

Focus on Obesity and on Medicare Plan Improvement



The State of Health
Care Quality 2012



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Printed in the U.S.A.

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INTRODUCTION

NCQA produces *The State of Health Care Quality Report* every year to call attention to key quality issues the United States faces and to drive improvement in the delivery of evidence-based medicine. This report documents performance trends over time, tracks variation in care and recommends quality improvements.

Thousands of consumers, health insurance executives, benefits managers, policy makers, academics, consultants and journalists read this report. More than 1,000 health plans voluntarily disclose the clinical quality, customer experience and resource use data that are the report's foundation. All data are rigorously audited. Consumer experience information is independently collected and verified.

We commend all the health plans that contributed data for this report, and for the commitment to accountability and quality improvement they show by disclosing their performance.

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We appreciate your interest in these topics and we welcome your feedback. You can reach us at communications@ncqa.org.

EXECUTIVE SUMMARY

The State of Health Care Quality Report is one of NCCQA's primary outlets for national results on health care quality trends, as measured by the HEDIS and CAHPS performance measures for health plans. This year, we find performance gains in measures of wellness and in the Medicare program, which is using a pay-for-performance program to reward performance. Although these developments are to be celebrated, there is still more we—providers, purchasers, policymakers and other stakeholders—can do to improve the quality of care and the value of health care spending in this country. We offer policy recommendations intended to move performance to a higher level.

Findings from 2012 HEDIS and CAHPS Submissions

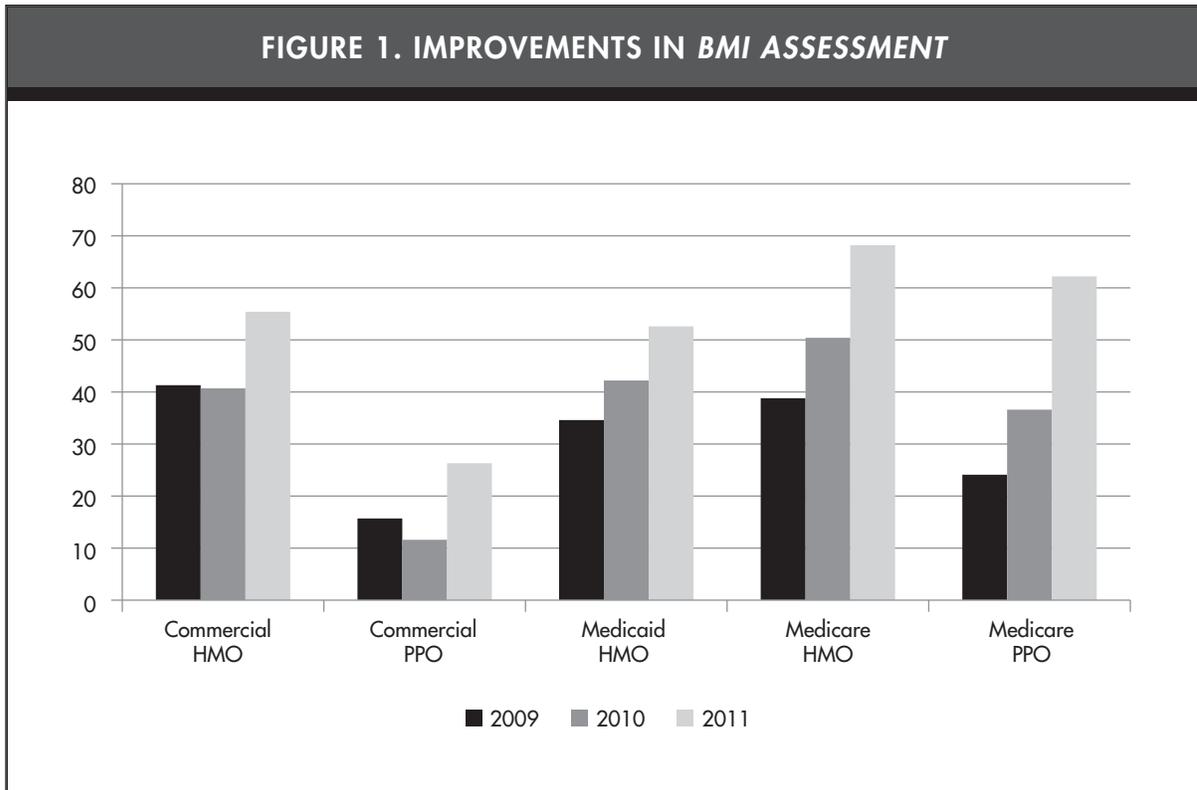
Clinicians are doing more to fight obesity, one of the biggest public health problems in the U.S., and early evidence suggests pay-for-performance is getting results in Medicare Advantage. These changes may be a result of the emphasis by purchasers and others on wellness and health promotion, and a sign that Medicare's significant quality incentives are yielding dividends in terms of improved health.

Improvements in wellness and prevention

Obesity can lead to chronic health conditions like diabetes and high blood pressure. Many reasons for obesity are related to lifestyle choices and issues outside of the health care system's control. That said, clinicians' focus on this issue can help their patients understand the health consequences of being overweight. Calculating body mass index (BMI)—the ratio of body fat determined by height and weight—is the first step toward developing a plan for weight management.

In 2009, NCCQA introduced a new HEDIS measure related to obesity (*Adult BMI Assessment*). This year we have seen major jumps in improvement on this measure across commercial, Medicaid and Medicare lines of business and for HMOs and PPOs. The greatest gains are among Medicare plans—with an increase of 18 percentage points for HMOs and almost 26 percentage points for PPOs. We find that the measure's focus on data collection can lead to better clinical focus on quality. Clinicians and plans that use electronic health records will find collecting data on BMI to be particularly straightforward.

We also see significant gains in three measures of care related to obesity in children 3–17 years of age. As in adults, obesity can lead to chronic disease in children, as well as to emotional and social health problems. One measure calls for clinicians to counsel on physical activity, another to counsel on nutrition and another to assess BMI. Each measure examines the percentage



of children who had an outpatient visit with a clinician and had documentation of their BMI percentile or counseling for nutrition during the measurement year. Across all types of plans, we see significant gains; for example, for commercial HMOs, the rates for nutrition counseling increased from 41 percent in 2009 to 46.4 percent in 2011. We saw a similar achievement for Medicaid HMOs—from 41.9 percent in 2009 to 50.1 percent in 2011.

Improvements in Medicare performance

This year we saw significant improvement in measures included in the Medicare Star rating pay-for-performance program for health plans that participate in Medicare Advantage. Although Medicare Advantage plans have reported on quality and results have been reported to consumers for many years, the Affordable Care Act required the Medicare program to make higher payments to health plans with better quality performance, starting in 2012. In addition to this new program, the Department of Health and Human Services established a demonstration program to complement it, making even higher payments to plans with better performance.

Measures where we see the largest gains are in the table below.

FIGURE 2. MEDICARE PERFORMANCE IMPROVES

| Measure | HMO 2010 | HMO 2011 | PPO 2010 | PPO 2011 |
|---|-------------|-------------|-------------|-------------|
| Smoking Cessation: Advising Smokers to Quit | 77.9 | 81.5 | 78.3 | 79.3 |
| Adult BMI Assessment | 50.4 | 68.2 | 36.6 | 62.2 |
| Colorectal Cancer Screening | 57.6 | 60.0 | 41.0 | 55.2 |
| Controlling High Blood Pressure | 61.9 | 64.0 | 55.7 | 60.6 |

We also find examples where performance on measures had essentially stalled, but the most recent year brought significant gains. For example, one HEDIS measure reviews the use of high-risk medications in the elderly. It identifies the share of Medicare beneficiaries 65 and older who use two or more medications that experts agree should usually be avoided in the elderly. After several years of almost no change, the usage rate has dropped by a third (lower rates of use are better)—from about 6 percent to 3.6 percent.

Other significant changes in HEDIS and CAHPS measures

Persistence of Beta-Blocker Treatment After a Heart Attack

Health plans improved their performance across all product lines. The largest gains were among commercial HMOs and PPOs; Medicare HMOs and PPOs continue to have the highest rates of performance across all types of plans and markets.

Improvement on Medicare measures suggest that the significant financial rewards for better quality are having a meaningful effect on this segment of the market—to the benefit of enrollees.

Commercial gains

Meaningful improvement outside of Medicare includes the following commercial measures:

FIGURE 3. IMPROVEMENT IN USE OF HIGH-RISK MEDICATIONS IN THE ELDERLY (LOWER RATE IS BETTER)

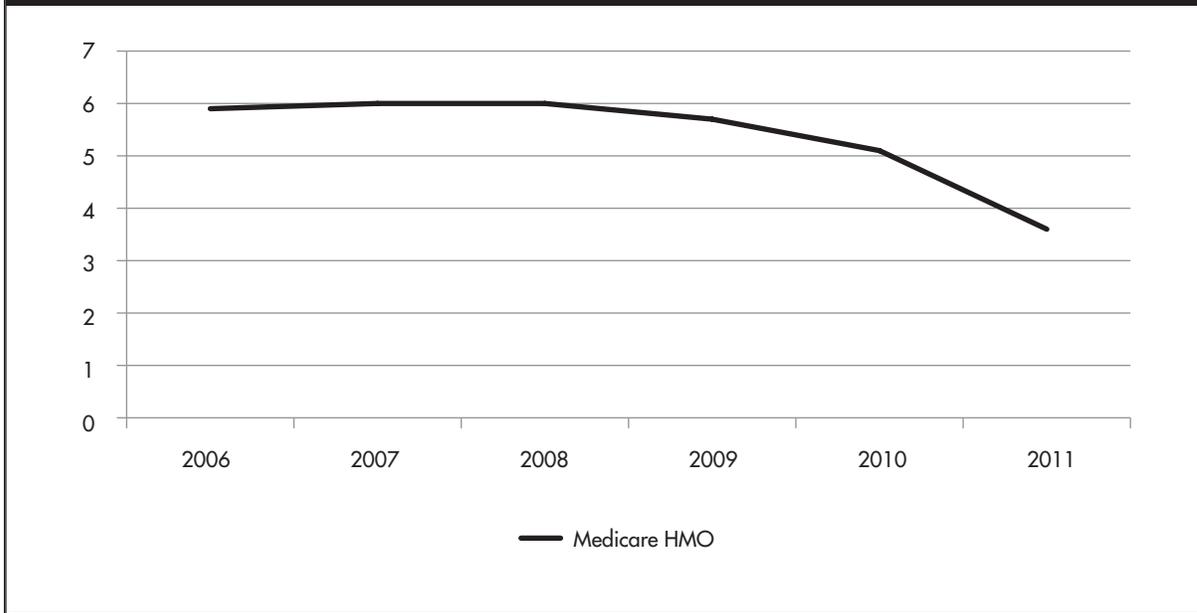
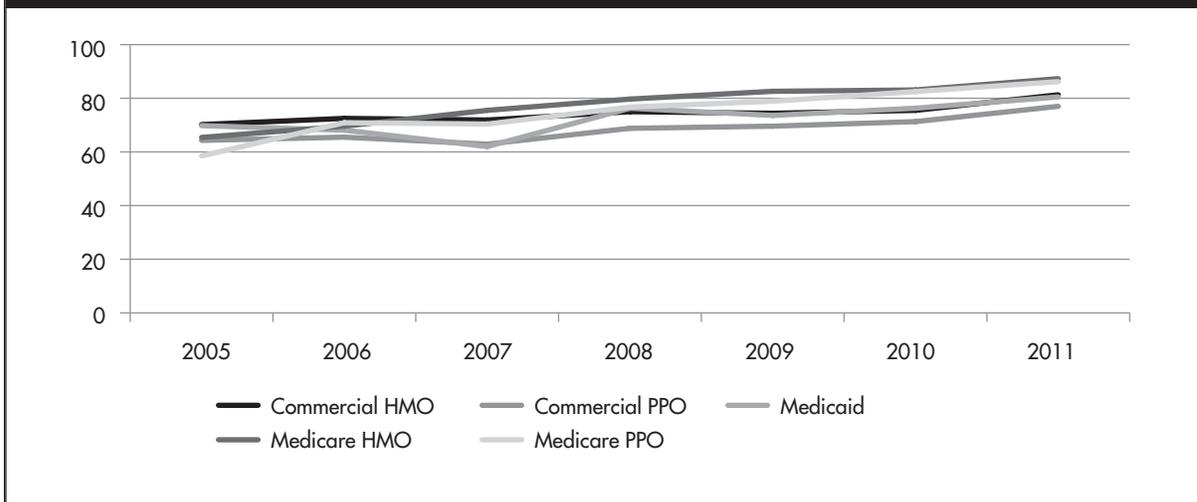


FIGURE 4. MEDICARE LEADS THE PACK IN PERSISTENCE OF BETA-BLOCKER TREATMENT AFTER A HEART ATTACK



- *Chlamydia Screening in Women*. Both HMOs and PPOs have gains of around 2 percentage points.
- *Pharmacotherapy for Chronic Obstructive Pulmonary Disease*, two relatively new HEDIS measures, are showing gains for commercial HMOs and PPOs.
- *Appropriate Testing for Children With Pharyngitis* is targeted at avoiding overuse of antibiotics for sore throat caused by a virus. Not only are antibiotics ineffective for treatment of viral infections, people who take them too often are at risk for becoming unresponsive to antibiotics. Commercial plans gained 2.6 percentage points in this measure; Medicaid plans are making progress, as well.
- Commercial HMOs improved on the CAHPS customer service measure. There was an almost 3 percentage point gain in the share of people with high ratings of plans on the following two questions: “How often did your health plan’s customer service give you the information or help you needed?” and “How often did your health plan’s customer service staff treat you with courtesy and respect?”

Medicaid gains

We also see improvement in *Follow-Up Care for Children Prescribed ADHD Medication*. This measure tracks the percentage of children 6–12 years of age with a prescription for ADHD medication, who remained on the medication and had at least two follow-up visits.

