step programs</li> <li>• Continuity of care for members needing BH counseling or treatment is essential for</li> </ul>

Domain	Recommendations	Rationale
	through local colleges and universities. <sup>5</sup>	ensuring the continued alleviation of mental illness symptoms, meaningful participation in society, and reducing costs associated with preventable hospitalizations.

## Introduction and Purpose

The Texas STAR program offers behavioral health care services for members with mental health or substance abuse disorders. Services include psychotherapy, inpatient psychiatric care, case management, and prescription benefits.<sup>6</sup> Members in the STAR program receive behavioral health services through three distinct models, depending on their managed care organization (MCO) and service area (SA). While some MCOs offer behavioral health as part of their integrated benefits package, others carve out behavioral health services to a sub-contracted behavioral health organization (BHO). STAR members living in the Dallas SA receive behavioral health care through the NorthSTAR program, which contracts with a BHO.

In 2009, the Texas Legislative Budget Board staff (LBB) recommended that the state implement surveys to assess member satisfaction and experiences with the behavioral health services they receive through their Medicaid MCO or BHO.<sup>7</sup> Member satisfaction surveys can identify aspects of behavioral health services and treatment that are important to patients. In addition, satisfaction surveys can help programs determine areas of behavioral health care that need improvement.<sup>8</sup> Members' satisfaction with their health care is an important indicator of health care quality and highlights members' preferences and needs.<sup>9</sup>

In Fiscal Year (FY) 2012, as part of external quality review activities for the State of Texas, the Institute for Child Health Policy (ICHP) conducted a survey of adult STAR members who had been diagnosed with a behavioral health condition in the past 12 months.

The purpose of the FY 2012 STAR Adult Behavioral Health Survey is to:

- Describe the demographic and health profile of adult members with behavioral health conditions.
- Document member experiences and satisfaction with the behavioral health care they received through their STAR MCO or BHO across five domains of care:
  - Utilization of behavioral health care
  - Access to and timeliness of behavioral health care
  - Patient-centered care
  - Perceived outcomes of behavioral health care
  - Behavioral health treatment benefits and assistance

- Compare the performance of the three behavioral health delivery models (STAR MCO, STAR BHO, and NorthSTAR) on the ECHO® composites and member ratings.

## Methodology

This section provides a brief overview of the methodology used to generate this report. Detailed descriptions of sample selection procedures, survey instruments, data collection, and data analyses are provided in Appendix A.

### **Sample Selection Procedures**

The EQRO selected survey participants from a random sample of adults 18 to 64 years old who were enrolled in STAR or NorthSTAR between July 2011 and December 2011, and who had a record of one or more mental health/chemical dependency diagnoses and procedure combinations during the measurement period (see **Table B1** in **Appendix B**). The sample included members who were enrolled in the same MCO, with no more than one 30-day break in enrollment, and was stratified to permit inclusion of members receiving services through three distinct behavioral health (BH) delivery models: (1) STAR MCO; (2) STAR BHO; and (3) NorthSTAR. A target of 900 completed surveys was set, representing 300 surveys for each of the three BH delivery models.

### **Survey Instruments**

The FY 2012 STAR Adult Behavioral Health Survey included:

- ECHO<sup>®</sup> Survey 3.0.<sup>10</sup>
- Items developed by ICHP pertaining to member demographic and household characteristics.

The ECHO<sup>®</sup> Survey is part of the Consumer Assessment of Healthcare Providers and Systems (CAHPS<sup>®</sup>) family of surveys. The adult version assesses patients' experiences and satisfaction with different 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. The EQRO calculated ECHO<sup>®</sup> composite scores in the following domains:

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

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

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

## **Survey Data Collection Techniques**

The EQRO sent letters written in English and Spanish to 3,684 STAR members and 539 NorthSTAR members who met the sample criteria, requesting their participation in the survey.

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

## **Data Analysis**

Descriptive statistics and statistical tests were performed using SPSS 19.0 (Statistical Package for the Social Sciences, predictive analytics software) and focused on the ECHO<sup>®</sup> composite measures and ratings. Statistical tests of differences were conducted among members in the STAR MCO, STAR BHO, and NorthSTAR groups, and among relevant demographic sub-groups of the sample.

## **Survey Results**

This section presents survey findings for adults with behavioral health conditions in STAR regarding: 1) Demographic characteristics; 2) Health status; 3) Utilization of behavioral health care; 4) Access to and timeliness of care; 4) Patient-centered care; 5) Perceived outcomes of behavioral health care; and 6) Behavioral health treatment benefits and assistance.

### **Demographic Characteristics**

The majority of survey respondents were female (86 percent), and the mean age among all respondents was 31 years old. Hispanic members represented the largest racial/ethnic group (52 percent), followed by White, non-Hispanic members (24 percent) and Black, non-Hispanic members (19 percent). Five percent of surveyed members were of “Other” race/ethnicity. The vast majority of members stated the language spoken in their home was English (89 percent).

Overall, STAR members had low employment status, moderate educational background, were most likely to be single, and most likely to live in a single-parent household.

- About a third of members had not attained a high school diploma (30 percent), while the rest had at least a high school diploma or equivalent (70 percent).

	<b>STAR Members</b>
<b>Mean Age (years)</b>	30.8 (SD = 10.1)
<b>Sex</b>	
<b>Female</b>	86%
<b>Male</b>	14%
<b>Race/Ethnicity</b>	
<b>Hispanic</b>	52%
<b>White, Non-Hispanic</b>	24%
<b>Black, Non-Hispanic</b>	19%
<b>Other</b>	5%

- The majority of members said they were not employed in the 6 months prior to the time of the survey (67 percent); however, one in seven members reported having been employed for all of the 6 months prior to the time of the survey (15 percent).
- More than half of members reported being single (59 percent). Divorced and separated individuals represented a combined 23 percent of the sample, and married individuals represented 10 percent of the sample.
- About two-thirds of members reported that they lived in a single-parent household (72 percent). Households most typically had three or four people living in them (26 percent and 25 percent, respectively), while less than one percent of members reported living alone.

### **Health Status**

**Figure 1** presents member self-reported ratings of their overall health and mental health. Members provided slightly more favorable ratings of their mental health compared with their overall health.

Over half of members rated their *overall health* as at least 'good' (57 percent), compared with 64 percent who rated their *mental health* as at least 'good.'

### **Mental Health Diagnosis**

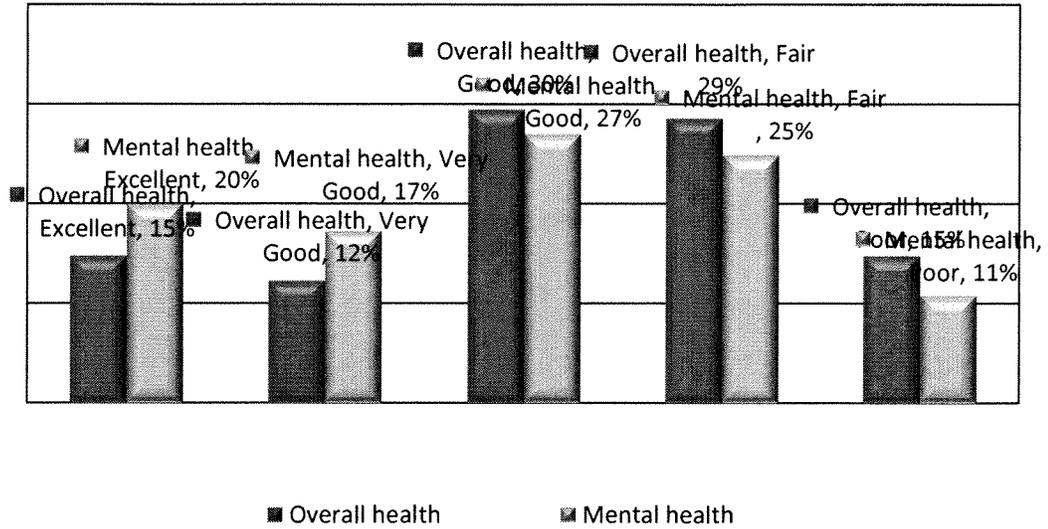
The EQRO obtained a primary mental health diagnosis from claims data for adults in the STAR Behavioral Health survey sample. To summarize this data, mental health diagnoses were grouped into the following eight categories based on the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) classification system: 1) Adjustment Disorders; 2) Anxiety Disorders; 3) Attention-Deficit Hyperactivity Disorder; 4) Bipolar Disorders; 5) Depressive Disorders; 6) Schizophrenia and Other Psychotic Disorders; and 7) Substance Abuse and Dependence Disorders.<sup>11</sup> **Appendix B** contains a list of specific mental health diagnoses included in each of the above categories.

**Figure 2** provides the percentage of STAR adults with a primary mental health diagnosis in each category. The most common primary mental health diagnoses among adults in the STAR sample were mood disorders. Thirty-four percent of adults had a depressive disorder, and 19 percent had a bipolar disorder.