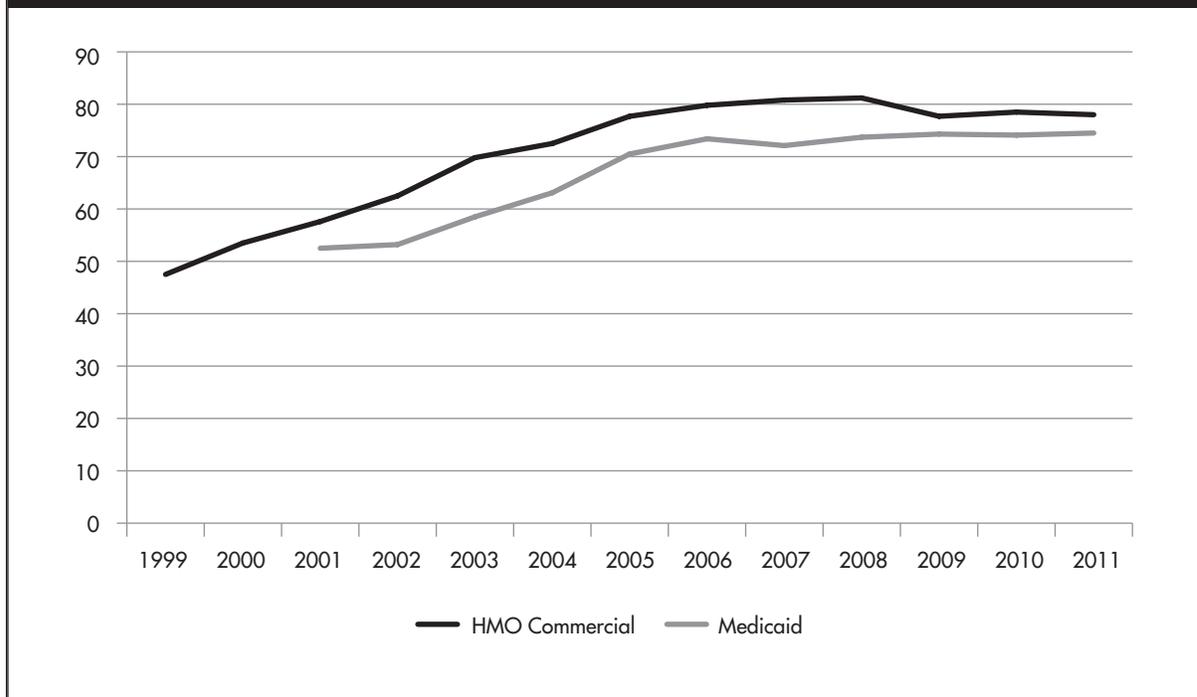
Changes in immunization measures

In 2010, NCCA reported a meaningful drop in immunizations for children. This year, the rate made no recovery in either the commercial or the Medicaid product line.

Performance on this composite measure is a useful “big picture” indicator of immunizations. We see a varying pattern of use across the different types of immunizations:

- Hepatitis B use is down for commercial and Medicaid HMOs, but up for commercial PPOs.
- Adolescent immunizations for rotavirus, influenza and meningococcus show gains in performance across all product lines.
- Other immunization types show small gains or losses of less than 2 percent.

FIGURE 5. CHILDHOOD IMMUNIZATION RATES CONTINUE TO STAGNATE



Where we are losing ground

Although it is most common for measures to increase or plateau over time, it is worth noting that in a few cases, we see declining performance.

We see declines in alcohol and drug dependence treatment across almost all product lines. The *Initiation and Engagement of Alcohol and Other Drug Dependence Treatment* measure assesses how quickly and intensively people receive care after they are diagnosed with dependence problems in a care setting. Treatment frequency and intensity is important for successful outcomes. The measure that captures the initiation of treatment had the largest declines: almost 10 percentage points for Medicare PPOs and 3.6 percentage points for Medicare HMOs. Medicaid performance fell 3.7 percentage points and commercial HMOs fell 2.5 percentage points. This could be the result of several factors, including that if plans do better at identification, there would be so many new cases it would be hard to keep up with initiation of treatment and engagement. (This has been the Department of Veterans Affairs' experience.)

Two measures saw drops for Medicaid populations. *Use of Appropriate Medications for People With Asthma* dropped 3.4 percentage points; *Annual Monitoring for Patients on Persistent Medications: Anticonvulsants* dropped 2.6 percentage points.

Bucking the Trend: Once a Low Performer, Always a Low Performer?

Each year, *The State of Health Care Quality Report* assesses overall health plan performance on each HEDIS measure, looking for encouraging trends across all plans. We also rank health plans against each other using HEDIS and accreditation scoring results; provide detailed scoring results on each plan in the Health Plan Report Card; and make Quality Compass available to those who want to perform a detailed analysis of performance by individual plan, compared with national and regional averages.

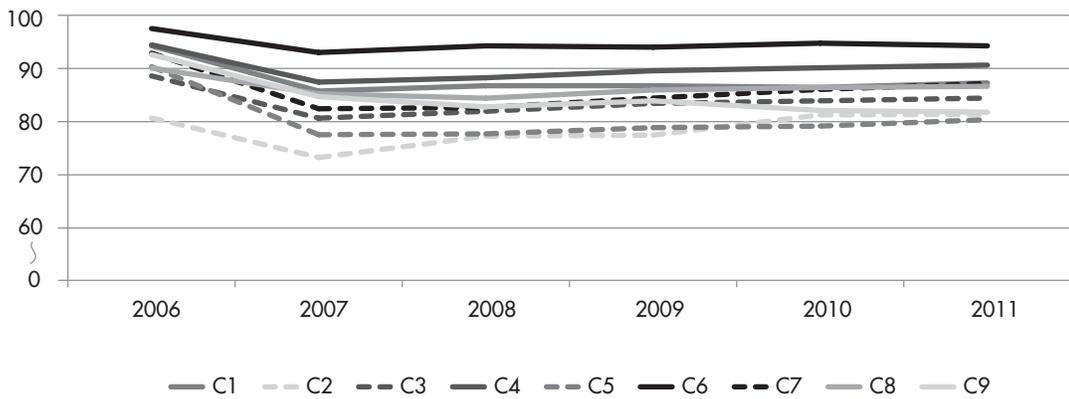
This year, we also performed an analysis of patterns of performance over time by cohorts of plans, to find out if groups of plans demonstrate unusual rates of improvement over time. Perhaps a plan began particularly meaningful quality improvement strategies that we can learn from, to accelerate future improvement. (The preliminary results of the analysis follow.)

We looked at patterns of performance for nine HEDIS measures—a mix of outcome and screening measures for cardiac and diabetes care, and one for mental health (with low performance that has been flat over time). We focused on commercial HMOs because they have the highest number of plans submitting data, the longest trends and the most stable results.

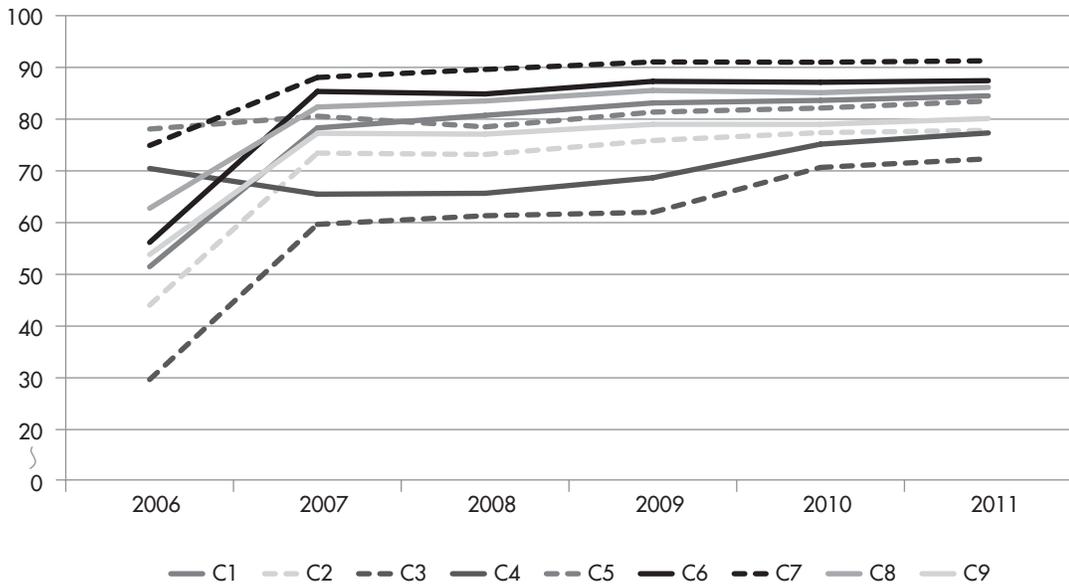
Plans with the lowest performance in early years show improvement over time, but their performance consistently falls in the lowest range of all plans. Plans with the strongest performance in early years tend to stay at the highest level. *Cholesterol Management for Patients With Cardiovascular Conditions—LDL Cholesterol Screening* exemplifies this pattern.

Although most cohorts stay in their relative positions over time on most measures, one group “bucks the trend” for *Comprehensive Diabetes Care—Medical Attention for Nephropathy*. Having started in the fifth position, those plans now occupy the second-highest position. Does this reflect special emphasis on strategies to increase the rate of lipid screening? We intend to find out.

**FIGURE 6. COMMERCIAL HMO PERFORMANCE BY CLUSTER:
LDL CHOLESTEROL SCREENING**



**FIGURE 7. COMMERCIAL HMO PERFORMANCE BY CLUSTER:
MEDICAL ATTENTION FOR NEPHROPATHY**

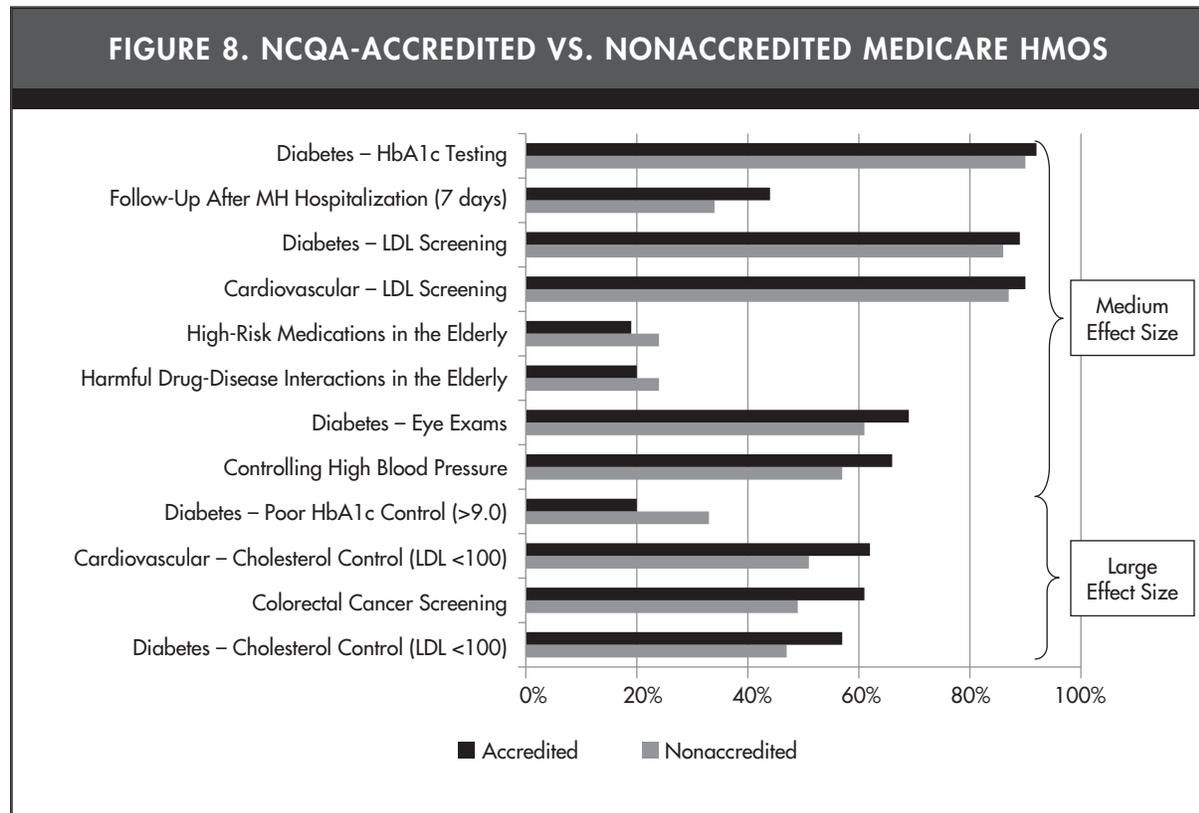


Accreditation and Health Care Quality: NCQA Analysis

NCQA-Accredited plans have higher quality, as measured by HEDIS, than nonaccredited plans. Although longtime readers of *The State of Health Care Quality Report* may have noticed the pattern of higher performance in the appendix tables at the end of the publication, this year we took a more systematic approach to evaluating the difference that NCQA Accreditation makes.

Evaluation is challenging. We do not have quality measures for every plan, only the ones that report to us. Thus, if plans of poorer quality are less likely to report quality measures (a probable scenario), it is harder to tell whether differences in performance are due to accreditation or to some other attribute. Fortunately, the Medicare Advantage program requires all participating plans to submit quality data, so we had a view of all performance in this product line for comparing accredited plans with nonaccredited plans.

Overall, accredited Medicare Advantage plans outperformed nonaccredited plans.



- For 39 percent of the measures, accreditation had a moderate (13 measures) or large (4 measures) effect.
- Nonaccredited plans outperformed accredited plans at a statistically significant level in only one measure.

Because it is possible that a plan's characteristics (for example, whether a plan is part of an integrated delivery system), rather than its decision to become accredited, might drive differences, we conducted a regression analysis that considered plan characteristics. As could be expected, this reduced the differences, but we continued to see significantly better performance among accredited plans for intermediate control measures, which are arguably among the most difficult to improve because they require a lot of patient participation. Measures where we saw significant differences were *Cholesterol Management for Patients With Cardiovascular Conditions*, and *HbA1C Control* and *LDL-C Screening* in the *Comprehensive Diabetes Care* measures.

We do not have a complete set of commercial or Medicaid plans reporting for a comparison of commercial and Medicaid product lines, but we did find that plans that do well in Medicare Advantage also tend to do well on the commercial side, and vice versa.

Although our analysis demonstrated that accredited plans tend to have higher quality scores, the reason for this—whether accreditation makes plans better, or that better plans choose to become accredited—is unclear. But correlation between accreditation and higher performance is clear. It may be that the types of plans that seek accreditation are the ones that devote resources and support to strategies for improving quality for their members. And even if this is the case, accreditation is an indicator of higher value—for Medicare plans, in particular, but probably also for plans in other product lines. Moreover, accreditation includes valuable consumer protections that go beyond clinical quality and patient experience.

Quality in Action at the State Level: Tennessee

The State of Health Care Quality Report provides measure-by-measure results across the U.S. Although this is a good way to understand overall trends, we are most excited by the quality innovations we see at the local level. There are so many initiatives underway around the country that it was difficult to pick only one to discuss. We chose a state where a number of purchasers,

providers and health plans have worked to improve quality—especially challenging in a Southern state, where health indicators tend to be low.

Quality in Tennessee health plans

Eleven commercial health plans (6 PPOs, 5 HMOs) in Tennessee are accredited by NCQA. Three of these (the Aetna and CIGNA HMOs and the Blue Cross Blue Shield of Tennessee PPO), are rated Excellent—meaning that their HEDIS, CAHPS and accreditation scores are among the highest among health plans in the U.S. Department of Health and Human Services South Central region. All 4 TennCare Medicaid plans are accredited, reflecting a mandate by the state for NCQA Accreditation; Amerigroup and Volunteer state plans are rated Excellent. Five Medicare plans are accredited, with Aetna and Cariten rated Excellent.

Public and private purchasers have actively promoted accreditation. One example is the Memphis Business Group on Health, which uses the eValu8 system to rate plans. Higher levels of NCQA Accreditation and HEDIS and CAHPS ratings all raise eValu8 scores.

One measure where the state's plans show sustained improvement is *Well-Child Visits in the First 15 Months of Life*. Although commercial HMOs and PPOs are improving gradually, Medicaid plans are consistently closing the gap.

Medicaid plans have also made meaningful gains in outcomes measures like *Blood Pressure Control for People With Diabetes* (where control is measured at less than 140/90 mm Hg). The state's Medicaid plans compare favorably with the national rate for Medicaid plans.

The following tables are presented for all measures that met NCQA minimum-effect size change methodology for 2006–2012.

Improving the delivery system in Tennessee

As of September 2012, 374 Tennessee clinicians are recognized as patient-centered medical homes (PCMH). BCBS of Tennessee, an NCQA PCMH sponsor, pays practices' fees for onsite training and pays a fee to practices recognized for care management. It provides a preferred provider site for providers with NCQA Recognition. All contracted providers must achieve Level 1 recognition within their first year and Level 2 or 3 recognition by the third year. Plan staff say NCQA PCMH Recognition "provides physicians with an effective roadmap to transform to a true PCMH. ... NCQA [is] the leading authority on recognition of PCMH sites."

FIGURE 9. RECOMMENDED NUMBER OF WELL-CHILD VISITS IMPROVEMENT OVER TIME IN TENNESSEE; MEDICAID PLANS NARROW THE PERFORMANCE GAP

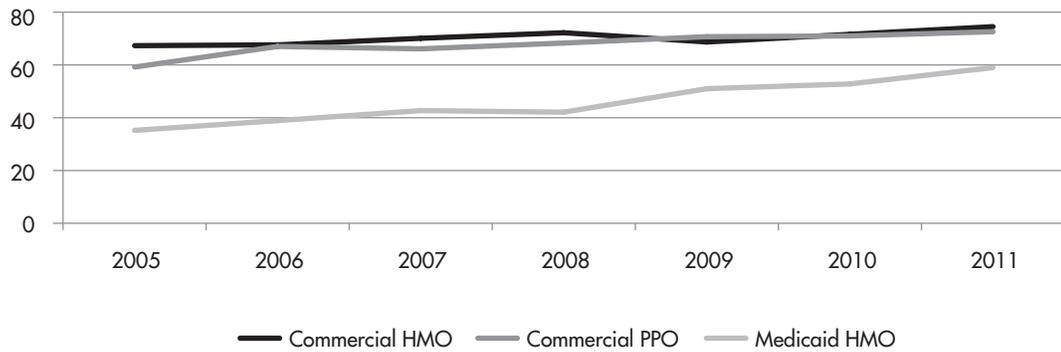
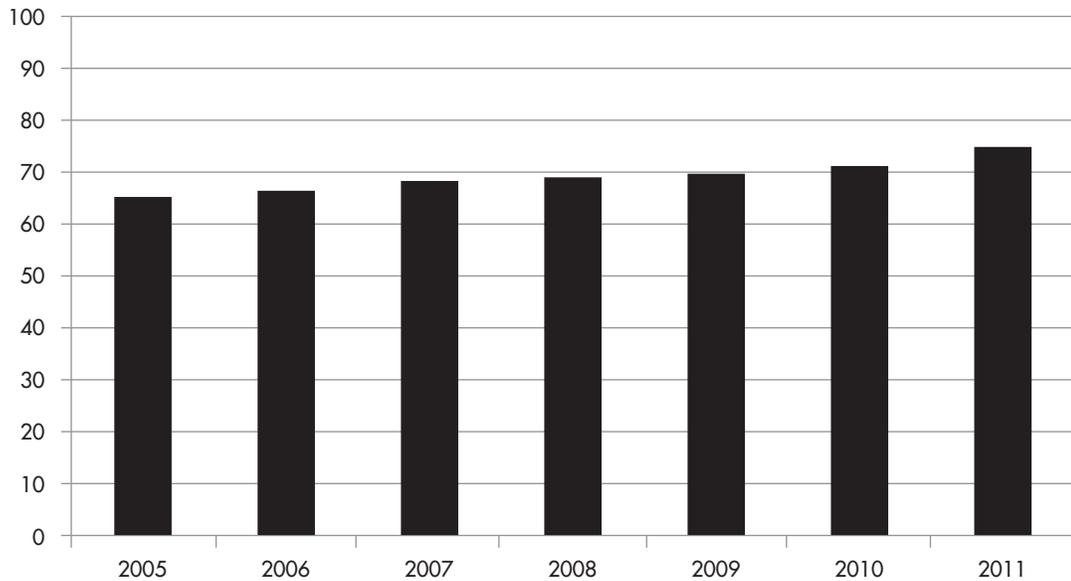
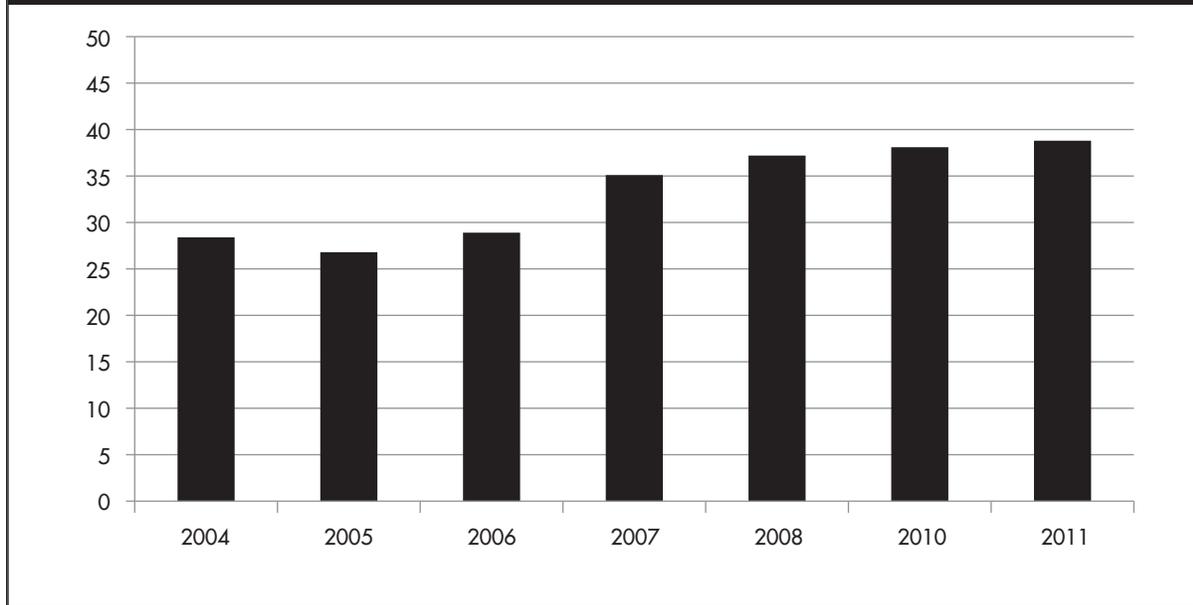


FIGURE 10. TENNESSEE MEDICAID HMO APPROPRIATE TESTING FOR CHILDREN WITH PHARYNGITIS



**FIGURE 11. TENNESSEE MEDICAID HMO
SMOKING CESSATION: DISCUSSING CESSATION MEDICATIONS**



One pioneering Tennessee PCMH practice is the Summit Medical Group. The largest primary care practice in Tennessee, Summit established three after-hours care centers in the Knoxville area, to improve access to care for patients with acute outpatient issues requiring early diagnosis and treatment. Better access to care can be instrumental in reducing ED visits and hospital readmissions.

Recommendations for the Next Presidential Term on Improving the Value of Health Care Spending

As this edition of *The State of Health Care Quality Report* goes to press, we await the outcome of the Presidential race, and many legislative races that could affect the momentum of the Affordable Care Act. We offer recommendations for the next Administration, which—regardless of the election’s outcome—will face the challenge of getting better value for health care spending. There is broad bipartisan support for many of these ideas.

Delivery system reform

The last three years have seen an encouraging trend toward delivery system reform and away from traditional fee-for-service payment methods that reward volume over value.

Patient-centered medical homes. The growth in the number of practices and providers involved in PCMH programs is a great example of delivery system reform. Growth has been stimulated by the many public and private purchasers that have embraced this effective model of care. Public purchasers include state Medicaid programs and federal government agencies, such as the Health Resources and Services Administration and the Department of Defense. Medicare is following the lead of these innovators by making payments for Medicare beneficiaries who are patients of clinicians participating in existing multi-payer pilots.

A growing body of evidence documents PCMH benefits (most studies evaluate NCQA-Recognized PCMHs):

- Significantly reduced gaps in care for people with lower incomes.¹
- Savings of \$1 billion to North Carolina's Medicaid program.²
- Promising cost, quality and access trends in several other state Medicaid programs.³

1. Achieving Better Quality of Care for Low-Income Populations: The Role of Health Insurance and the Medical Home for Reducing Health Inequities, Berenson, Commonwealth Fund, May 2012
2. Analysis of Community Care of North Carolina Cost Savings, Milliman, January 2012
3. Reinventing Medicaid: State Innovations To Qualify And Pay For Patient-Centered Medical Homes Show Promising Results, Takach, Health Affairs, July 2011

Summit Medical Group's Journey

Summit Medical Group—a physician-owned enterprise that employs 220 physicians and is spread across 11 Tennessee counties—stands out for its commitment to quality.

“We have worked diligently to ensure that our physicians understand the importance of achieving NCQA Recognition,” says Chief Medical Officer and Executive Vice President, Dr. Randy Curnow.

Forty-seven Summit physicians have achieved a level of PCMH recognition; most are at Level 3, the highest level.

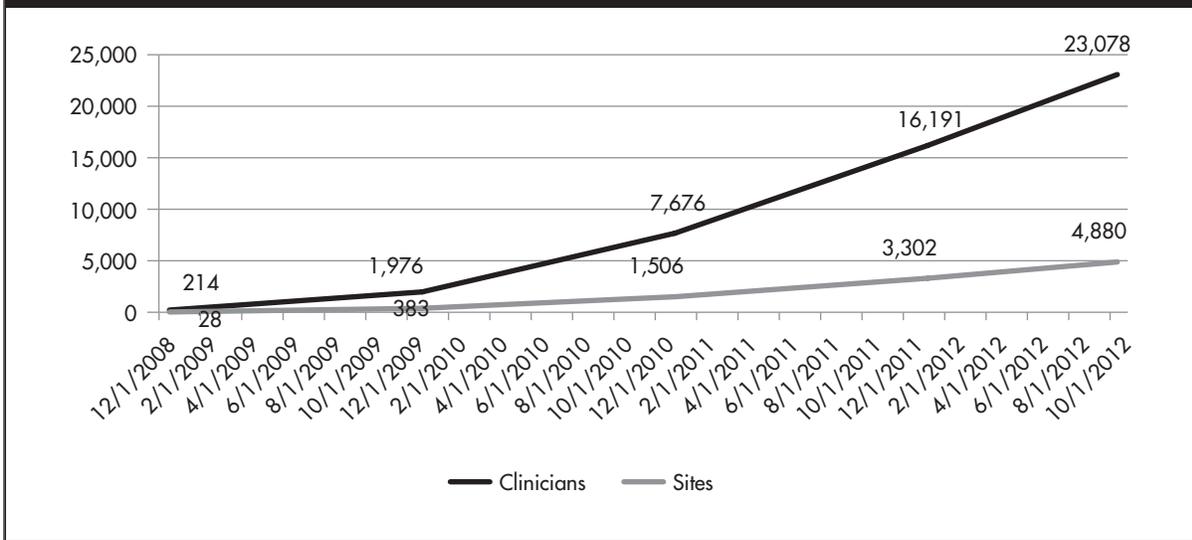
Three years ago, 69 Summit physicians held NCQA Recognition for high-quality diabetes care. Today, there are 146, an increase Dr. Curnow attributes to intervention. “We worked with individual sites and standardized documentation, provided common methods, removed variability and, ultimately, showed physicians how they are compensated for quality,” he says.

Summit's push to have all physicians use electronic medical records (EMR) led to uniform, easy-to-use documentation. “EMRs forced us to assess our processes and workflows,” Curnow recalls. “It allowed us to drive out the unnecessary steps.

Summit is proud of our steady increases in the number of physicians earning NCQA Recognition. Since NCQA Recognition is based on outcomes, this progress is tangible proof of our quality.”

- Reduced emergency department (ED) visits, increased evidence-based care, improved control of diabetes and reduced overall cost trends for the private insurer Cigna, in Texas.⁴
- Improved patient satisfaction and reduced provider burnout.⁵

FIGURE 12. GROWTH IN NCQA-RECOGNIZED PATIENT-CENTERED MEDICAL HOMES



The next challenge is building from this model and developing others that include specialists and hospitals.

Accountable care organizations. Medicare is leading the development of ACOs. Other purchasers, including private insurance companies and Medicaid programs, are beginning to experiment with the concept, but employers are not the driving force in this area. Payers should work together to set the same requirements, to make it worthwhile for providers to invest in the systems and changes needed to run a successful ACO. Based on our experience with PCMHs, we recommend that payers go beyond the set of performance measures in these initiatives and include standards that articulate—in clear and unambiguous terms—the program elements

4. Cigna's Collaborative Accountable Care Program with Medical Clinic of North Texas Shows Improved Quality, Lower Costs, August 2011 <http://newsroom.cigna.com/NewsReleases/cigna-s-collaborative-accountable-care-program-with-medical-clinic-of-north-texas-shows-improved-quality--lower-costs.htm>
5. The Group Health Medical Home at Year Two: Cost Savings, Higher Patient Satisfaction and Less Burnout for Providers, Soman, Health Affairs, May 2010

necessary for success that can be evaluated consistently. (Too often, these programs require lengthy descriptions that can be hard to evaluate, severely curtailing their usefulness.)