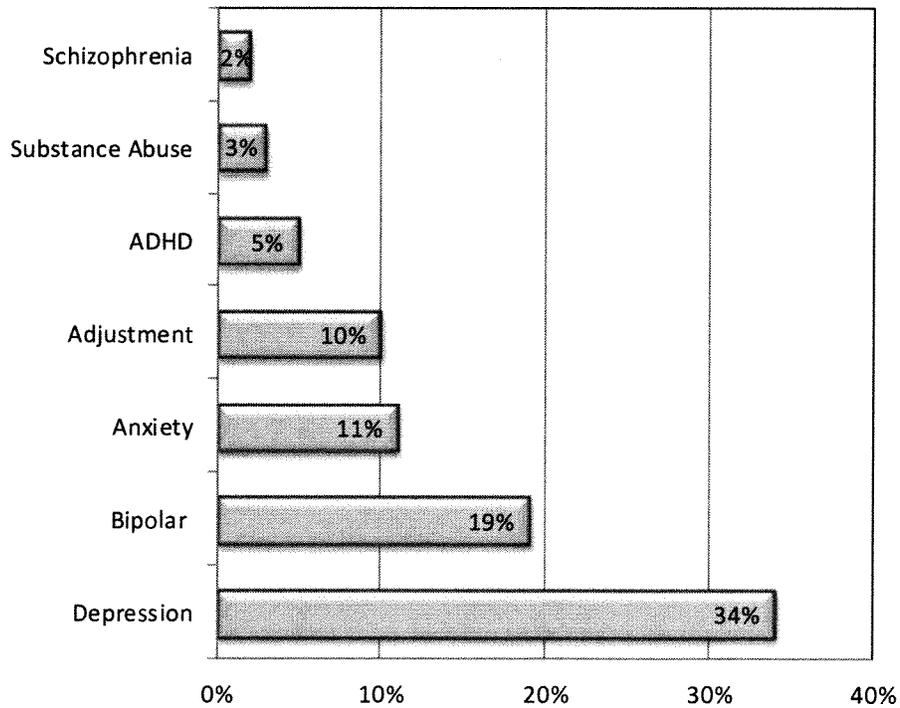
Eleven percent had an anxiety disorder, and 11 percent had an adjustment disorder. Few adults in the STAR sample had either a substance abuse disorder (3 percent) or schizophrenia and other psychotic disorders (2 percent).

Comorbid mental health conditions were present in almost one-third of the sample. Twenty-nine percent of adults had two or more mental health diagnoses, and nine percent had three or more mental health diagnoses.

**Figure 1. Member Reports of Overall Health and Mental Health**



**Figure 2. Mental Health Diagnostic Categories**



Note. The diagnostic categories do not add up to 100 percent.

**Body Mass Index**

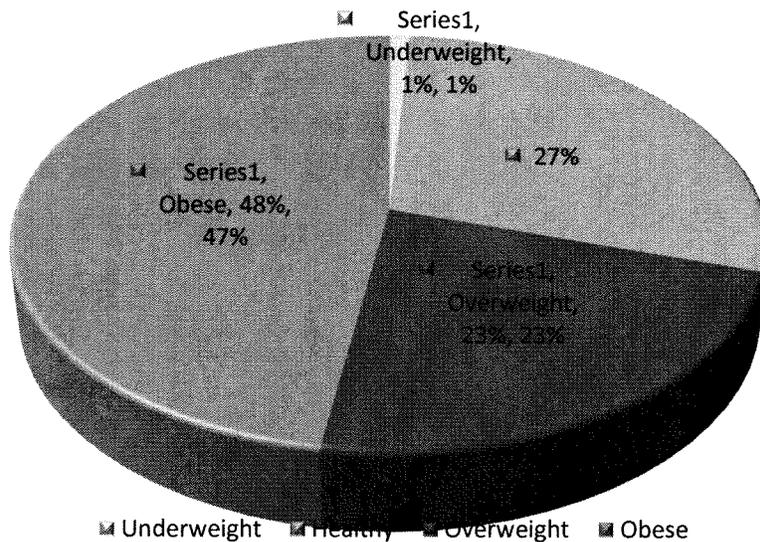
**Figure 3** provides the BMI results for members in the sample. Based on their weight and height data, nearly half of members were classified as obese (48 percent), and an additional one quarter were classified as overweight (23 percent). Members' obesity rate was considerably higher than that of adults in the national population (34 percent) or the Texas population (31 percent), as reported by the Centers for Disease Control and Prevention (CDC) in 2010.<sup>13</sup>

- Female members had a significantly higher rate of obesity than male members (50 percent vs. 37 percent).<sup>14</sup> The gender difference in the sample was greater than that observed for the U.S. adult population.

	% obese in population
Men	36%
Women	36%
Hispanic	38%
Non-Hispanic Black	50%
Non-Hispanic White	35%

<sup>a</sup> Based on the National Health Examination and Nutrition Survey, 2009-2010<sup>12</sup>

**Figure 3. BMI Classification of STAR Members**



## Utilization of Behavioral Health Care

Members were asked about their utilization of behavioral health services in the STAR program during the last 6 months. Overall,

- 63 percent reported attending a routine appointment for counseling or treatment.
- 18 percent said they called someone to get professional telephone counseling.
- 62 percent indicated that they took prescription medicine as part of their treatment.
- 32 percent stated they needed emergency counseling or treatment.
- 18 percent reported that they visited an emergency room or crisis center one or more times to get counseling or treatment.

Members who reported visiting an emergency room or crisis center for counseling or treatment were also asked the reasons why they visited the emergency room or crisis center. This type of open-ended question can provide detailed information on how members are utilizing emergency services for behavioral health related issues. The response rate of these members was 98 percent. **Table 1** shows the ten main reasons members visited the emergency room or crisis center for counseling or treatment.<sup>15</sup>

**Table 1. Reasons Why Members Visited the Emergency Room or Crisis Center**

Reason for trip to ED or Crisis Center	N	% Reported
Depression	26	21.5%
Anxiety/ "stressed out"/ panic attacks	25	20.7%
Physical Ailment	25	20.7%
Suicide Attempt or Thoughts	15	12.4%
Medication or Treatment Issues	13	10.7%
Schizophrenia/Bipolar	11	9.1%
Nervous breakdown/Traumatic Experience	10	8.3%
Other	10	8.3%
Generic Statement of Mental Health	5	4.1%
Family Issues	4	3.3%

<sup>a</sup> Percentages are based upon members who visited the emergency room or crisis center in the last six months. Total exceeds 100 percent because some respondents discussed multiple issues.

Anxiety, depression, and physical ailments were the most common reasons reported. The category "Physical Ailments" was included because mental health issues sometimes present with physical symptoms. This category should be interpreted with caution as these physical symptoms could also be associated with non-behavioral health related issues.

Members also reported whether the counseling or treatment they received in the last 6 months was for personal problems/family problems/mental illness, or for alcohol or drug use. Whereas the majority of members reported having received counseling or treatment for personal problems or mental illness (71 percent), only a small percent of members reported having received such services for drug use (5 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.

#### **Getting Treatment Quickly**

Members were asked about their immediate and routine needs for counseling or treatment across three domains. About one in five members said that they had called to get professional counseling by phone (18 percent), half of members made routine appointments for counseling or treatment (50 percent), and a third of members reported having immediate counseling or treatment needs (32 percent). Three ECHO® survey questions assess how often members were able to get these services when needed. **Figure 4** displays the percentage of members who were able to receive such services when they needed them.

- Among respondents who tried to get counseling over the phone, only 37 percent of respondents were able to obtain this service when needed, and 30 percent never received this service.
- Among respondents who made routine appointments for treatment or counseling, 66 percent reported that they were able to get a routine appointment as soon as they wanted.
- Among respondents who needed counseling or treatment right away, 58 percent reported that they received this service as soon as they wanted.

**Getting Treatment Quickly Items**

In the last 6 months...

How often did you get the professional counseling you needed on the phone?

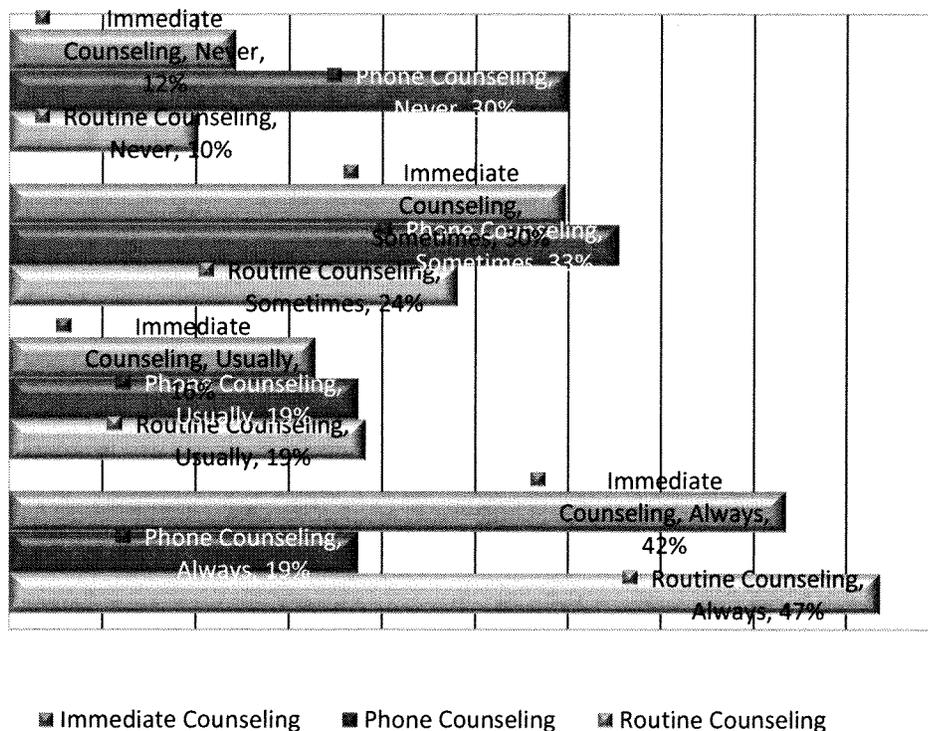
When you needed counseling or treatment right away, how often did you see someone as soon as you wanted?