Specialists and PCMHs. Another approach for building from the PCMH is the “PCMH neighborhood” idea, aspects of which we are building into the NCQA Specialty Practice Recognition program. This program is designed to recognize the commitment specialists make to coordinating the care of patients in their practice, and to coordinating with their patients’ primary care providers.

Medicare physician payment

As Congress considers changing Medicare’s physician payment system, now is the time to use the powerful incentives in payment systems to motivate better outcomes in quality and cost. Medicare has begun to rebalance payment in favor of primary care, but should do more to reward the challenging work of primary care. It should adopt payment strategies that create incentives for physicians to provide other than in face-to-face visits and coordinate care among different providers. Given the looming shortage of primary care providers and some specialists, the payment system must create innovative ways to deliver care.

Exchanges

Although NCQA supports many policies regarding health plans in Exchanges, we wish there was greater emphasis on using Exchanges as a strategy to pursue a value agenda, rather than on operational issues. We would like to see quality measures articulated and health plans encouraged to participate in statewide delivery-reform initiatives. There should be development of useful measures of value: overuse, misuse, waste. And although we support transparency with respect to health plan and provider cost, we feel there is too much importance on the medical loss ratio. A plan that does little to rein in medical spending will find it easier to meet its target ratio than a plan that actively invests in medical management and reduces medical spending—a perverse and unintended outcome.

To keep subsidies relatively affordable, Exchanges’ benefit packages will probably have high deductibles. We encourage both federal and state policymakers to look for flexibility in the law, to use elements of value-based insurance design to keep premiums down in place of high

cost-sharing requirements. Plans and purchasers are developing benefit designs that waive cost sharing for effective services (like those measured by HEDIS).

Quality measure development priorities

Quality measurement has tended to follow development of medical guidelines that reflect areas with a strong clinical-evidence base. But some populations (including the aged) and some types of patients (including those with multiple conditions) are routinely excluded from the clinical trials that we rely on to develop quality measures. We need more research on these populations to discover effective therapies and care management strategies.

Using quality measures for payment initiatives

Although health reformers have developed more complex payment models, with stronger incentives than the simpler versions of the pay-for-performance schemes of the 1990s, rigorous and meaningful measurement is critical to help plans and providers focus on how to attain success and reassure consumers that more affordable care will not be mean lower quality care. The patterns of improved performance we see in Medicare Advantage's pay-for-performance system illustrate the power of incentives. We recommend a number of ways to use measures in payment models:

- **Highlight disparities in care.** Pay-for-value programs could use this information to reward plans and providers working to reduce gaps, as well as to improve overall performance.
- **Make health care costs (including price) more visible to policymakers, purchasers and consumers.** This is not a simple task, given the variety of payment methods and accounting systems, but as health economists often find that higher prices underlie higher costs, it would serve an important public policy objective. We support strategies like tiering and reference pricing, to give consumers incentives to choose alternatives with higher value (i.e., lower cost, higher quality).
- **Develop programs that rely on competition among plans or providers and contain robust consumer protections** (against excessive cost sharing, which can work against access and quality), as well as a strong set of quality measures. Show consumers the difference in premiums and provider prices; use financial incentives to encourage patient engagement and choice of higher-value options.

Incorporating Patient Perspective and Engaging Consumers on Health— An Agenda for All Purchasers in the Health Care System

Although the clinical perspective is important, we should also measure patients' experience of care. NCQA has long supported collection and use of patient experience data in surveys like CAHPS. We want to develop measures of patient-reported outcomes of care with regard to specific health care conditions, to determine if patients feel their condition improved as a result of care. We need measures like these, which capture dimensions of care that mean something to consumers. The agenda for investing in comparative effectiveness research should incorporate the patient perspective as much as possible.

Unfortunately, we understand very little about how to motivate patients to adopt positive health behaviors. Many people do not understand basic health care language and are mystified by insurance benefit design. Faced with a daunting "to do" list, they have no idea where to begin. Nor do we effectively communicate the benefits and harms of treatments, or encourage consumers and their families to be active partners in treatment decisions.

We need to learn more from consumers about how to keep them healthy and engage them in their own care. As delivery systems transform and we increase the emphasis on quality measures for plans and providers, consumers' active participation in their own wellness and care is critical to move the country toward better health. Quality measures, like control of high blood pressure, can translate into avoided deaths, strokes and heart attacks, yet results of these measures have begun to plateau at less-than-optimal levels. Motivating patients to make diet and lifestyle changes and to take needed medications can turn this around.

The following recommendations, reprinted from a recent Atlantic health blog (<http://www.theatlantic.com/health/archive/2012/06/engage-the-patient-to-improve-health-literacy/258079/>), would put us on the path to better patient engagement.

Ensure that every American knows his or her wellness priorities and has a plan to implement them

While millions of Americans already complete a health risk appraisal survey—usually through their employer—more should. Ideally, the results of these surveys will be used to establish a plan and priorities for improving or maintaining good health, rather than sitting in a database somewhere. Employers are using financial incentives to encourage more employees to develop

and act on plans from these appraisals. Incentives should be used more widely and more wisely to encourage people to improve their health.

Improve health literacy

The Institute of Medicine estimates that more than 90 million Americans do not understand the basic language of health care. While this problem has complex roots, a program to improve health care should involve efforts to teach patients to understand their health, treatment options and the health care system. For example, a program could let diabetic patients earn points toward more affordable insurance coverage by completing a self-taught module on diabetes. Tools that track progress (e.g., lowered blood sugar) can be used to help evaluate success and reinforce healthy behaviors.

Establish a research agenda on health behavior motivation

We are at a primitive stage of understanding how people think about their health and about illness, and how to work around denial and magical thinking. The field of patient behavior—like behavioral economics in the 1980s—needs to be developed.

Make informed decision making a standard of care

Patients routinely overestimate the benefits of medical treatments—and underestimate the risks. For example, many patients with coronary artery disease are unaware that their odds of benefiting from risky surgical procedures are often no better than with standard drug treatment. When patients are fully informed, they are often more conservative in their choices than the clinicians who treat them.

Act now

There is no immediate solution to the problems of cost and quality. But as patients bear more and more of the burden of health care coverage because of benefit cutbacks and joblessness, we must engage them as partners in their own health.

HEDIS MEASURES OF CARE

About HEDIS

The Healthcare Effectiveness Data and Information Set (HEDIS) is a tool used by most HMOs and PPO plans to measure performance on important dimensions of care and service. By providing objective, clinical performance data measures against a detailed set of measurement criteria, HEDIS helps purchasers and consumers compare health plans' performance. HEDIS measures address a broad range of important health issues:

- Appropriate antibiotic use.
- Asthma.
- Breast, cervical and colorectal cancers.
- Care for older adults.
- Childhood and adolescent immunizations.
- Cholesterol management.
- COPD.
- Diabetes.
- High blood pressure.
- Hospital readmissions.
- Medication management.
- Mental illness.
- Prenatal and postpartum care.
- Smoking.
- Weight assessment.
- Patient experience (CAHPS).
- Vaccinations for adults and older adults (CAHPS).

HEDIS includes the CAHPS 4.0 Survey. The CAHPS survey measures members' experiences with their health care in areas such as claims processing and getting needed care quickly, and asks them to rate their health plan on a scale of 0–10.

HEDIS 2012 data collected for this report generally reflect services delivered during calendar year 2011. To ensure validity of HEDIS results, certified analysts audit all data, using a process NCQA designed. See the appendices for more details about national averages and performance trends.

HOS Measures

Medicare Health Outcomes Survey (HOS) measures evaluate the physical and mental health of seniors enrolled in Medicare. HOS measures are the first quality measures for elderly populations that are based on patients' self-reported health status. Including HOS as part of HEDIS measurement creates a broad way to evaluate the quality of care that health plans provide to Medicare beneficiaries. This report includes four HOS measures:

- *Fall Risk Management.*
- *Management of Urinary Incontinence in Older Adults.*
- *Osteoporosis Testing in Older Adults.*
- *Physical Activity in Older Adults.*

Terms

NA: Measure rates have no available data. In some instances, data are not collected for a measure in a product line.

Rate: Unless otherwise stated, the statistical mean for reported data. Each measure is described by an average rate for each applicable product line.

A Note on Medicare Survey Data

Medicare CAHPS survey data and HEDIS measures collected through the survey (such as *Flu Shots for Adults* and *Medical Assistance With Smoking and Tobacco Use Cessation*) are not available when NCCQA prints *The State of Health Care Quality Report* in October. NCCQA will include those data in an updated version of this report in November.

AVOIDANCE OF ANTIBIOTIC TREATMENT IN ADULTS WITH ACUTE BRONCHITIS

Acute bronchitis, or chest cold, clinically presents as a cough lasting more than five days (typically, from one to three weeks). The underlying cause in about 90 percent of cases is viral.¹ The *Avoidance of Antibiotic Treatment in Adults With Bronchitis* measure evaluates whether adults with a diagnosis of acute bronchitis were treated appropriately (i.e., were not prescribed antibiotics).

- Antibiotics are ineffective against viral illnesses and are not justified for routine treatment of acute bronchitis.² Although patients with this diagnosis may expect antibiotics, studies have demonstrated that there is no apparent benefit to treating acute bronchitis with antibiotics.^{2,3} Antibiotics are only recommended in cases where the patient has complicating comorbid conditions.^{4,5}
- Antibiotics continue to be prescribed in more than 60 percent of visits for acute respiratory infections. According to the Centers for Disease Control and Prevention, 80 percent of antibiotic prescriptions are unnecessary.⁶ As many as 93 percent of antibiotic prescriptions are for patients with a diagnosis of acute bronchitis alone.⁷

The Case for Improvement

- Antibiotic-resistant infections are responsible for roughly \$20 billion in excess costs annually.⁸ More than \$1.1 billion is spent annually on unnecessary antibiotics for respiratory infections in adults.⁹
- Infections due to antibiotic-resistant pathogens place a significant burden on the health care system and result in longer and more expensive hospital stays.^{10,11}
- The diminished effectiveness of widely used antibiotics reduces the treatment options available for more serious or life-threatening infections. Treatment for drug-resistant pathogens includes prescribing medications that are more expensive and more likely to have negative side effects.¹²

HEDIS Measure Definition

The percentage of adults 18–64 years of age with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription. A higher rate indicates better performance.

The Bottom Line

Prescribing antibiotics is rarely an appropriate treatment for acute bronchitis in an otherwise healthy adult because the infection is often caused by a virus. Reducing inappropriate use of antibiotics is vital to slowing the spread of drug-resistant pathogens and reducing unnecessary health care costs.

| APPROPRIATE TREATMENT RATE | | | | | |
|----------------------------|------------|------|----------|----------|-----|
| YEAR | COMMERCIAL | | MEDICAID | MEDICARE | |
| | HMO | PPO | HMO | HMO | PPO |
| 2011 | 23.5 | 21.5 | 24.3 | - | - |
| 2010 | 22.5 | 21.3 | 23.5 | - | - |
| 2009 | 24.0 | 22.6 | 25.6 | - | - |
| 2008 | 24.6 | 26.8 | 25.8 | - | - |
| 2007 | 25.4 | 29.3 | 25.9 | - | - |
| 2006 | 28.7 | 29.7 | 28.0 | - | - |

USE OF IMAGING STUDIES FOR LOW BACK PAIN

Low back pain is the fifth most common reason for all physician visits in the U.S.¹ In the absence of clear risk factors, imaging of the lower spine within the first four weeks of diagnosis does not improve outcome, but does increase costs. The *Use of Imaging Studies for Low Back Pain* measure assesses the number of patients with lower back pain who *did not* have an X-ray, MRI or CT scan within the first four weeks of diagnosis.

- An estimated 75 percent–85 percent of Americans will experience back pain at some point, and approximately 25 percent of Americans will experience at least one day of back pain during any three-month period.^{1,2}
- Guidelines call for imaging only for patients who have severe or progressive neurologic deficits or signs or symptoms that suggest a serious or specific underlying condition.³ However, many patients with low back pain receive routine spinal imaging when these risk factors are not present.
- Inappropriate use of routine imaging exposes patients to unnecessary radiation, resulting from an invasive procedure with limited or questionable benefit.^{3,4,5}

The Case for Improvement

- Total U.S. health care expenditures for low back pain were estimated at \$90 billion in 2005.⁶ Average health expenditures for patients with back and neck problems increased from \$4,795 per year in 1997 to about \$6,096 per year in 2007, representing a 65 percent increase in costs after adjusting for inflation.⁷
- Routine lower back imaging studies, in addition to generating costs for the health system, tend to increase the downstream cost of caring for the patient. Studies have associated MRI for low back pain with an eight-fold increase in the likelihood of surgery and a five-fold increase in total cost.³

HEDIS Measure Definition

The percentage of adults with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI or CT scan) within 28 days of diagnosis.

The Bottom Line

Imaging studies for low back pain are often inappropriate and do not produce positive health outcomes for patients. Imaging studies in the absence of neurologic deficits or other serious underlying conditions increase costs and expose patients to greater risk.

| APPROPRIATE TREATMENT RATE | | | | | |
|----------------------------|------------|------|----------|----------|-----|
| YEAR | COMMERCIAL | | MEDICAID | MEDICARE | |
| | HMO | PPO | HMO | HMO | PPO |
| 2011 | 74.4 | 73.7 | 75.8 | - | - |
| 2010 | 74.2 | 73.3 | 75.5 | - | - |
| 2009 | 73.9 | 72.7 | 76.1 | - | - |
| 2008 | 73.1 | 72.3 | 75.7 | - | - |
| 2007 | 74.6 | 73.3 | 77.3 | - | - |
| 2006 | 73.9 | 72.1 | 78.3 | - | - |
| 2005 | 75.4 | 72.6 | 79.0 | - | - |

ADULT BMI ASSESSMENT

Obesity is defined by body mass index (BMI), which provides various weight ranges that correlate to height and gender. Higher BMIs correlate to being overweight or obese.¹ The higher the BMI, the higher the risk of developing certain life-threatening diseases.² Obesity is a major public health problem that contributes to 112,000 preventable deaths each year.³ The *Adult BMI Assessment* measure evaluates whether adults had their BMI measured at least once in the past two years, to assess their risk for being overweight or obese and their risk for developing health-related complications.

- According to the Centers for Disease Control and Prevention, more than 68 percent of U.S. adults are overweight and more than 33.8 percent are considered obese.⁴
- A number of factors can affect overweight and obesity: behavior, environment, culture, socioeconomic status, heredity and metabolism.⁵
- The U.S. Preventive Services Task Force recommends that clinicians screen all adult patients for obesity and offer counseling and behavioral interventions to promote weight loss.⁶
- As few as 31 percent of U.S. adults report that they participate in regular leisure-time physical activity (defined as three sessions per week of vigorous physical activity lasting 20 minutes or more, or five sessions per week of light-to-moderate physical activity lasting 30 minutes or more). Approximately 40 percent of adults report no leisure-time physical activity at all.⁴

The Case for Improvement

- Obesity is a national epidemic that is causing higher medical costs and lower quality of life.¹
- According to a 2009 study, the direct and indirect cost of obesity is more than \$147 billion annually. Obese patients spend 42 percent (an average of \$1,429) more per year for their medical care than those in a healthy weight range.⁸
- Obese men are more likely to develop cancer of the colon, rectum or prostate; obese women are more likely to develop cancer of the gallbladder, uterus, cervix or ovaries.⁷
- Losing 5 percent–7 percent of body weight will help prevent type 2 diabetes in people who are classified as at high risk for the disease.⁷

HEDIS Measure Definition

The percentage of adults 18–74 years of age who had an outpatient visit and who had their BMI documented during the measurement year or the year prior to the measurement year.

The Bottom Line

Losing 5 percent–10 percent of body weight will help lower an obese person’s risk of developing diseases associated with obesity. Understanding and tracking BMI can help health care providers identify patients at risk and offer focused advice or services.

| ADULT BMI ASSESSMENT RATE | | | | | |
|---------------------------|------------|------|----------|----------|------|
| YEAR | COMMERCIAL | | MEDICAID | MEDICARE | |
| | HMO | PPO | HMO | HMO | PPO |
| 2011 | 55.4 | 26.3 | 52.6 | 68.2 | 62.2 |
| 2010 | 40.7 | 11.6 | 42.2 | 50.4 | 36.6 |
| 2009 | 41.3 | 15.7 | 34.6 | 38.8 | 24.1 |

BREAST CANCER SCREENING

Breast cancer ranks as the second leading cause of cancer-related mortality in women, accounting for nearly 40,000 estimated deaths in 2011.¹ The *Breast Cancer Screening* measure assesses whether women received biennial mammogram screening for breast cancer.

- Other than skin cancer, breast cancer is the most commonly diagnosed cancer among women in the United States. Just under 30 percent of cancers in women are breast cancers.²
- About 85 percent of breast cancers occur in women who have no family history of breast cancer.² Mammography is particularly valuable to these patients, detecting on average about 80 percent–90 percent of breast cancers in women with no symptoms.²
- A woman's chance of developing breast cancer increases with age. In the U.S., a woman has about a 12 percent, or 1 in 8, risk of developing breast cancer over the course of her lifetime.²

The Case for Improvement

- Screening can improve outcomes: breast cancer deaths have decreased over the years as a result of early detection using mammography.³
- The five-year survival rate for women who are diagnosed early is 98 percent, compared with the late-diagnosed breast cancer survival rate of only 23 percent.²
- Of the estimated \$7 billion spent annually on breast cancer treatment costs, 30 percent of total costs, or nearly \$2 billion, are spent on late-stage treatment.⁴

HEDIS Measure Definition

The percentage of women 40–69 years of age who had at least one mammogram to screen for breast cancer in the past two years.

The Bottom Line

Early detection and better treatment have resulted in increased survival rates for women with breast cancer. If breast cancer is diagnosed in its earliest stages, treatment may be more effective and less expensive.⁴

| BREAST CANCER SCREENING RATE | | | | | |
|------------------------------|------------|------|----------|----------|------|
| YEAR | COMMERCIAL | | MEDICAID | MEDICARE | |
| | HMO | PPO | HMO | HMO | PPO |
| 2011 | 70.5 | 66.7 | 50.4 | 68.9 | 65.8 |
| 2010 | 70.8 | 67.0 | 51.3 | 68.5 | 65.8 |
| 2009 | 71.3 | 67.1 | 52.4 | 69.3 | 65.5 |
| 2008 | 70.2 | 66.0 | 50.8 | 68.0 | 65.2 |
| 2007 | 69.1 | 64.6 | 49.8 | 67.3 | 64.5 |
| 2006 | 68.9 | 63.5 | 49.1 | 69.5 | 68.6 |
| 2005 | 72.0 | 63.9 | 53.9 | 71.6 | 69.0 |
| 2004 | 73.4 | - | 54.1 | 74.0 | - |
| 2003 | 75.3 | - | 55.9 | 74.0 | - |
| 2002 | 74.9 | - | 56.0 | 74.5 | - |
| 2001 | 75.5 | - | 55.1 | 75.3 | - |
| 2000 | 74.5 | - | - | - | - |
| 1999 | 73.4 | - | - | - | - |

CERVICAL CANCER SCREENING

In the United States, more than 12,000 women will be diagnosed with cervical cancer each year, and over 4,000 will die of the disease.¹ Cervical cancer represents 9.8 percent of all cancers in women.² Early detection can greatly improve outcome. The *Cervical Cancer Screening* measure assesses whether women received screening for cervical cancer at least once in the past three years, as recommended by guidelines.

- Screening can identify cancer in the early stages, when treatment is more effective and the chance of recovery is high.³
- In the U.S., 60 percent–80 percent of newly diagnosed invasive cancers are in women who have not had a Pap test in the past five years, or who have never had one.⁴
- In 2010, the prevalence of Pap test use was lowest among older women, women with no health insurance and recent immigrants.⁵
- Health economists generally agree that an intervention is cost-effective if it can save one year of life for less than \$50,000. Receiving a Pap test every three years could extend a life at a cost of about \$5,392 per year of life saved, making the Pap test a very cost-effective screening for cervical cancer.⁶
- Compared to women whose cervical cancer is detected because of symptoms, those diagnosed after a routine Pap test increased their cure rate from 66 percent to more than 90 percent.⁵

The Case for Improvement

- The direct annual health care costs for screening, treating and managing clinical issues related to cervical cancer in the United States are estimated to be as high as \$4.6 billion.²

HEDIS Measure Definition

The percentage of women 21–64 years of age who received one or more Pap tests to screen for cervical cancer in the past three years.

The Bottom Line

For women who are diagnosed with cervical cancer using Pap tests, the likelihood of survival, given appropriate evaluation, treatment and follow up, is nearly 100 percent.⁵

| CERVICAL CANCER SCREENING RATE | | | | | |
|--------------------------------|------------|------|----------|----------|-----|
| YEAR | COMMERCIAL | | MEDICAID | MEDICARE | |
| | HMO | PPO | HMO | HMO | PPO |
| 2011 | 76.5 | 74.4 | 66.7 | - | - |
| 2010 | 77.0 | 74.5 | 67.2 | - | - |
| 2009 | 77.3 | 74.6 | 65.8 | - | - |
| 2008 | 80.7 | 74.0 | 66.0 | - | - |
| 2007 | 81.7 | 73.5 | 64.8 | - | - |
| 2006 | 81.0 | 72.6 | 65.7 | - | - |
| 2005 | 81.8 | 74.6 | 65.2 | - | - |
| 2004 | 80.9 | - | 64.7 | - | - |
| 2003 | 81.8 | - | 64.0 | - | - |
| 2002 | 80.5 | - | 62.2 | - | - |
| 2001 | 80.0 | - | 61.1 | - | - |
| 2000 | 78.1 | - | - | - | - |
| 1999 | 71.8 | - | - | - | - |

COLORECTAL CANCER SCREENING

The National Cancer Institute estimates that in 2012, 143,460 men and women will be diagnosed with colorectal cancer and approximately 51,690 will die from the disease.¹ Colorectal cancer is currently the third leading cause of cancer death in the United States.² The *Colorectal Cancer Screening* measure assesses whether adults 50–75 years of age received screening for colorectal cancer, based on the recommendation of the U.S. Preventive Services Task Force.³

- Fecal occult blood tests, colonoscopy and flexible sigmoidoscopy are effective screening methods.⁴ Colorectal screening of individuals with no symptoms and removal of identified polyps can reduce colorectal cancer deaths by 90 percent.⁵
 - Deaths associated with colorectal cancer declined in 2010, continuing a 15-year trend mostly attributed to increased screening and early detection.^{2,6} Thirty-five states saw significant decreases in the number of new cases of colorectal cancer between 2003 and 2007, but rates remain above the national goals set by the *Healthy People 2020* initiative.⁷
 - Doctors' recommendations have been found to be a major predictor of whether patients receive the supported screening.⁸
- adults do not receive the necessary colorectal cancer screenings.⁹
- 90 percent of people diagnosed at the earliest stage of colorectal cancer have a five-year survival rate,² but only 39 percent of new cases are diagnosed at the earliest stage because there are often no symptoms until the disease has progressed.¹⁰
 - Screening for colorectal cancer is cost effective for the health care system. The cost of screening far outweighs the costs of treating colorectal cancer that has progressed to a later stage.^{11,12}

HEDIS Measure Definition

The percentage of adults 50–75 years of age who had appropriate screening for colorectal cancer with any of the following tests: fecal occult blood test during the measurement year; flexible sigmoidoscopy during the measurement year or the four years prior to the measurement year; or colonoscopy during the measurement year or in any of the nine years prior to the measurement year.

The Case for Improvement

- Although screening is extremely effective in detecting early- and late-stage colorectal cancer, it remains underutilized. Approximately 58 percent of American

The Bottom Line

Colorectal cancer screening in asymptomatic adults between 50 and 75 years of age can catch dangerous polyps before they become cancerous, or can detect colorectal cancer in its early stages, when treatment is most effective.

| COLORECTAL CANCER SCREENING RATE | | | | | |
|----------------------------------|------------|------|----------|----------|------|
| YEAR | COMMERCIAL | | MEDICAID | MEDICARE | |
| | HMO | PPO | HMO | HMO | PPO |
| 2011 | 62.4 | 54.6 | – | 60.0 | 55.2 |
| 2010 | 62.6 | 47.6 | – | 57.6 | 41.0 |
| 2009 | 60.7 | 47.0 | – | 54.9 | 40.1 |
| 2008 | 58.6 | 45.3 | – | 53.1 | 41.8 |
| 2007 | 55.6 | 42.5 | – | 50.4 | 39.5 |
| 2006 | 54.5 | 42.1 | – | 53.3 | 47.1 |
| 2005 | 52.3 | 43.4 | – | 54.0 | 49.7 |
| 2004 | 49.0 | – | – | 52.6 | – |

FLU SHOTS

Each year, 5 percent–20 percent of Americans contract influenza (flu). More than 200,000 people are hospitalized from flu-related complications, which include pneumonia, dehydration and deterioration of chronic health conditions, such as cardiac disease, diabetes and asthma.^{1,2} The *Flu Shots for Adults Ages 50–64* and *Flu Shots for Adults Ages 65+* measures assess whether adults received a flu vaccination.

- The flu shot is recommended for everyone older than 6 months of age.³ Flu especially affects the health of people over 50 years of age.⁴ One-third of all Americans 50–64 have one or more chronic medical conditions that put them at increased risk for serious flu complications.⁵
- Flu shots are the most effective way to prevent severe illness or death resulting from influenza and its complications. Influenza vaccines may prevent 50 percent–60 percent of hospitalizations and 68 percent of deaths from flu-related complications in adults.⁶
- Flu shots have been shown to be highly cost-effective for adults 50–64.⁹ The vaccination is estimated to cost \$16.70 per person vaccinated—including direct and indirect medical costs and costs associated with potential side-effects¹⁰—whereas a flu epidemic can result in more than \$6 billion in direct hospitalization costs alone.²

HEDIS Measure Definition

A rolling average represents the percentage of adults 50–64 years of age who received an influenza vaccination between September 1 of the measurement year and the date when the CAHPS 4.0H survey was completed.

The Case for Improvement

- In 2007, approximately 42 percent of adults between 50 and 64 years of age reported receiving an influenza vaccination.⁷ Over the course of an average flu season, more than 15,000 lives could be saved if 90 percent vaccination coverage was achieved.⁸

The Bottom Line

Flu shots for adults 50–64 years of age could save thousands of lives and result in dramatic cost savings for the health care system.

| FLU VACCINATION RATE | | | | | |
|----------------------|------------|------|----------|----------|-----|
| YEAR | COMMERCIAL | | MEDICAID | MEDICARE | |
| | HMO | PPO | HMO | HMO | PPO |
| 2011 | 53.3 | 51.4 | - | - | - |
| 2010 | 52.5 | 51.6 | - | - | - |
| 2009 | 51.3 | 50.5 | - | - | - |
| 2008 | 49.8 | 49.2 | - | - | - |
| 2007 | 48.6 | 48.1 | - | - | - |
| 2006 | 45.6 | 44.5 | - | - | - |
| 2005 | 36.2 | 37.1 | - | - | - |
| 2004 | 38.9 | - | - | - | - |
| 2003 | 47.9 | - | - | - | - |
| 2002 | 44.0 | - | - | - | - |
| 2001 | 30.3 | - | - | - | - |

| FLU VACCINATION RATE FOR OLDER ADULTS | | | | | |
|---------------------------------------|------------|-----|----------|----------|------|
| YEAR | COMMERCIAL | | MEDICAID | MEDICARE | |
| | HMO | PPO | HMO | HMO | PPO |
| 2011 | - | - | - | 68.8 | 69.5 |
| 2010 | - | - | - | 68.8 | 69.4 |
| 2009 | - | - | - | 64.5 | 65.1 |
| 2008 | - | - | - | 65.8 | 66.7 |
| 2007 | - | - | - | 68.6 | 68.9 |
| 2006 | - | - | - | 67.8 | 68.2 |
| 2005 | - | - | - | 70.3 | 69.9 |
| 2004 | - | - | - | 74.8 | - |
| 2003 | - | - | - | 74.4 | - |
| 2002 | - | - | - | 72.5 | - |
| 2001 | - | - | - | 71.2 | - |

MEDICAL ASSISTANCE WITH SMOKING AND TOBACCO CESSATION

Smoking is the leading cause of preventable deaths in the U.S. and is the cause of more than 1 in 5 deaths each year.^{1,2} In 2010 an estimated 45.3 million adults in the U.S.—more than 19 percent of the population—were cigarette smokers.³ More than 78 percent of these adults smoked every day.³ The *Medical Assistance With Smoking and Tobacco Use Cessation* measure assesses whether adults who use tobacco products receive counseling, medications and strategies to help them quit.