Not counting the times you needed counseling or treatment right away, how often did you get an appointment for counseling or treatment as soon as you wanted?

These three survey items comprise the ECHO® composite *Getting Treatment Quickly*. The mean score for this composite was 1.96 (SD = 0.77) on a 3-point scale. Mean scores for *Getting Treatment Quickly* differed between members with different educational backgrounds. Specifically, members who had at least a high school diploma reported lowered scores than did members who did not have a high school diploma.<sup>16</sup> This discrepancy could be due to either genuine differences in timeliness of care or to differences in expectations about timeliness of care.

Overall, the results for these three survey items reveal that the timeliness of receiving counseling or treatment depends on the type of treatment (e.g., routine appointment, urgent, and telephone) that members need. When such services were needed, a majority of members were usually or always able to obtain immediate and routine counseling, while approximately one-third of members were able to obtain phone counseling.

**Figure 4. How Often Members Got Needed Counseling or Treatment Quickly\***



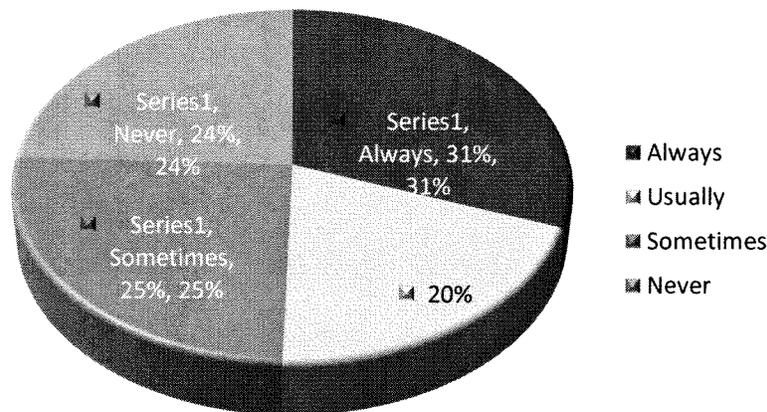
\*Percentages are based upon members who needed these services in the last six months

**Office Wait**

Sixty-three percent of members reported attending a routine appointment for counseling or treatment. These members were asked how often they were seen within 15 minutes of their appointment in the past 6 months. Figure 5 provides the results for how often members reported they waited less than 15 minutes before they were seen for counseling or treatment.

Half of members indicated they were usually or always seen within 15 minutes of their scheduled appointment (51 percent). The remaining half reported that they sometimes (25 percent) or never (24 percent) were seen within 15 minutes.

**Figure 5. How Often Member Was Seen Within 15 Minutes of Appointment\***



\*Percentages are based upon members who attended a routine visit in the last 6 months

### Members' Rating of Counseling or Treatment

When asked to rate their overall perceptions of their behavioral health counseling and treatment on a scale of 0 to 10, less than half of members gave a rating of 9 or 10 (44 percent). The mean rating for behavioral health counseling and treatment was 7.3 (SD = 3.1).

### Patient-Centered Care

#### Clinician Communication and Shared Decision-Making

The survey assessed aspects of patient-centered care, specifically members' satisfaction with their clinicians' communication skills and ability to engage them in treatment. Six ECHO<sup>®</sup> survey questions comprise the composite *How Well Clinicians Communicate*. This composite assesses how often the clinician or therapist listened carefully, explained things well, showed respect for their patients, spent enough time with them, made them feel safe, and involved them in treatment.

The mean for *How Well Clinicians Communicate* was 2.26 (SD = 0.72) on a 3-point scale. **Figure 6** 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.

#### How Well Clinicians Communicate Items

How often did the people you went to for counseling or treatment...

listen carefully to you?

explain things in a way you could understand?

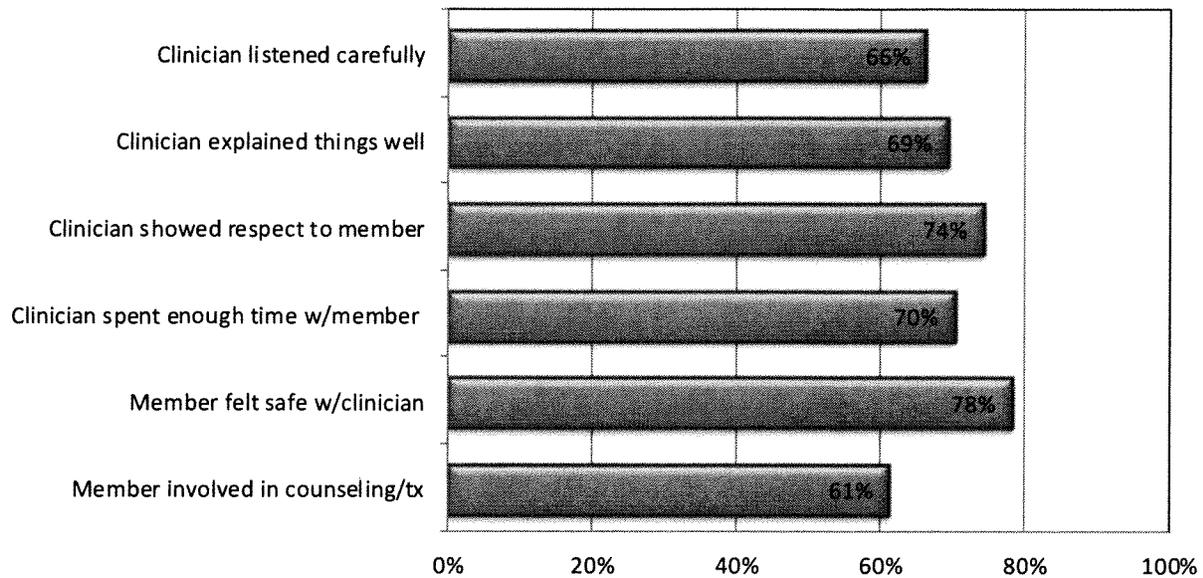
show respect for what you had to say?

spend enough time with you?

How often did you feel safe with the people you went to for counseling or treatment?

How often were you involved as much as you wanted in your counseling or treatment?

**Figure 6. The Percentage of Members Who Reported They *Usually* or *Always* Had Positive Communication Experiences with Their Clinician**



A majority of members were generally satisfied with their clinician and quality of communication:

- 66 percent said their clinician *usually* or *always* listened carefully to what they had to say.
- 69 percent said their clinician *usually* or *always* explained things well.
- 74 percent said their clinician was *usually* or *always* respectful to them.
- 70 percent said their clinician *usually* or *always* spent enough time with them.
- 78 percent said they *usually* or *always* felt safe with their clinician.
- 61 percent said they *usually* or *always* were involved as much as they wanted in their counseling and treatment.

Members’ assessment of their clinician varied by survey item, with the greatest percentage reporting they felt safe with their clinician (78 percent), followed by feeling respected by their clinician (74 percent).

A fraction of members were dissatisfied with the relationship they had with their clinician, particularly with not being involved in treatment and feeling that their clinician did not always explain things or listen carefully to what they had to say. Thirty-nine percent indicated they were not involved as much as they wanted in their counseling or treatment, which suggests that their clinicians may not be providing them with enough information and choices about treatment options. In addition, 34 percent were dissatisfied with their clinician’s listening ability, and 31 percent were dissatisfied with their clinician’s ability to explain things well.

## Patient Information about Treatment and Management of their Condition

Members were asked if their clinician or therapist provided them with pertinent information about treatment options. Two ECHO<sup>®</sup> survey items comprise the composite *Information about Treatment Options*, which 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.

### **Information about Treatment Options Items**

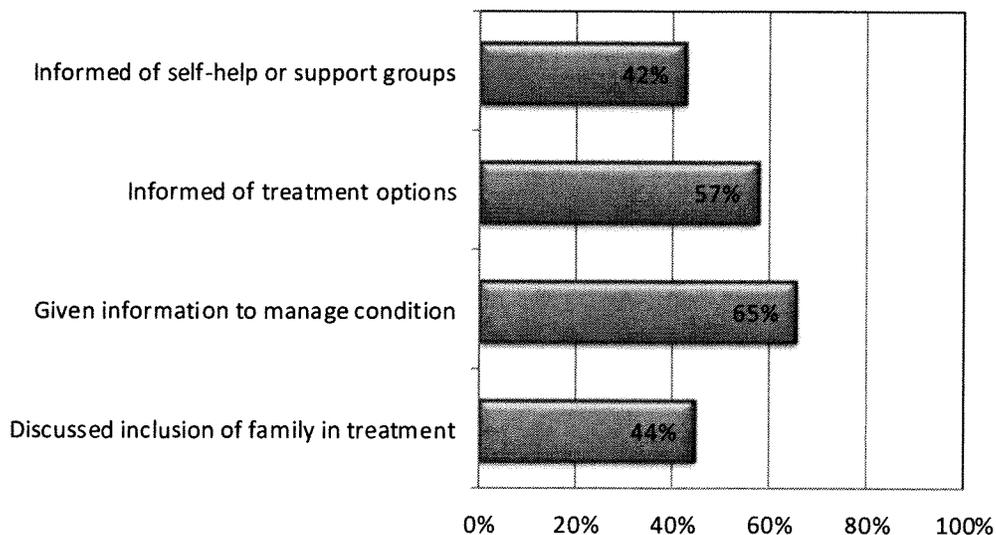
Were you told about self-help or support groups such as consumer run groups or 12-step programs?

Were you given information about different kinds of counseling or treatment that are available?

The mean for the *Information about Treatment Options* composite was 0.50 (SD = 0.43) on a scale from 0 to 1. Importantly, scores on this composite differed by member sex, such that women reported higher scores than men.<sup>17</sup> **Figure 7** provides results for the two survey items that comprise the *Information About Treatment Options* composite, and two additional items that assess whether members were provided with information and support to better manage their behavioral health condition.

- 42 percent reported they were told about self-help or support groups, such as consumer-run groups or 12-step programs.
- 57 percent reported they were informed about the counseling or treatment options available to them.
- 65 percent were given as much information as they needed to manage their condition.
- 44 percent reported that someone discussed with them whether to include family and friends in their counseling or treatment.

**Figure 7. Percentage of Members Provided Information to Better Manage Their Condition**

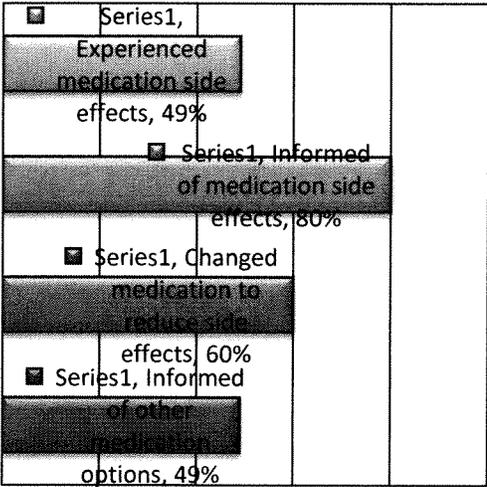


Members were also asked if their clinician provided them with information about prescription medication and associated side effects (**Figure 8**). Sixty-two percent of members reported that they took prescription medicines as part of their mental health treatment. Among these members, almost half reported experiencing side effects from their medication (49 percent). The following percentages of members were informed about medication side effects and other medications that could be used to treat their behavioral health conditions:

- 80 percent reported they were told which medication side effects to watch for.
- 60 percent reported that changes were made to their medication to reduce side effects.
- 49 percent reported they were told about medication options that might be helpful in their mental health treatment.

In addition, 76 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.

**Figure 8. Percent of Members Provided Information about Medication and Side Effects\***



\*Percentages are based upon members who took prescription medicines in the last 6 months

## Patient Rights and Privacy

The survey assessed whether members had been given information about their rights as patients. Patient rights are usually discussed by clinicians at the beginning of counseling and treatment, and include rights such as participating in developing a treatment plan, explanation of and consent to treatment, being afforded privacy, and objecting to or terminating treatment. Eighty-two percent of patients said they were given information about their rights as patients.

Members were also asked if anyone they saw for treatment or counseling shared information with others that should have been kept private. The vast majority of respondents reported their clinician did not inappropriately share information about their treatment or counseling with others (95 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.

Six 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, 57 percent reported their behavioral health care was responsive to those needs and 43 percent reported their care was not responsive to those needs.

## Members' Ratings of Their Clinician and Counseling

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

These members were asked to rate the quality of the clinician that provided most of their counseling or treatment on a 0- to 10-point scale (from worst to best). A majority of members gave their clinician a high satisfaction rating of a "9" or "10" (68 percent). On average, members gave their clinician a rating of 8.7 (SD = 2.0).

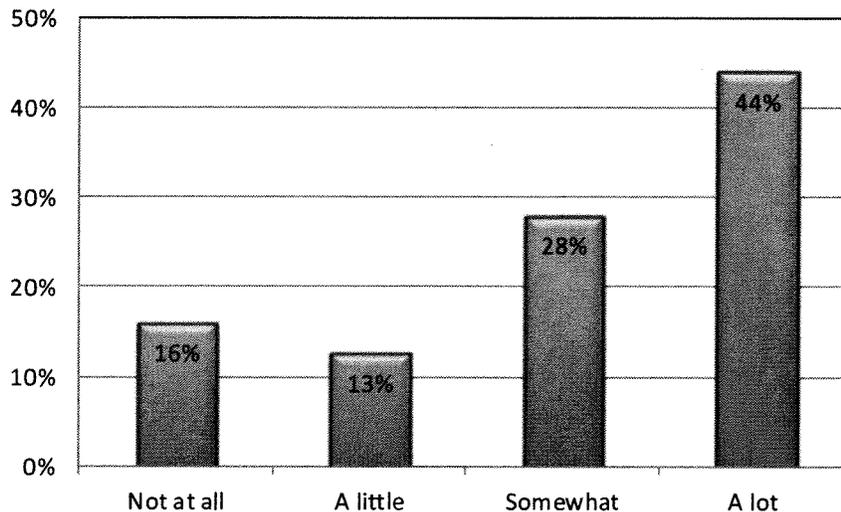
Members' Rating of Their Clinician
Sixty-eight percent gave their clinician a high satisfaction rating (a "9" or "10").
The average clinician rating was 8.7 on a 0- to 10-point scale.

## Perceived Outcomes of Behavioral Health Care

Members were asked a series of questions about how much behavioral health counseling or treatment has helped them by improving their quality of life and daily functioning. **Figure 9** provides the percentage of members indicating how much they were helped by the counseling or treatment they received in the last six months.

Most members felt they had been helped by the behavioral health counseling and treatment they received in the STAR Program. Forty-four percent of members felt they had been helped a *lot*, and 40 percent felt they had been helped a *little* or *somewhat* from their counseling and treatment. A small percentage felt they had not been helped by counseling or treatment (16 percent).

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



The impact of counseling or treatment on member's quality of life (i.e., overall well-being in physical, social, and emotional functioning) was also assessed. The following breakdown provides the members' ratings on how behavioral health counseling or treatment had impacted their quality of life in the past six months:

- 51 percent said it was *very helpful*;
- 32 percent said it was *a little helpful*;
- 14 percent said it was *not helpful or harmful*; and
- 3 percent said it was *a little or very harmful*.

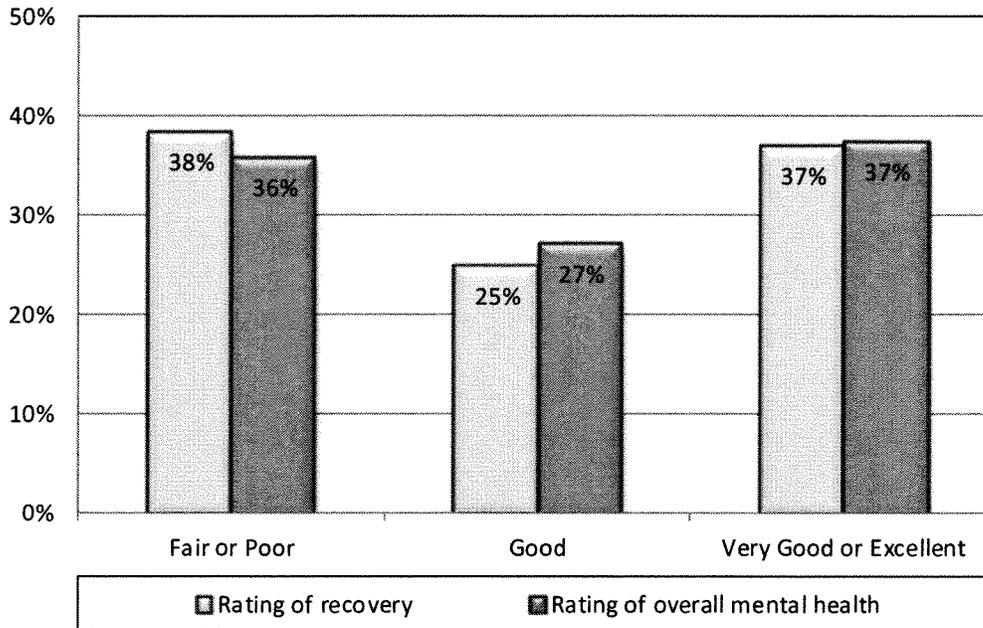
Overall, the majority of members felt they were helped by their counseling and treatment, and that it had positively influenced their well-being and functioning.