- The number of heavy smokers (e.g., consume a pack of cigarettes a day) has declined in recent years, but use of cigars or smokeless tobacco has increased.⁴ Cigars are addictive and contain toxic chemicals.⁵
 - Tobacco use increases the risk of developing cancer and other chronic conditions, and events such as coronary heart disease, heart attack and stroke.^{1,6}
 - Almost 69 percent of adult smokers expressed a desire to quit smoking in 2010, but only 48 percent of smokers were offered advice and support for smoking cessation.⁷
 - Current research shows that provider participation and advice lead to a greater likelihood of successfully quitting smoking by as much 66 percent.^{8,9} As few as three minutes of counseling or other primary care interventions can increase the success rate of smoking cessation.¹⁰
- ### The Case for Improvement
- Tobacco use and related illnesses have fatal outcomes. Approximately 443,000 deaths occur in the U.S each year from tobacco-related conditions.⁶
 - Tobacco use is the leading cause of lung cancer deaths for both men and women.¹¹ Up to 90 percent of lung cancer deaths for men and 80 percent of all lung cancers for women are attributed to tobacco use.² Tobacco use contributes to 30 percent of all cancer deaths in the U.S.⁶
 - Remaining tobacco free for five years can decrease the risk of mouth, throat, esophageal and bladder cancer by 50 percent. Within two–five years, it is possible for the risk of stroke to decrease to the same level as a person who did not smoke.¹²
 - Nonsmokers are not immune to the damage caused by tobacco use. Around 46,000 people die each year from diseases caused by exposure to secondhand smoke. Nearly 3,400 of these nonsmoker deaths are from lung cancer.¹¹

- Smoking costs Americans \$96 billion in direct health care costs each year.³ A total of \$193 billion is lost each year when also accounting for lost work productivity.¹¹

HEDIS Measure Definition

The following components of this measure assess different facets of providing medical assistance with tobacco use cessation:

Advising Tobacco Users to Quit. The percentage of people 18 years of age and older who were current tobacco users, were seen by a health plan practitioner during the measurement year and received advice to quit smoking or using tobacco

Discussing Cessation Medications. The percentage of people 18 years of age and older who were current tobacco users, were seen by a practitioner during the measurement year and discussed or were recommended cessation medications

Discussing Cessation Strategies. The percentage of people 18 years of age and older who were current tobacco users, were seen by a practitioner during the measurement year and discussed or were recommended cessation methods or strategies.

The Bottom Line

Smoking and tobacco use leads to many preventable deaths and poor health outcomes in the U.S. Smoking cessation education and support is an important service for providers to promote success in a patient’s efforts to quit. Reducing exposure to harmful chemicals and carcinogens from tobacco use can also create significant savings to health care costs.

| ADVISING SMOKERS AND TOBACCO USERS TO QUIT | | | | | |
|--|------------|------|----------|----------|------|
| YEAR | COMMERCIAL | | MEDICAID | MEDICARE | |
| | HMO | PPO | HMO | HMO | PPO |
| 2011 | 77.6 | 72.4 | 74.6 | 81.5 | 79.3 |
| 2010 | 76.7 | 71.7 | 73.6 | 77.9 | 78.3 |
| 2009 | – | – | – | 77.9 | 75.2 |
| 2008 | 76.7 | 71.6 | 69.3 | 76.9 | 76.5 |
| 2007 | 75.8 | 71.0 | 69.4 | 75.8 | 75.4 |
| 2006 | 73.8 | 70.1 | 68.2 | 76.1 | 77.3 |
| 2005 | 71.2 | 66.9 | 65.6 | 75.5 | 77.3 |
| 2004 | 69.6 | – | 66.7 | 64.7 | – |
| 2003 | 68.6 | – | 65.8 | 62.9 | – |
| 2002 | 67.7 | – | 63.6 | 61.6 | – |
| 2001 | 65.7 | – | 63.9 | 60.9 | – |
| 2000 | 66.3 | – | – | – | – |

| DISCUSSING CESSATION STRATEGIES | | | | | |
|---------------------------------|------------|------|----------|----------|-----|
| YEAR | COMMERCIAL | | MEDICAID | MEDICARE | |
| | HMO | PPO | HMO | HMO | PPO |
| 2011 | 47.6 | 40.1 | 40.3 | - | - |
| 2010 | 45.0 | 39.0 | 38.5 | - | - |
| 2008 | 49.7 | 43.3 | 40.8 | - | - |
| 2007 | 48.0 | 44.2 | 39.2 | - | - |
| 2006 | 43.2 | 42.6 | 36.7 | - | - |
| 2005 | 38.9 | 35.1 | 33.9 | - | - |
| 2004 | 36.8 | - | 32.7 | - | - |
| 2003 | 36.0 | - | 32.3 | - | - |

| DISCUSSING CESSATION MEDICATIONS | | | | | |
|----------------------------------|------------|------|----------|----------|-----|
| YEAR | COMMERCIAL | | MEDICAID | MEDICARE | |
| | HMO | PPO | HMO | HMO | PPO |
| 2011 | 53.1 | 47.9 | 44.3 | - | - |
| 2010 | 52.4 | 47.2 | 42.7 | - | - |
| 2008 | 54.4 | 50.9 | 40.6 | - | - |
| 2007 | 50.9 | 49.6 | 38.7 | - | - |
| 2006 | 43.9 | 43.8 | 35.1 | - | - |
| 2005 | 39.4 | 36.7 | 31.8 | - | - |
| 2004 | 37.8 | - | 31.3 | - | - |
| 2003 | 37.6 | - | 31.5 | - | - |

USE OF SPIROMETRY TESTING IN THE ASSESSMENT AND DIAGNOSIS OF COPD

Chronic obstructive pulmonary disease (COPD), characterized by blocked airflow and diminished capacity to breathe, is a major health problem in the U.S. The most significant risk factor is long-term cigarette smoking.^{1,2} Other factors include old age and exposure to occupational and environmental pollutants. The *Use of Spirometry Testing in the Assessment and Diagnosis of COPD* measure evaluates whether adults with a new COPD diagnosis received a spirometry test, which helps with diagnosis confirmation, enabling early identification and appropriate treatment planning.

- COPD now ranks as the third leading cause of death in the United States.^{1,2}
- According to the Global Initiative for Chronic Obstructive Lung Disease (GOLD) guidelines, the spirometry test is an effective and objective screening tool.³ But despite the known importance of spirometry for accurate diagnosis and effective management of the disease, it remains underused in primary care.^{4,5}
- Early detection of COPD is crucial for promoting smoking cessation and instituting appropriate therapy before patients reach more costly stages of the disease.^{4,5,6}

The Case for Improvement

- In 2010, total annual costs were estimated to exceed \$50 billion. Of this, \$29.5 billion was for direct health care costs, including hospitalizations, drugs and physician office and ED visits.⁷ Patients 40–65 represented 67 percent of physician office visits and 43 percent of hospitalizations.⁷
- In 2008, 13.1 million adults over 18 were estimated to have COPD, but close to 24 million U.S. adults have evidence of impaired lung function, underscoring the magnitude of underdiagnosis.^{1,2,7}
- Disability and premature death from COPD cost an additional \$14.1 billion in lost income.¹

HEDIS Measure Definition

This measure assesses the percentage of adults 40 years of age and older with a new diagnosis or newly active COPD who received spirometry testing to confirm the diagnosis.

The Bottom Line

Spirometry tests can improve confirmation of a diagnosis of COPD and enhance future symptom and disease management.^{8,9,10}

| SPIROMETRY TESTING RATE | | | | | |
|-------------------------|------------|------|----------|----------|------|
| YEAR | COMMERCIAL | | MEDICAID | MEDICARE | |
| | HMO | PPO | HMO | HMO | PPO |
| 2011 | 42.9 | 40.5 | 32.0 | 36.3 | 35.6 |
| 2010 | 41.7 | 40.2 | 31.3 | 33.9 | 35.3 |
| 2009 | 38.8 | 36.7 | 28.6 | 28.5 | 28.8 |
| 2008 | 37.6 | 36.4 | 29.3 | 27.7 | 26.5 |
| 2007 | 35.7 | 33.7 | 28.4 | 27.2 | 25.4 |
| 2006 | 36.1 | 33.7 | 27.3 | 26.2 | 30.2 |

PHARMACOTHERAPY MANAGEMENT OF COPD EXACERBATION

COPD is a progressive condition in which airflow becomes limited, making it difficult to breathe. Exacerbations are characterized by acute worsening of clinical symptoms (e.g., breathlessness or sputum production). Exacerbations may range from temporary decline in functional status to fatal events.^{1,2} After an exacerbation, patients' symptoms and lung function can take several weeks to recover to baseline, and quality of life declines drastically.² Studies have found that smoking is associated with more frequent episodes of COPD exacerbation.² The *Pharmacotherapy Management of COPD Exacerbation* measure evaluates whether patients received appropriate medical treatment after an event and assesses effective outpatient management of the disease.

- Emphysema and chronic bronchitis are the most important conditions that compose COPD, and they frequently coexist.
 - COPD exacerbations are responsible for the majority of COPD-related costs from unscheduled physician and ED visits, and hospitalizations and days lost from work.² Patients who have acute exacerbations of COPD, as compared with patients with COPD who do not have acute exacerbations, have an increased risk of death, a more rapid decline in lung function and reduced quality of life.³
- The Case for Improvement**
- COPD exacerbations are estimated to result in approximately 110,000 deaths and more than 500,000 hospitalizations annually. More than \$18 billion is spent on direct costs every year.⁴ Hospital admissions for COPD exacerbations average a 10-day length of stay, at a cost of \$10,000 per stay.^{5,6}
 - Approximately one-third of patients discharged from the ED after an acute exacerbation have recurrent symptoms within 14 days. 17 percent relapse and require hospitalization—an indicator that patients are not getting the care they require.⁴
 - Benefits of appropriate medical treatment include decreased duration of hospital stays and less likelihood of treatment failure. Patients also exhibit decreased frequency of exacerbations and maintain longer disease-free intervals.^{5,7}

HEDIS Measure Definition*Pharmacotherapy Management of COPD*

Exacerbation evaluates whether adults 40 years of age and older received appropriate medical treatment after an event, and assesses effective outpatient management of the disease.

The Bottom Line

COPD medications aimed at controlling symptoms have been shown to increase exercise capacity, improve health status and reduce exacerbations.^{8,9} Decreasing the frequency of exacerbations can slow the progression of COPD and should be a critical goal of care management.^{8,9}

USE OF BRONCHODILATORS

| YEAR | COMMERCIAL | | MEDICAID | MEDICARE | |
|------|------------|------|----------|----------|------|
| | HMO | PPO | HMO | HMO | PPO |
| 2011 | 79.9 | 76.8 | 80.4 | 78.4 | 75.9 |
| 2010 | 77.8 | 73.5 | 82.1 | 78.2 | 76.1 |
| 2009 | 78.0 | 75.0 | 80.7 | 76.2 | 74.9 |
| 2008 | 76.1 | 68.1 | 78.2 | 74.1 | 71.3 |

SYSTEMIC CORTICOSTEROIDS

| YEAR | COMMERCIAL | | MEDICAID | MEDICARE | |
|------|------------|------|----------|----------|------|
| | HMO | PPO | HMO | HMO | PPO |
| 2011 | 71.3 | 69.5 | 64.1 | 66.8 | 68.8 |
| 2010 | 69.8 | 66.2 | 65.3 | 66.6 | 69.6 |
| 2009 | 66.1 | 64.1 | 61.8 | 60.9 | 64.2 |
| 2008 | 67.0 | 58.2 | 61.7 | 60.0 | 60.8 |

USE OF APPROPRIATE MEDICATIONS FOR PEOPLE WITH ASTHMA

Asthma is one of the most common lifelong chronic diseases affecting the lungs, causing repeated episodes of wheezing, breathlessness, chest tightness and coughing. The *Use of Appropriate Medications for People With Asthma* measure assesses whether adults and children diagnosed with persistent asthma receive appropriate therapeutic medications.

- In 2010, approximately 25.7 million Americans (18.7 million adults and 7 million children) reported having asthma.^{1,2,3} From 2008–2010, asthma prevalence was higher among children (9.5 percent) than adults (7.7 percent).^{1,2,3}
- According to the Asthma Regional Council, two-thirds of adults and children who display asthma symptoms are considered “not well controlled” or “very poorly controlled,” as defined by clinical practice guidelines.⁴
- A key component for adults and children is to create and follow an asthma treatment plan that aligns with clinical guidelines, to help reduce the severity of symptoms and the occurrence of asthma-related events (e.g., hospitalizations, ED visits).³
- In 2009, asthma caused approximately 480,000 hospitalizations, 1.9 million ED visits and 8.9 million primary care visits. In 2008 there were 10.5 million missed work days for adults and 14.2 million missed school days for children 5–17 years of age.^{3,4,5}
- Adults and children with persistent asthma are at increased risk of complications.¹ Among the 4 million individuals who reported missing at least one work or school day due to asthma attacks, at least 1 in 7 (13.6 percent) required additional outpatient treatment.^{6,7}

HEDIS Measure Definition

The percentage of adults and children 5–64 years of age during the measurement year who were identified as having persistent asthma and who were appropriately prescribed medication during the measurement year.