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. Members were asked to rate their current recovery and their overall mental health. **Figure 10** provides the results for these survey items. Members' ratings of recovery and mental health were similar:

- 37 percent rated both their recovery and mental health as *very good or excellent*.
- 25 percent rated their recovery as *good*, and 27 percent rated their mental health as *good*.
- 38 percent rated their recovery as *fair or poor*, and 36 percent rated their mental health as *fair or poor*.

Although a majority of members reported being helped by counseling or treatment, more than a third rated their mental health outcomes as *fair or poor*.

**Figure 10. Ratings of Recovery and Overall Mental Health**



Four ECHO<sup>®</sup> survey items comprise the composite *Perceived Improvement*, which assesses respondents' perceptions of their ability to deal with daily problems and social situations, to accomplish the things they want to do, and the overall improvement in their problems or symptoms.

The mean for the *Perceived Improvement* composite was 2.78 (SD = 0.91) on a 4-point scale. Importantly, perceived improvement was higher among men than women.<sup>18</sup> **Figure 11** presents respondents' ratings of their improvement on each of the four survey items that comprise the *Perceived Improvement* composite. The response categories for each item were *much better*, *a little better*, *about the same*, *a little worse*, or *much worse*. For data display and interpretation, these categories were collapsed into three categories – *better*, *about the same*, and *worse*.

***Perceived Improvement Items***

Compared to 6 months ago...

How would you rate your ability to deal with daily problems now?

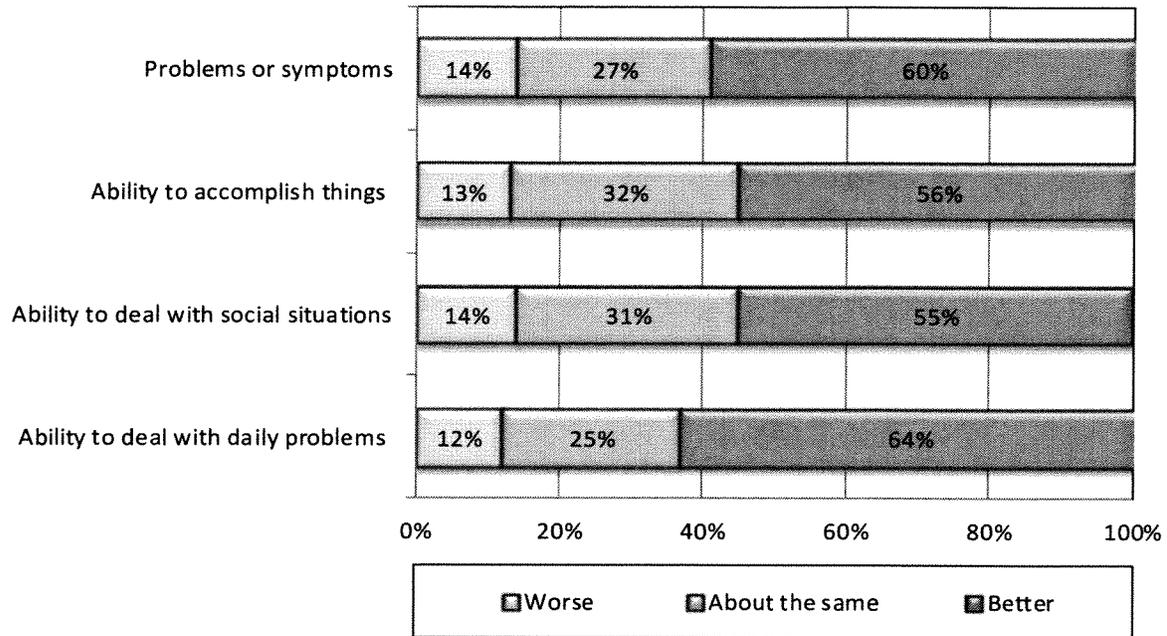
How would you rate your ability to deal with social situations now?

How would you rate your ability to accomplish the things you want to do now?

How would you rate your problems or symptoms now?

Between 55 and 64 percent of members reported improvement across the four functional domains compared with six months ago. Between 25 and 32 percent of members perceived no change in their problems, symptoms, or functioning, and between 12 and 14 percent reported a worsening of issues.

**Figure 11. Members' Ratings of Improvement**



### ***Behavioral Health Treatment Benefits and Assistance***

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

#### **Benefits**

Members were asked about their benefits for counseling or treatment under their health plan in the past 6 months. The majority of members reported that most or all of their counseling and treatment expenses were paid for by their health plan (82 percent); in contrast, about one in ten members said that none of their expenses were paid for by their health plan (12 percent).

Members were also asked about whether they had used up all of their benefits, and about one in five members said they had (21 percent).

Of members who reported having used up their benefits,

- About two-thirds said they felt they still needed counseling or treatment (68 percent), with women reporting feeling a greater need than males for additional counseling (72 percent vs. 33 percent).<sup>19</sup>
- Less than half reported having been told about other ways to get counseling, treatment, or medicine for themselves (41 percent).

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.<sup>20</sup> Results of this survey suggest that one in five members in STAR may

still be in need of behavioral health services after exhausting their counseling or treatment benefits. It is possible that members do not understand the health plan's behavioral benefits package. It is also possible that members may disagree with their provider and/or health plan regarding which extended benefits are "medically necessary." If a clinician requests prior authorization for additional counseling or treatment visits and the health plan denies the request based on lack of medical necessity, the member may still believe that they are in need of additional treatment.

## **Getting Treatment, Information, and Assistance**

**Figure 12** presents members' experiences with getting treatment, information, and assistance from their health plan and/or behavioral health organization in the past 6 months. The *Getting Treatment and Information from the Health Plan* composite was not computed due to an insufficient number of respondents answering the majority of these questions.

Most of the items in Figure 12 assessed only STAR MCO members, with the exception of two items – how much members had problems with delays for approval, and how much members received help when they called customer service. These particular items assessed both STAR MCO and BHO members. The results reveal that members generally had few problems getting treatment and information. However, their experiences did vary considerably depending on the type of treatment or information.

### Experiences with counseling and approval

- Sixteen percent of STAR members indicated that they had to get someone new for counseling or treatment when they joined their health plan. Among these members, 64 percent had 'no problem' getting someone they are happy with, and approximately one quarter indicated that they had a 'big problem' getting someone they are happy with (24 percent).
- One in five members reported that they needed approval for counseling or treatment (20 percent). Among these members, 38 percent had 'no problem' with delays for approval, while 37 percent indicated that they had a 'big problem' with delays.
- Three in four members had 'no problem' receiving the counseling or treatment they needed (75 percent). However, eleven percent of members had a 'big problem' getting the counseling or treatment they needed.

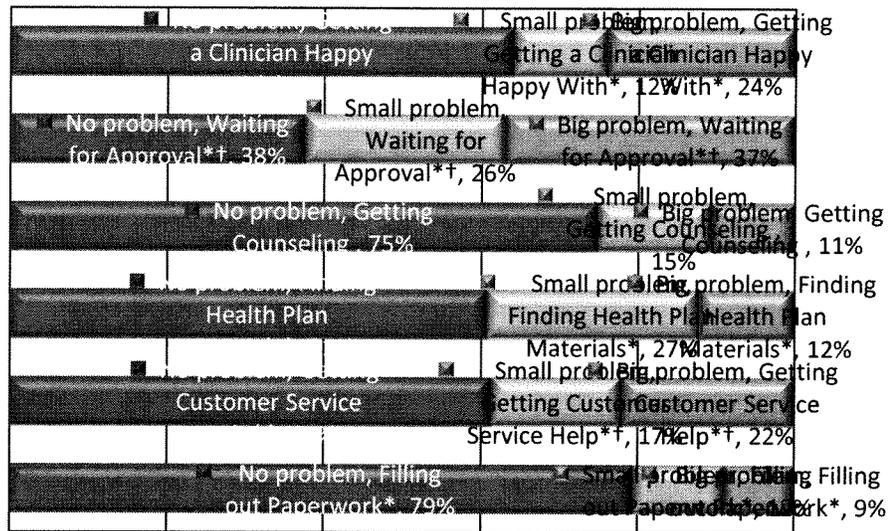
### Experiences with information, customer service, and paperwork

- One out of three members said they had looked for information about counseling or treatment from their health plan in written materials or on the Internet (29 percent). Out of these members, the majority said they had no problem finding or understanding the information (61 percent), and only 12 percent said they had a big problem finding/understanding the information.
- About one in five members reported that they called their health plan's customer service to get information or help about counseling or treatment (22 percent). Of these

members, most said that they had no problem getting the information they needed (61 percent). However, 22 percent had a big problem getting the information they needed when they called customer service.

- Only thirteen percent of members reported that they had to fill out paperwork for their health plan regarding counseling or treatment. Of these members, 79 percent said it was not a problem to fill out and complete this paperwork, 12 percent said it was a small problem, and 9 percent said it was a big problem to fill out the paperwork.

**Figure 12. STAR MCO Member Experiences in Getting Treatment and Information.**  
**How Much of a Problem was:**



■ No problem ■ Small problem ■ Big problem

\*These percentages are based upon members who needed these services in the last 6 months.

†These items assessed STAR MCO and BHO members.

STAR BHO members were asked questions about accessing information on the Internet. Three out of five members said they had access to the Internet (59 percent). Only 16 percent of members said they had looked for information about counseling or treatment at their BHO’s website. Out of these members, 67 percent said they had “no problem” finding or understanding the information, and 15 percent said they had a “big problem” finding or understanding the information.

Lastly, both STAR MCO and BHO members were asked a few questions regarding office staff. Almost half of members said they had called or talked with office staff where they received counseling or treatment (42 percent). Of these members, the majority said that they were

usually or always treated with courtesy and respect (89 percent), and 78 percent thought that the staff was as helpful as they thought they should be.

### Members' Rating of Their Health Plan or BHO

Members were asked to provide an overall rating of their health plan or behavioral health organization related to counseling and treatment on a scale from 0 to 10, with 0 indicating the worst care and 10 indicating the best care. Fifty percent of members gave a rating of 9 or 10 for their health plan with a mean rating of 7.80 (SD = 2.73). Fifty-five percent gave a rating of 9 or 10 for their behavioral health organization with a mean rating of 7.65 (SD = 3.04) (For the NorthSTAR BHO rating, see Table 2 in the Behavioral Health Delivery Model Comparison section below).

### Behavioral Health Delivery Model Comparison

This section compares behavioral health delivery model performance on ECHO® composites and member ratings. Thirty-seven percent of the STAR Behavioral Health Survey sample received counseling or treatment directly from their health plan, 45 percent received counseling or treatment from their health plan's sub-contracted BHO, and 18 percent received counseling or treatment from NorthSTAR.

**Table 2** below presents mean results for ECHO® composites and members' ratings. Analysis of variance (ANOVA) and t-tests (used when either an item pertained to only two of the behavioral health models or the sample for one behavioral health model was too low to compare its mean against the others) revealed no significant differences among the delivery models on any of the measures.

**Table 2. ECHO® Composites and Ratings, by BH Delivery Model**

	Total Sample	MCO	BHO	NorthSTAR	T or F Significance
<b>Composite</b>					
<i>Getting Treatment Quickly</i>	1.97	2.08	1.89	-	N.S.
<i>How Well Clinicians Communicate</i>	2.23	2.27	2.25	2.13	N.S.
<i>Information and Treatment Options</i>	0.49	0.49	0.49	0.50	N.S.
<i>Perceived Improvement</i>	2.80	2.85	2.74	2.83	N.S.
<b>Rating</b>					
Counseling/Treatment	7.28	7.32	7.24	7.27	N.S.
Clinician	8.60	8.61	8.75	8.24	N.S.
BHO	7.61	-	7.65	7.52	N.S.

*Note.* The rating for Health Plan was not included in this table because only one of the delivery models (STAR MCO) had data, and therefore could not be compared against the other delivery models.

## Summary Points and Recommendations

This report presents results from the FY 2012 STAR Adult Behavioral Health Survey that focused on members who had been diagnosed with a behavioral health condition in the past six months. The survey focuses on: (1) member demographic characteristics; (2) member health status, including BMI and overall ratings of health; (3) utilization of behavioral health care; and (4) member experiences and satisfaction with the behavioral health care delivered through STAR MCOs, STAR BHOs, and NorthSTAR. Satisfaction was assessed across the following domains: access and timeliness of their behavioral health care; elements of patient-centered care, such as clinician communication, shared decision-making, and patient privacy and rights; members' experiences with their health plan, including health plan information and customer service; and members' perceived improvement across personal and social domains.

### Demographic and household characteristics

- **Member demographics.** A majority of the members were female (86 percent) with a mean age of 31 years old. Hispanic members represented the largest ethnic group (52 percent), followed by White, non-Hispanic (24 percent), Black, non-Hispanic (19 percent), and Other, non-Hispanic (5 percent). English was the most commonly spoken language (89 percent). Although members reported high rates of unemployment (67 percent), over two-thirds of members had received at least a high school diploma (70 percent).
- **Member household characteristics.** Over two-thirds of members reported living in a single-parent household (72 percent). The average per house occupancy was four people, while less than one percent of members reported living alone.
- **Mental health diagnosis.** Mood disorders were the most common general diagnosis in the sample, with depression representing the most common diagnosis overall (34 percent). About one third of the sample had multiple mental health diagnoses (29 percent).

### Health status

- **Overall health and mental health.** Less than half of members rated their overall health as fair or poor (43 percent). Only a third of members rated their mental health as fair or poor (36 percent). Because this population has higher rates of chronic illness and disability than other Medicaid programs, these rates are expected.
- **Body mass index.** Nearly three out of four members were overweight or obese (72 percent), and half of all members were categorized as obese (48 percent), which is higher than the national average (34 percent). Obesity was higher among women than men (50 percent vs. 37 percent).

### Utilization of behavioral health care

- **Utilization of behavioral health care.** Members reported a diverse usage of behavioral health care, including attending routine appointments (63 percent), taking prescription medication (62 percent), calling by phone for professional counseling (18 percent), and visiting the emergency room or crisis center for counseling or treatment (18 percent). Members utilized emergency services for a variety of problems, ranging from personal problems (e.g. mental illness) to physical problems (e.g. drug abuse, physical ailments).

### Access to and timeliness of care

- **Getting treatment quickly.** The mean score for *Getting Treatment Quickly* was 1.96 (SD = 0.77). Scores for *Getting Treatment Quickly* were higher among members with less than a high school diploma than among members with at least a high school diploma. Among members who needed immediate and routine counseling or treatment, rates varied based on the type of treatment, ranging from 37 percent of members getting phone counseling to 66 percent getting routine appointments in a timely manner.
- **Office wait.** Among members who attended a routine appointment for counseling or treatment, half said they were always taken to exam room within 15 minutes of their appointment (51 percent). Nearly one in four members reported never being taken to the exam room within 15 minutes (24 percent).
- **Rating of counseling or treatment.** Members rated the counseling or treatment they received from their health plan in the past six months on a scale from 0 to 10, with an average rating of 7.3. Forty-four percent of the members assigned a rating of 9 or 10 to their health plan.

### Patient-centered care

- **Clinician communication and shared decision-making.** The mean for *How Well Clinicians Communicate* was 2.26 (SD = 0.72). A majority of members were satisfied with their provider's communication skills across every aspect of *How Well Clinicians Communicate*, with satisfaction ratings ranging considerably from involvement in counseling and treatment (61 percent) to feeling safe with clinician (78 percent).
- **Patient Information about Treatment and Management of their Condition.** The mean for the *Information about Treatment Options* composite, which 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, was 0.50 (SD = 0.43) on a scale from 0 to 1. Scores on this composite were higher among women than among men. About two-thirds of members felt they were given as much information as they needed to manage their condition. Among members on prescription medicines, most were told about potential side effects from their medication (80 percent), and over half reported having medication changes made to reduce such side effects (60 percent). Nearly three out of four members felt they could refuse a medicine or treatment suggested by their clinician (76 percent).

- **Patient Privacy.** A vast majority of members reported that their clinician did not share private information with others (95 percent).
- **Cultural Competency.** Only 6 percent of members indicated that their race/ethnicity, language and culture, or religion was important to the type of counseling and treatment they received. Among these members, 43 percent reported their care was not responsive to those needs.
- **Ratings of Clinician.** Over two-thirds of members said that they had a usual source of behavioral health care (70 percent). These members were generally satisfied with their primary clinicians, with 68 percent giving their clinician the highest satisfaction rating (a 9 or 10 on a scale of 0 to 10). The overall rating of clinicians was 8.7 out of 10.

#### Perceived Outcomes of Behavioral Health Care

- **Perceived Improvement.** Members were asked a series of questions about how much behavioral health counseling or treatment has helped them by improving their quality of life and daily functioning. About half of members reported being helped ‘a lot’ by their care (44 percent), whereas 16 percent reported not having been helped at all. Additionally, 51 percent of members stated that their treatment was ‘very helpful’ in improving their quality of life, and about a third of members reported that their recovery of mental health was ‘very good’ or ‘excellent.’
- **Improvement in Daily Life.** Members were asked to report their perceptions of improvement in several aspects of daily life compared to 6 months ago. The mean for the *Perceived Improvement* composite was 2.8 (SD = 0.9) on a 4-point scale. Perceived improvement was higher among men than among women. The percent of members doing ‘better’ ranged from 55 percent in their ability to deal with social situations to 64 percent in their ability to deal with daily problems.