The Case for Improvement

- The financial burden of asthma is nearly \$56 billion annually.⁵ Asthma costs the U.S. about \$3,300 per person with asthma each year in medical expenses, missed school and work days and early deaths.³

The Bottom Line

Adults and children with asthma can manage their symptoms through use of long-term controller medications and through environmental control measures that reduce exposure to irritants.⁶

**ASTHMA MEDICATION RATE
(5–11 YEARS)**

| YEAR | COMMERCIAL | | MEDICAID | | MEDICARE | |
|------|------------|------|----------|-----|----------|--|
| | HMO | PPO | HMO | HMO | PPO | |
| 2011 | 96.0 | 96.6 | 90.5 | – | – | |
| 2010 | 96.7 | 97.0 | 91.8 | – | – | |
| 2009 | 96.6 | 97.0 | 91.8 | – | – | |

**ASTHMA MEDICATION RATE
(12–18 YEARS)**

| YEAR | COMMERCIAL | | MEDICAID | | MEDICARE | |
|------|------------|------|----------|-----|----------|--|
| | HMO | PPO | HMO | HMO | PPO | |
| 2011 | 92.7 | 93.1 | 86.6 | – | – | |

**ASTHMA MEDICATION RATE
(19–50 YEARS)**

| YEAR | COMMERCIAL | | MEDICAID | | MEDICARE | |
|------|------------|------|----------|-----|----------|--|
| | HMO | PPO | HMO | HMO | PPO | |
| 2011 | 88.3 | 74.7 | – | – | – | |

**ASTHMA MEDICATION RATE
(51–64 YEARS)**

| YEAR | COMMERCIAL | | MEDICAID | | MEDICARE | |
|------|------------|------|----------|-----|----------|--|
| | HMO | PPO | HMO | HMO | PPO | |
| 2011 | 93.2 | 93.0 | 72.9 | – | – | |

ASTHMA MEDICATION RATE (OVERALL)

| YEAR | COMMERCIAL | | MEDICAID | | MEDICARE | |
|------|------------|------|----------|-----|----------|--|
| | HMO | PPO | HMO | HMO | PPO | |
| 2011 | 91.9 | 91.6 | 85.0 | – | – | |
| 2010 | 92.9 | 93.0 | 88.4 | – | – | |
| 2009 | 92.7 | 92.8 | 88.6 | – | – | |
| 2008 | 92.4 | 92.7 | 88.7 | – | – | |
| 2007 | 92.3 | 92.9 | 86.9 | – | – | |
| 2006 | 91.6 | 92.7 | 87.1 | – | – | |
| 2005 | 89.9 | 91.6 | 85.7 | – | – | |
| 2004 | 72.9 | – | 64.5 | – | – | |
| 2003 | 71.4 | – | 64.1 | – | – | |
| 2002 | 67.9 | – | 62.5 | – | – | |
| 2001 | 65.6 | – | 60.1 | – | – | |
| 2000 | 62.6 | – | – | – | – | |
| 1999 | 57.7 | – | – | – | – | |

CHOLESTEROL MANAGEMENT FOR PATIENTS WITH CARDIOVASCULAR CONDITIONS

High cholesterol is associated with elevated levels of LDL-C (“bad cholesterol”). A person with a serum total cholesterol of 240 mg/dL or greater is considered to have high cholesterol.¹ There are 33.6 million American adults at or above this threshold.²

- High cholesterol causes fatty deposits to adhere to artery walls and impedes blood flow.
- There are no signs or symptoms of high cholesterol, which increases a person’s risk for heart failure or stroke due to reduced blood flow to the heart and brain.³
- An estimated 82.6 million adults in the United States suffer from a cardiovascular condition.⁴
- With more than 600,000 deaths each year, heart disease is the leading cause of death in the United States.⁴ The *Cholesterol Management for Patients With Cardiovascular Conditions* measure assess whether adults who have cardiovascular conditions are screened for high cholesterol.

The Case for Improvement

- According to research from the National Institutes of Health, cardiovascular diseases are the most costly health condition in the United States. Direct and indirect cost from mortality and loss of productivity total \$297.7 billion.⁵ Lowering LDL-C level by 50 percent can reduce a patient’s costs of cardiovascular needs by \$19,500 and increase the net lifetime benefit by \$53,200.⁶
- Lifestyle and behavioral changes can reduce cholesterol levels. Exercise, healthier food choices and use of necessary medications can all play a role.^{7,8}
- An American Heart Association study estimates that more than 40 percent of the U.S. population will be diagnosed with a form of cardiovascular disease.⁹ A 10 percent decrease in the total cholesterol of the entire U.S. population would result in an estimated 30 percent drop in the number of new cases of cardiovascular disease.¹⁰

HEDIS Measure Definition

The percentage of adults 18–75 years of age who were discharged alive for acute myocardial infarction, coronary artery bypass graft or percutaneous transluminal coronary angioplasty from January 1–November 1 of the year prior to the measurement year, or who had a diagnosis of ischemic vascular disease during the measurement year and the year prior to measurement year and had each of the following during the measurement year:

- LDL-C screening.
- LDL-C control (<100 mg/dL).

The Bottom Line

High cholesterol is often a silent threat to health and increases the risk of poor cardiovascular health. If cholesterol is monitored and reduced, it is possible to lower the risk of stroke or heart attack. Incorporating needed lifestyle and diet changes, in addition to necessary medications, is key to lowering cholesterol and improving health outcomes.

LDL SCREENING RATE

| YEAR | COMMERCIAL | | MEDICAID | MEDICARE | |
|------|------------|------|----------|----------|------|
| | HMO | PPO | HMO | HMO | PPO |
| 2011 | 88.1 | 83.5 | 82.0 | 88.8 | 88.3 |
| 2010 | 88.9 | 81.3 | 82.0 | 88.5 | 87.1 |
| 2009 | 88.4 | 80.2 | 80.7 | 88.4 | 86.7 |
| 2008 | 88.9 | 75.2 | 79.6 | 88.6 | 85.6 |
| 2007 | 88.2 | 74.4 | 76.3 | 87.9 | 84.4 |
| 2006 | 87.5 | 68.2 | 75.5 | 88.0 | 84.6 |

LDL CONTROL RATE (<100 mg/dL)

| YEAR | COMMERCIAL | | MEDICAID | MEDICARE | |
|------|------------|------|----------|----------|------|
| | HMO | PPO | HMO | HMO | PPO |
| 2011 | 59.8 | 50.1 | 42.1 | 56.5 | 56.6 |
| 2010 | 59.9 | 45.2 | 42.8 | 56.7 | 50.6 |
| 2009 | 59.2 | 42.3 | 41.2 | 55.7 | 47.2 |
| 2008 | 59.7 | 17.3 | 40.1 | 56.7 | 27.4 |
| 2007 | 58.7 | 13.4 | 38.3 | 55.9 | 23.2 |
| 2006 | 56.6 | 16.8 | 35.5 | 56.0 | 28.0 |

CONTROLLING HIGH BLOOD PRESSURE

High blood pressure is a condition caused by the increased force of blood flow against artery walls, by constriction of arteries or by an increase in the amount of blood pumped by the heart. Also known as hypertension, high blood pressure increases the risk of heart disease, stroke, heart attack, congestive heart failure and kidney disease.^{1,2} Stage 1 high blood pressure begins at 140/90 mm Hg.³ Hypertension can be minimized by incorporating behavioral changes, such as decreasing sodium intake and increasing exercise.^{4,5} The *Controlling High Blood Pressure* measure assesses whether adults with high blood pressure manage their condition by taking steps to lower their blood pressure and keeping their scores within the normal range.

- Hypertension was a contributing or primary factor for 347,000 deaths in the U.S. in 2008.⁶ Research shows that more than 90 percent of U.S. adults will develop hypertension in their lifetime.⁴
- Hypertension is a disease with no symptoms. A person can be unaware of the condition while it is causing damage to heart, kidneys and blood vessels.⁷ More than 20 percent of Americans have high blood pressure and do not know it.⁸
- As many as 1 in 3 U.S. adults have high blood pressure.⁷ 69 percent of these adults need to use medication to help control their blood pressure.⁶
- Although high blood pressure is more prevalent with age, almost 1 in 5 adults 24–32 have high blood pressure.

The Case for Improvement

- High blood pressure is a significant factor for other serious events. It was a contributing factor for 77 percent of people who had their first stroke, 69 percent of people who had their first heart attack and 74 percent of people who experienced congestive heart failure.¹
- Health care costs for hypertension are high for U.S. health and social systems. Estimated costs in 2010 for medical services, prescriptions and decreased work productivity was \$93.5 billion.⁹
- Only an estimated 50 percent of adults with high blood pressure have it under control. In 2006, 40 million doctor visits were related to treating high blood pressure.^{6,10}

- Incorporating behavioral changes can help reduce blood pressure levels. Becoming physically active can have a significant effect on hypertension. Exercise can lower blood pressure between 4 mm Hg and 9 mm Hg—the same effect as using some medications.⁵ Weight loss has the largest impact on reducing blood pressure. Losing as few as 10 pounds can influence improvement.¹¹

HEDIS Measure Definition

The percentage of members 18–85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90 mm Hg) during the measurement year.

The Bottom Line

Hypertension can lead to serious cardiovascular health conditions. Incorporating healthy lifestyle behaviors and taking medications to reduce blood pressure can provide health benefits and can lead to improved longevity for many Americans.

CONTROLLING HIGH BLOOD PRESSURE

| YEAR | COMMERCIAL | | MEDICAID | | MEDICARE |
|------|------------|------|----------|------|----------|
| | HMO | PPO | HMO | HMO | PPO |
| 2011 | 65.4 | 58.4 | 56.8 | 64.0 | 60.6 |
| 2010 | 63.4 | 56.7 | 55.6 | 61.9 | 55.7 |
| 2009 | 64.1 | 48.3 | 55.3 | 59.8 | 54.8 |
| 2008 | 63.4 | – | 55.8 | 58.5 | – |
| 2007 | 62.2 | – | 53.5 | 57.6 | – |
| 2006 | 59.7 | 48.9 | 53.1 | 56.8 | 51.2 |
| 2005 | 68.8 | 60.9 | 61.5 | 66.4 | 60.6 |
| 2004 | 66.8 | – | 61.4 | 64.6 | – |
| 2003 | 62.2 | – | 58.6 | 61.4 | – |
| 2002 | 58.4 | – | 52.3 | 56.9 | – |
| 2001 | 55.4 | – | 53.0 | 53.6 | – |
| 2000 | 51.5 | – | – | – | – |
| 1999 | 39.0 | – | – | – | – |

PERSISTENCE OF BETA-BLOCKER TREATMENT AFTER A HEART ATTACK

A heart attack is caused by blockage to primary blood vessels leading to the heart. The limited blood flow caused from the blockage can cause permanent damage to heart tissues.¹ Each year, an estimated 785,000 Americans will experience a heart attack for the first time.² Each year, an additional 470,000 Americans who have had a heart attack will have another.² Medications called beta-blockers can be prescribed to regulate heart rate and improve heart function.³ The *Persistence of Beta-Blocker Treatment After a Heart Attack* measure reports the number of people who had a heart attack and received beta-blocker treatment during the six months following their discharge from the hospital.

- Beta-blocker therapy reduces heart attack risk by improving blood flow to the heart muscle, decreasing heart rate and lowering blood pressure.^{3,4} These drugs also prevent irregular heartbeat by blocking nervous impulses or stress responses to the heart.^{4,5}
- Beta-blocker therapy can reduce the risk of mortality by 25 percent in the first 48 hours after a heart attack⁶ and lower risk for hospital readmission.⁵
- Of all adults who are good candidates for beta-blocker medication, only 43.8 percent of nursing home residents and 61.4 percent of community-dwelling residents receive beta-blockers. Research has shown that mortality is significantly lower for nursing home patients who receive beta-blockers.⁹

HEDIS Measure Definition

The percentage of adults 18 years of age and older during the measurement year who were hospitalized with a diagnosis of AMI and discharged alive from July 1 of the year prior to the measurement year to June 30 of the measurement year, and who received persistent beta-blocker treatment for six months after discharge.

The Case for Improvement

- Although beta-blockers lower the risk of mortality or repeat heart attacks, adherence to beta-blocker therapy is low.^{7,8}

The Bottom Line

Beta-blockers are an important component to recovery from heart attacks and prevention of future events. Ensuring their use will prevent cardiac-related mortality.

PERSISTENCE OF BETA-BLOCKER TREATMENT RATE

| YEAR | COMMERCIAL | | MEDICAID | MEDICARE | |
|------|------------|------|----------|----------|------|
| | HMO | PPO | HMO | HMO | PPO |
| 2011 | 81.3 | 77.0 | 80.5 | 87.3 | 86.2 |
| 2010 | 75.5 | 71.3 | 76.3 | 83.1 | 82.5 |
| 2009 | 74.4 | 69.6 | 76.6 | 82.6 | 78.9 |
| 2008 | 75.0 | 68.8 | 73.6 | 79.7 | 76.7 |
| 2007 | 71.9 | 62.9 | 62.0 | 75.5 | 70.4 |
| 2006 | 72.5 | 65.5 | 68.1 | 69.6 | 70.9 |
| 2005 | 70.2 | 64.3 | 69.8 | 65.4 | 58.5 |

COMPREHENSIVE DIABETES CARE

Nearly 26 million Americans have diabetes, the seventh leading cause of death in the U.S.—there are 18.8 million diagnosed cases and 7 million undiagnosed cases.¹ Diabetes, especially when unmanaged, can cause serious health complications, including kidney failure, heart disease, lower-extremity amputation and blindness.² The *Comprehensive Diabetes Care* measure assesses whether patients are receiving guideline-recommended care to help manage their disease by achieving control levels of blood sugar, cholesterol and blood pressure.

- Diabetes is a major cause of heart disease and stroke.² For individuals with diabetes, the risk of death is nearly twice that of people without diabetes.¹
- Type 2 diabetes accounts for 90 percent–95 percent of all diagnosed cases of diabetes. Risk factors for type 2 diabetes include old age, family history of diabetes, history of gestational diabetes, impaired glucose tolerance, physical inactivity, race/ethnicity and—most important—obesity.² About 80 percent of people with type 2 diabetes are overweight or obese.³
- Basic therapies for type 2 diabetes include healthy eating, physical activity and regular blood glucose testing. Medication or insulin are also needed by many people with type 2 diabetes, to control their blood glucose levels.²
- In 2010, 46 percent of adults with diagnosed diabetes reported having only fair or poor general health.⁴
- Between 1988 and 2009, the number of hospital discharges for patients with diabetes almost doubled, from nearly 2.8 million to 5.5 million.⁵ Diabetes was the primary diagnosis in almost 575,000 hospitalizations in 2010, with an average medical charge of \$12,369 for diabetes without complications and \$30,947 for diabetes with complications.⁶

HEDIS Measure Definition

The percentage of adults 18–75 years of age with diabetes (type 1 and type 2) who had each of the following:

- Hemoglobin A1c (HbA1c) testing.
- HbA1c poor control (>9.0%).
- HbA1c control (<8.0%).
- HbA1c control (<7.0%) for a selected population.
- Eye exam (retinal) performed.
- LDL-C screening.

The Case for Improvement

- Diabetes was estimated to have cost the U.S. \$174 billion in 2007—\$116 billion in direct medical costs and \$58 billion in indirect costs (i.e., disability, missed work and premature mortality).¹

- LDL-C control (<100 mg/dL).
- Medical attention for nephropathy.
- Blood pressure control (<140/80 mm Hg).
- Blood pressure control (<140/90 mm Hg).