#### Behavioral Health Treatment, Benefits, and Assistance

- **Benefits.** The majority of members said that all of their counseling or treatment was paid for by their health plan (73 percent). Twenty-one percent of members indicated that they used up all of their benefits; of this group, 68 percent said that they still needed counseling or treatment services, and less than half reported being told of other ways to receive counseling or treatment (41 percent). Women were more likely than men to feel that they still needed counseling after they had used up all of their benefits.
- **Getting Treatment, Information, and Assistance.** Members who needed treatment, information, or assistance generally had few problems getting such services. Among these members, those in the STAR MCO group reported having the fewest problems with getting counseling and filling out paper work (with 75 percent and 79 percent reporting ‘no problem’, respectively) and reported the most problems with delays in treatment while they waited for approval (37 percent reporting a ‘big problem’). In

addition, STAR MCO members were generally highly satisfied with getting information and assistance from customer service. Sixty-one percent of members who called their health plan's customer service had no problem getting the information they needed, and 89 percent of members who talked with office staff where they received counseling said that they were treated with courtesy and respect. Among STAR MCO and BHO members who spoke with office staff, 78 percent thought that the staff was helpful.

- **Rating of Health Plan or Behavioral Health Care Organization.** Members rated their health plan or the BHO that handled their behavioral health benefits, using a scale from 0 to 10. Fifty percent of members in the MCO group gave their health plan a rating of 9 or 10. The overall rating of health plans was 7.8 out of 10. Over half of members in the BHO group gave their BHO a rating of 9 or 10 (55 percent). The overall rating of BHO was 7.7 out of 10.

#### Behavioral Health Delivery Model Comparison

- Thirty-seven percent of the STAR Behavioral Health Survey sample received counseling or treatment directly from their health plan, 45 percent received counseling or treatment from a BHO their health plan contracted with, and 18 percent received counseling or treatment from NorthSTAR. Member satisfaction and experiences—as measured by the composites and ratings—did not differ across the delivery models. These findings suggest that behavioral health care was delivered consistently regardless of delivery health model used.

## Recommendations

Domain	Recommendations	Rationale
Obesity among members with behavioral health conditions	<ul style="list-style-type: none"> <li>• Both STAR MCOs and BHOs should implement or improve upon efforts to measure and manage members' obesity. Potential strategies include:               <ul style="list-style-type: none"> <li>○ Standardized programs, such as those implemented by the New York State Office of Mental health to monitor weight of patients in outpatient settings;<sup>21</sup></li> <li>○ Behavior modification specifically targeting members with mental illness to reduce calorie intake, increase physical activity, and avoid medications with high weight gain risk.<sup>22</sup></li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Half of all STAR BH members were obese (48 percent), and women had a particularly high obesity rate (50 percent).</li> <li>• Research has shown that adults with mental disorders die, on average, 25 years earlier than adults in the general population, and obesity is a likely contributor. In addition, obesity is an obstacle to full participation in society, and can contribute to and/or exacerbate barriers present due to mental illness.<sup>23</sup></li> </ul>
Information about additional counseling options	<ul style="list-style-type: none"> <li>• For members needing additional counseling and treatment, beyond what is covered by the health plan, MCO and BHO network providers should be aware of and educate members about resources in their community, including:               <ul style="list-style-type: none"> <li>○ Self-help groups, which members can utilize at no cost.</li> <li>○ Other low-cost treatment options for anxiety and depression, such as therapy offered through federally funded health centers and through local colleges and universities.<sup>24</sup></li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• A substantial minority (about one-fifth) of members reported having used up all their BH benefits. Among these members, less than half said they were told of other ways to get counseling.</li> <li>• In addition, less than half (42 percent) of members were told about self-help or support groups, such as consumer-run groups or 12-step programs</li> <li>• Continuity of care for members needing BH counseling or treatment is essential for ensuring the continued alleviation of mental illness symptoms, meaningful</li> </ul>

		participation in society, and reducing costs associated with preventable hospitalizations.
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## Appendix A. Detailed Methodology

The EQRO used a stratified sampling strategy to permit comparison of survey responses across the three behavioral health delivery models in STAR:

- STAR MCO – MCOs who provide behavioral health services in-house:
  - AMERIGROUP
  - Community First
  - Driscoll
  - Texas Children’s
  
- STAR BHO – MCOs who carve-out behavioral health services to a Behavioral Health Organization (BHO):
  - Aetna
  - Community Health Choice
  - Cook Children’s
  - El Paso First
  - FirstCare
  - Molina
  - Superior
  - UnitedHealthcare-Texas
  
- NorthSTAR – AMERIGROUP and Parkland in the Dallas Service Area.

A stratified random sample of adult STAR members was selected, with a target of 900 completed telephone interviews (representing 300 respondents per quota). STAR members 18 years of age and older were considered for inclusion in this survey if they met the following criteria: 1) Continuous STAR for six months (allowing for a 30-day gap in enrollment) between July 2011 and December 2011; and 2) Having a record of one or more mental health or chemical dependency diagnoses (ICD-9-CM code) and procedural (CPT code) combinations, as determined from claims data (**Table B1** in Appendix B). **Table A1** presents the stratification strategy by delivery model, showing both the number of targeted interviews (N = 900) and the number of completed interviews (N = 697).

**Table A1. STAR Adult Behavioral Health Survey Sampling Strategy**

Delivery Model	Targeted Interviews	Completed Interviews
STAR MCO	300	258
STAR BHO	300	313
NorthSTAR	300	126
TOTAL	900	697

Using a 95 percent confidence interval, the responses provided in the tables and figures are within  $\pm 3.5$  percentage points of the “true” responses in the STAR member population, and  $\pm 5.6$  percentage points in the STAR MCO quota,  $\pm 5.1$  in the STAR BHO quota, and  $\pm 7.7$  in the NorthSTAR quota.

Enrollment data were used to identify the members who met the sample selection criteria and to obtain their contact information. Member names, mailing addresses, and telephone contact information for eligible STAR members were collected and provided to interviewers. For households with multiple members enrolled in STAR, one member from the household was randomly chosen as the member to respond to the survey. Member age, sex, and race/ethnicity were also collected from the enrollment data to allow for comparisons between respondents and non-respondents, and identify any participation biases in the final sample.

### Survey instruments

The FY 2012 STAR Adult Behavioral Health Survey included:

- ECHO<sup>®</sup> Survey 3.0.<sup>25</sup>
- Items developed by ICHP pertaining to member demographic and household characteristics.

The ECHO<sup>®</sup> Survey is part of the CAHPS<sup>®</sup> family of surveys. The adult version assesses patients' experiences and satisfaction with various aspects of their behavioral health care. The survey allows for calculation and reporting of behavioral health care composites, which are scores that combine results for closely related survey items. ECHO<sup>®</sup> composite scores were calculated in the following domains:

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

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

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

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

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

#### Survey data collection

The EQRO sent letters written in English and Spanish to 4,049 sampled STAR adult members, requesting their participation in the survey. Of the advance letters sent, 12 were returned undeliverable.

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

Attempts were made to contact 4,049 STAR adult members sampled for the survey. Forty-four percent of members could not be located. The response rate was 64 percent and the cooperation rate was 87 percent.

To test for participation bias, the distributions of member age, sex, and race/ethnicity were collected from the enrollment data and compared between members who responded to the survey and members who did not participate. Among members contacted by NORC, participation rates between respondents and non-respondents were significantly different by biological sex.<sup>26</sup> Seventy-four percent of males who were contacted by NORC participated in the survey, while 63 percent of females who were contacted participated in the survey. Results for program-level frequencies and means were weighted to account for participation bias by biological sex, as shown in **Table A2**, below.

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

## Data analysis

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

To facilitate inferences from the survey results to the STAR member population, results were weighted to the full set of eligible beneficiaries in the enrollment dataset. Because sampling for STAR+PLUS was stratified by behavioral health delivery model, a separate weight was calculated for each quota, in which frequencies were multiplied by the inverse probability of inclusion in the sample (the total number of eligible MCO members in the dataset divided by the number of MCO members with completed surveys). **Table A2** provides the weights for each delivery model quota.

**Table A2. Survey Weighting Strategy**

<b>Quota</b>	<b>Population of Eligible Members (N)</b>	<b>Number of Completed Surveys (n)</b>	<b>Weight</b>
STAR MCO	1,584	258	6.14
STAR BHO	2,100	313	6.71
NorthSTAR	539	126	4.28
<b>Sex</b>	<b>Members Contacted (%)</b>	<b>Completed Surveys (%)</b>	<b>Weight</b>
Female	85.1%	83.8%	0.92
Male	14.9%	16.2%	1.02

The frequencies and means presented in this report and the technical appendix that accompanies this report incorporate survey weights.

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

BMI was calculated by dividing the member’s weight in kilograms by their height in meters squared. BMI could be calculated for 688 members in the sample (99 percent) for whom height and weight data were complete. Height data were missing for 2 members , and weight data were missing for 9 members.

Survey respondents were classified into one of four clinically relevant BMI categories, which are recognized by the Centers for Disease Control and Prevention.<sup>27</sup>

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

## **Appendix B. Supplementary Tables**

**Table B1. Primary Mental Health Diagnoses for Sampling**

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

**Table B2. ECHO<sup>®</sup> Composite Scores, by Member Demographics**

	<b>Getting Treatment Quickly</b>	<b>How Well Clinicians Communicate</b>	<b>Information About Treatment Options</b>	<b>Perceived Improvement</b>
<b>Race/Ethnicity</b>				
Hispanic	1.96	2.24	0.50	2.90 <sup>b</sup>
White, NH	1.90	2.36	0.46	2.67 <sup>a</sup>
Black, NH	2.18	2.23	0.54	2.68 <sup>a</sup>
F significance *	N.S.	N.S.	N.S.	= 0.02**
<b>Education</b>				
Less than high school degree	2.27	2.22	0.56	2.80
High school degree/GED or higher	1.84	2.27	0.47	2.78
T-test significance *	< 0.001	N.S.	= 0.03	N.S.
Cohen's d	.57	-	.21	-
<b>Member Sex</b>				
Male	2.01	2.15	0.38	3.06
Female	1.96	2.28	0.51	2.74
T-test significance *	N.S.	N.S.	= .01	= 0.003
Cohen's d	-	-	.31	.37
<b>Health Status- Comorbidity</b>				
Comorbid	1.99	2.34	0.57	2.77
Non-comorbid	1.95	2.23	0.46	2.80
T-test significance *	N.S.	N.S.	= .008	N.S.
Cohen's d	-	-	.25	-

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

\*\* Hispanic vs. White,  $p = 0.01$ ,  $d = 0.27$ ; Hispanic vs. Black,  $p = 0.03$ ,  $d = 0.24$ .

**Table B3. ECHO® Ratings, by Member Demographics**

	<b>Counseling/ Treatment Rating</b>	<b>Clinician Rating</b>	<b>Health Plan Rating</b>	<b>BHO Rating</b>
<b>Race/Ethnicity</b>				
Hispanic	7.33	8.67	7.96	7.72
White, NH	7.11	8.58	7.53	7.61
Black, NH	7.48	8.83	7.91	7.91
F significance *	N.S.	N.S.	N.S.	N.S.
<b>Education</b>				
Less than high school degree	7.48	8.83	8.15	8.19
High school degree/ GED or higher	7.19	8.63	7.70	7.40
T-test significance *	N.S.	N.S.	N.S.	= 0.04
Cohen's d	-	-	-	.26
<b>Member Sex</b>				
Male	7.10	8.87	7.94	7.60
Female	7.31	8.66	7.78	7.66
T-test significance *	N.S.	N.S.	N.S.	N.S.
Cohen's d	-	-	-	-
<b>Health Status- Comorbidity</b>				
Comorbid	7.50	8.70	7.83	8.12
Non-comorbid	7.19	8.68	7.79	7.45
T-test significance *	N.S.	N.S.	N.S.	N.S.
Cohen's d	-	-	-	-

\* Analyses performed on unweighted data. In the case of a significant F, post hoc pairwise comparisons were performed.

## Endnotes

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- <sup>1</sup> Consumer Assessment of Healthcare Providers and Systems (CAHPS®). 2011. "ECHO® Survey and Reporting Kit." Available at: <http://www.cahps.ahrq.gov/Surveys-Guidance/ECHO.aspx>.
- <sup>2</sup> Mangurian, C., G.A. Miller, C.T. Jackson, H. Li, S.M. Essock, and L.I. Sederer. 2011. "State Mental Health Policy: Physical health screening in state mental health clinics: The New York health indicators initiative." *Psychiatric Services* 61(4): 1331-1337.
- <sup>3</sup> Parks J, A.Q. Radke, and T.J. Ruter. 2008. *Obesity Reduction & Prevention Strategies for Individuals with Serious Mental Illness. 15th Technical Report*. Alexandria, VA: National Association of State Mental Health Program Directors, 2008. Available at: [http://servedelaware.org/dhss/dsamh/files/obesity\\_reduct\\_prevent\\_article.pdf](http://servedelaware.org/dhss/dsamh/files/obesity_reduct_prevent_article.pdf).
- <sup>4</sup> Parks J, D. Svendsen, P. Singer P, M.E. Foti, and B. Mauer. 2006. *Morbidity and Mortality in People With Serious Mental Illness. 13th Technical Report*. Alexandria, VA: National Association of State Mental Health Program Directors, 2006. Available at: <http://theempowermentcenter.net/>.
- <sup>5</sup> ADA (Anxiety and Depression Association of America). 2012. "Low-Cost Treatment." Available at: <http://www.adaa.org/finding-help/treatment/low-cost-treatment>.
- <sup>6</sup> HHSC (Texas Health and Human Services Commission). 2011. *Texas Medicaid in Perspective, Eighth Edition*. "Chapter 5: Medicaid Benefits." Available at: <http://www.hhsc.state.tx.us/Medicaid/reports/PB8/PinkBookTOC.html>.
- <sup>7</sup> The Legislative Budget Board staff (LBB). 2009. *Texas State Government Effectiveness and Efficiency: Selected Issues and Recommendations*. Available at: <http://www.lbb.state.tx.us/>.
- <sup>8</sup> Shaul, J.A., S.V. Eisen, V.L. Stringfellow, B.R. Clarridge, R.C. Hermann, D. Nelson. E. Anderson, A.I. Kubrin, H.S. Leff, and P.D. Cleary. 2001. "Use of consumer ratings for quality improvement in behavioral health insurance plans." *The Joint Commission Journal on Quality Improvement*, 27(4): 216-219.
- <sup>9</sup> Pascoe, G.C. 1983. "Patient Satisfaction in Primary Health Care: A Literature Review and Analysis." *Evaluation and Program Planning* 6: 185-210
- <sup>10</sup> CAHPS® (Consumer Assessment of Healthcare Providers and Systems). 2011. "ECHO® Survey and Reporting Kit." Previously available at: <http://www.cahps.ahrq.gov/Surveys-Guidance/ECHO.aspx>.
- <sup>11</sup> APA (American Psychiatric Association). 2000. *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR)*. Washington, DC: American Psychiatric Association.
- <sup>12</sup> Ogden, C.L., M.D. Carroll, B.K. Kit, K.M. Flegal. 2012. "Prevalence and trends in obesity among U.S. adults, 2009 – 2010." Available at <http://www.cdc.gov/nchs/data/databriefs/db82.pdf>.
- <sup>13</sup> CDC (Centers for Disease Control and Prevention). 2011. U.S. Obesity Trends. Available at: <http://www.cdc.gov/obesity/data/trends.html>.
- <sup>14</sup> Chi-square = 5.29, p = 0.02,  $\phi$  = 0.10.
- <sup>15</sup> The coding scheme for the open-ended question was developed to parse out responses of mental health and non-mental health issues. Within the category of mental health, further categorization was developed. Multiple behavioral health issues were each given a separate code (e.g., "My husband hit me

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and then I had a breakdown.”). The category “Family Issues” comprised responses relating to abusive family members or death of a loved one.

<sup>16</sup>  $p < 0.001$ ,  $d = 0.57$ .

<sup>17</sup>  $p < 0.01$ ,  $d = 0.31$ .

<sup>18</sup>  $p < 0.003$ ,  $d = 0.37$ .

<sup>19</sup> Chi-square = 7.31,  $p < 0.007$ ,  $\phi = 0.25$ .

<sup>20</sup> 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>.

<sup>21</sup> Mangurian, C., G.A. Miller, C.T. Jackson, H. Li, S.M. Essock, and L.I. Sederer. 2011. “State Mental Health Policy: Physical health screening in state mental health clinics: The New York health indicators initiative.” *Psychiatric Services* 61(4): 1331-1337.

<sup>22</sup> Parks J, A.Q. Radke, and T.J. Ruter. 2008. *Obesity Reduction & Prevention Strategies for Individuals with Serious Mental Illness. 15th Technical Report*. Alexandria, VA: National Association of State Mental Health Program Directors, 2008. Available at: [http://servedelaware.org/dhss/dsamh/files/obesity\\_reduct\\_prevent\\_article.pdf](http://servedelaware.org/dhss/dsamh/files/obesity_reduct_prevent_article.pdf).

<sup>23</sup> Parks J, D. Svendsen, P. Singer P, M.E. Foti, and B. Mauer. 2006. *Morbidity and Mortality in People With Serious Mental Illness. 13th Technical Report*. Alexandria, VA: National Association of State Mental Health Program Directors, 2006. Available at: <http://theempowermentcenter.net/>.

<sup>24</sup> ADAA (Anxiety and Depression Association of America). 2012. “Low-Cost Treatment.” Available at: <http://www.adaa.org/finding-help/treatment/low-cost-treatment>.

<sup>25</sup> CAHPS®. 2011.

<sup>26</sup> Chi-square = 8.166,  $p = 0.004$ .

<sup>27</sup> CDC. 2011