The Bottom Line

People with diabetes must take responsibility for their day-to-day care. Comprehensive diabetes control can prevent health complications and improve the quality of life for millions of Americans.¹ Studies have shown the following benefits of properly managing diabetes:

- Reducing A1c blood test results by 1 percentage point (e.g., from 8.0 percent to 7.0 percent) reduces the risk of microvascular complications (eye, kidney and nerve diseases) by as much as 40 percent.¹
- Blood pressure control reduces the risk of cardiovascular disease by as much as 50 percent and the risk of microvascular complications by 33 percent.¹
- Improved LDL cholesterol control can reduce cardiovascular complications by as much as 50 percent.¹

BLOOD PRESSURE CONTROL (<140/80 mm Hg)

| YEAR | COMMERCIAL | | MEDICAID | | MEDICARE | |
|------|------------|------|----------|------|----------|--|
| | HMO | PPO | HMO | HMO | PPO | |
| 2011 | 44.2 | 38.1 | 39.4 | 48.2 | 46.5 | |

BLOOD PRESSURE CONTROL (<140/90 mm Hg)

| YEAR | COMMERCIAL | | MEDICAID | | MEDICARE | |
|------|------------|------|----------|------|----------|--|
| | HMO | PPO | HMO | HMO | PPO | |
| 2011 | 65.8 | 59.4 | 60.9 | 63.1 | 60.3 | |
| 2010 | 65.7 | 51.1 | 60.4 | 62.3 | 55.6 | |
| 2009 | 65.1 | 46.3 | 59.8 | 60.5 | 49.0 | |
| 2008 | 65.6 | 0.3 | 56.9 | 59.5 | 0.3 | |
| 2007 | 63.9 | 0.1 | 55.6 | 58.9 | 0.3 | |

EYE EXAMS

| YEAR | COMMERCIAL | | MEDICAID | | MEDICARE | |
|------|------------|------|----------|------|----------|--|
| | HMO | PPO | HMO | HMO | PPO | |
| 2011 | 56.9 | 48.4 | 53.3 | 66.0 | 63.8 | |
| 2010 | 57.7 | 45.5 | 53.1 | 64.6 | 62.3 | |
| 2009 | 56.5 | 42.6 | 52.7 | 63.5 | 59.4 | |
| 2008 | 56.5 | 35.8 | 52.8 | 60.8 | 52.2 | |
| 2007 | 55.0 | 34.0 | 49.8 | 62.7 | 50.4 | |
| 2006 | 54.6 | 36.1 | 51.4 | 62.3 | 53.8 | |
| 2005 | 54.8 | 42.7 | 48.6 | 66.5 | 53.8 | |
| 2004 | 50.9 | – | 44.9 | 67.2 | – | |
| 2003 | 48.8 | – | 45.0 | 64.9 | – | |
| 2002 | 51.7 | – | 46.8 | 68.4 | – | |
| 2001 | 52.1 | – | 46.4 | 66.0 | – | |
| 2000 | 48.1 | – | – | – | – | |
| 1999 | 45.3 | – | – | – | – | |

| HbA1c SCREENING | | | | | |
|-----------------|------------|------|----------|----------|------|
| YEAR | COMMERCIAL | | MEDICAID | MEDICARE | |
| | HMO | PPO | HMO | HMO | PPO |
| 2011 | 90.0 | 87.0 | 82.5 | 91.0 | 91.1 |
| 2010 | 89.9 | 85.2 | 82.0 | 90.4 | 90.6 |
| 2009 | 89.2 | 83.3 | 80.6 | 89.6 | 89.3 |
| 2008 | 89.0 | 79.5 | 80.5 | 88.3 | 85.7 |
| 2007 | 88.1 | 75.6 | 77.3 | 88.1 | 81.9 |
| 2006 | 87.5 | 72.1 | 78.0 | 87.2 | 83.3 |
| 2005 | 87.5 | 82.8 | 76.1 | 88.9 | 80.0 |
| 2004 | 86.5 | – | 75.9 | 89.1 | – |
| 2003 | 84.6 | – | 74.8 | 87.9 | – |
| 2002 | 82.6 | – | 73.0 | 85.0 | – |
| 2001 | 81.4 | – | 71.6 | 85.7 | – |
| 2000 | 78.4 | – | – | – | – |
| 1999 | 75.0 | – | – | – | – |

| GOOD HbA1c CONTROL (HbA1c <7% FOR A SELECTED POPULATION) | | | | | |
|--|------------|------|----------|----------|-----|
| YEAR | COMMERCIAL | | MEDICAID | MEDICARE | |
| | HMO | PPO | HMO | HMO | PPO |
| 2011 | 42.2 | 36.4 | 35.4 | – | – |
| 2010 | 42.5 | 28.2 | 34.7 | – | – |
| 2009 | 42.1 | 30.3 | 33.9 | – | – |
| 2008 | 43.3 | 13.5 | 32.9 | – | – |
| 2007 | 43.1 | 10.0 | 31.4 | – | – |

| GOOD HbA1c CONTROL (HbA1c <8.0%) | | | | | |
|----------------------------------|------------|------|----------|----------|------|
| YEAR | COMMERCIAL | | MEDICAID | MEDICARE | |
| | HMO | PPO | HMO | HMO | PPO |
| 2011 | 61.2 | 55.2 | 48.1 | 65.2 | 63.2 |
| 2010 | 62.3 | 50.2 | 46.9 | 65.6 | 57.3 |
| 2009 | 61.6 | 48.0 | 45.7 | 63.7 | 51.8 |

| POOR HbA1c CONTROL (HbA1c >9.0%)* | | | | | |
|-----------------------------------|------------|------|----------|----------|------|
| YEAR | COMMERCIAL | | MEDICAID | MEDICARE | |
| | HMO | PPO | HMO | HMO | PPO |
| 2011 | 28.3 | 33.5 | 43.0 | 26.5 | 28.8 |
| 2010 | 27.3 | 46.6 | 44.0 | 25.9 | 35.2 |
| 2009 | 28.2 | 44.6 | 44.9 | 28.0 | 41.3 |
| 2008 | 28.4 | 74.4 | 44.8 | 29.4 | 67.0 |
| 2007 | 29.4 | 84.1 | 48.0 | 29.0 | 74.7 |
| 2006 | 29.6 | 75.9 | 48.7 | 27.3 | 71.8 |
| 2005 | 29.7 | 55.4 | 49.2 | 23.6 | 27.3 |
| 2004 | 30.7 | – | 48.6 | 22.3 | – |
| 2003 | 32.0 | – | 48.6 | 23.4 | – |
| 2002 | 33.9 | – | 48.9 | 24.5 | – |
| 2001 | 36.9 | – | 48.3 | 26.8 | – |
| 2000 | 42.5 | – | – | – | – |
| 1999 | 44.9 | – | – | – | – |

*Lower rates signify better performance.

| LDL CHOLESTEROL SCREENING | | | | | |
|---------------------------|------------|------|----------|----------|------|
| YEAR | COMMERCIAL | | MEDICAID | MEDICARE | |
| | HMO | PPO | HMO | HMO | PPO |
| 2011 | 85.3 | 81.2 | 75.0 | 88.3 | 86.7 |
| 2010 | 85.6 | 79.9 | 74.7 | 87.8 | 86.3 |
| 2009 | 85.0 | 78.6 | 74.2 | 87.3 | 85.5 |
| 2008 | 84.8 | 74.7 | 74.1 | 86.3 | 82.3 |
| 2007 | 83.9 | 72.7 | 70.8 | 85.7 | 80.0 |
| 2006 | 83.3 | 67.4 | 71.1 | 84.8 | 79.4 |
| 2005 | 92.3 | 87.0 | 80.6 | 93.3 | 87.1 |
| 2004 | 91.0 | – | 79.6 | 93.5 | – |
| 2003 | 88.4 | – | 75.9 | 91.1 | – |
| 2002 | 85.1 | – | 70.8 | 87.9 | – |
| 2001 | 81.4 | – | 66.5 | 85.7 | – |
| 2000 | 76.5 | – | – | – | – |
| 1999 | 69.0 | – | – | – | – |

| LDL CHOLESTEROL CONTROL (<100 mg/dL) | | | | | |
|---|------------|------|----------|----------|------|
| YEAR | COMMERCIAL | | MEDICAID | MEDICARE | |
| | HMO | PPO | HMO | HMO | PPO |
| 2011 | 48.1 | 41.8 | 35.2 | 52.5 | 50.9 |
| 2010 | 47.7 | 37.3 | 34.6 | 52.1 | 45.9 |
| 2009 | 47.0 | 36.8 | 33.5 | 50.0 | 40.5 |
| 2008 | 45.5 | 14.8 | 33.8 | 48.7 | 24.3 |
| 2007 | 43.8 | 10.4 | 31.3 | 46.8 | 22.4 |
| 2006 | 43.0 | 14.4 | 30.6 | 46.9 | 20.4 |
| 2005 | 43.8 | 24.4 | 32.7 | 50.0 | 48.4 |
| 2004 | 40.2 | – | 30.6 | 47.6 | – |

| MONITORING NEPHROPATHY | | | | | |
|------------------------|------------|------|----------|----------|------|
| YEAR | COMMERCIAL | | MEDICAID | MEDICARE | |
| | HMO | PPO | HMO | HMO | PPO |
| 2011 | 83.8 | 77.9 | 77.8 | 89.9 | 88.1 |
| 2010 | 83.6 | 74.3 | 77.7 | 89.2 | 87.3 |
| 2009 | 82.9 | 69.9 | 76.9 | 88.6 | 85.2 |
| 2008 | 82.4 | 65.9 | 76.6 | 87.9 | 82.1 |
| 2007 | 80.6 | 64.2 | 74.3 | 85.7 | 81.7 |
| 2006 | 79.7 | 60.7 | 74.6 | 85.4 | 83.0 |
| 2005 | 55.1 | 44.4 | 48.9 | 60.3 | 51.5 |
| 2004 | 52.0 | – | 46.7 | 58.6 | – |
| 2003 | 48.2 | – | 43.7 | 53.6 | – |
| 2002 | 51.8 | – | 48.2 | 57.3 | – |
| 2001 | 46.3 | – | 42.3 | 51.9 | – |
| 2000 | 41.3 | – | – | – | – |
| 1999 | 36.0 | – | – | – | – |

DISEASE MODIFYING ANTI-RHEUMATIC DRUG THERAPY IN RHEUMATOID ARTHRITIS

Rheumatoid arthritis (RA) is a chronic inflammatory disease in which the immune system attacks healthy joints.¹ RA is among the most disabling forms of arthritis and causes joint destruction, bone erosion and damage to muscles, kidneys and other organs.² RA affects almost 2 million Americans.^{2,3} The *Disease Modifying Anti-Rheumatic Drug Therapy (DMARD) in Rheumatoid Arthritis* measure assesses whether RA patients receive medications that slow the disease's progression and help them maintain functional capacity longer.

- People with persistent RA are at greater risk for premature death.⁴ In particular, people with RA die from heart-related problems at higher rates than people without RA.⁵
- Arthritis and other rheumatic conditions are the most common causes of disability in the United States.⁶
- Although there is no cure for RA, DMARDs may effectively protect joints and minimize inflammation, slowing progression of the disease and reducing pain.⁷

The Case for Improvement

- Arthritis and related conditions, including RA, cost the U.S. economy \$128 billion each year. Direct costs, like medical expenses, are estimated at \$81 billion, and indirect costs, such as lost wages and disability payments, are estimated at \$47 billion.^{6,7}
- Despite evidence-based guidelines recommending early and aggressive treatment of RA, recent population-based studies report consistently low rates of DMARD receipt (30 percent–52 percent) in patients 65 years of age and older with active RA.⁸

HEDIS Measure Definition

The percentage of diagnosed adults with RA who were dispensed at least one ambulatory prescription for a DMARD.

The Bottom Line

RA is a debilitating disease affecting over 2 million Americans.³ Although there is no cure for RA, treatment with DMARDs can slow the disease's progression, reduce pain and lower medical and disability costs.

| DMARD TREATMENT RATE | | | | | |
|----------------------|------------|------|----------|----------|------|
| YEAR | COMMERCIAL | | MEDICAID | MEDICARE | |
| | HMO | PPO | HMO | HMO | PPO |
| 2011 | 87.6 | 86.7 | 68.9 | 72.7 | 77.2 |
| 2010 | 87.7 | 87.0 | 70.1 | 72.8 | 77.8 |
| 2009 | 86.4 | 86.6 | 70.5 | 72.3 | 76.4 |
| 2008 | 85.7 | 81.5 | 69.4 | 70.4 | 75.1 |
| 2007 | 85.3 | 78.9 | 68.1 | 68.7 | 73.5 |
| 2006 | 84.8 | 82.3 | 67.6 | 68.2 | 69.7 |

ANTIDEPRESSANT MEDICATION MANAGEMENT

Major depression affects nearly 15 million adults in the United States and is highly recurrent.^{1,2} Symptoms include persistent sadness, loss of energy, loss of appetite and inability to concentrate.³ Antidepressant medication has proven to be effective for patients with severe symptoms.⁴ The *Antidepressant Medication Management* measure assesses short-term and long-term medication adherence rates for adults newly diagnosed with major depression.

- About 80 percent of those who suffer from depression reported that their depression makes it harder to function in everyday life.⁵
- Depression is the leading cause of disability in the United States and if left untreated, can lead to suicide.¹
- The need for antidepressant medication increases as the severity of depression intensifies.³
- A 2011 study reported by the *Journal of the American Geriatrics Society*, examining antidepressant treatment patterns, found that older adults tend to discontinue antidepressant treatment, making them at a higher risk of relapse.⁸

HEDIS Measure Definition

The percentage of adults 18 years of age and older who were diagnosed with a new episode of major depression and treated with antidepressant medication, and who remained on an antidepressant medication treatment.

Two rates are reported:

Effective Acute Phase Treatment. The percentage of newly diagnosed and treated people who remained on an antidepressant medication for at least 84 days (12 weeks).

Effective Continuation Phase Treatment. The percentage of newly diagnosed and treated people who remained on an antidepressant medication for at least 180 days (6 months).

The Case for Improvement

- 80 percent–90 percent of those diagnosed with major depression are able to relieve symptoms through proper treatment.¹ Without antidepressant medication, 50 percent–80 percent of patients have major depressive relapses and recurrences.⁶
- Employees with severe depression are less productive and more likely to miss work, costing the United States over \$1 billion a year in lost productivity.⁷

The Bottom Line

Continuation of treatment is important to relieve health and economic strains on society. Effective management of therapy can increase a person's well-being and prevent relapse.

| EFFECTIVE ACUTE PHASE TREATMENT | | | | | |
|---------------------------------|------------|------|----------|----------|------|
| YEAR | COMMERCIAL | | MEDICAID | MEDICARE | |
| | HMO | PPO | HMO | HMO | PPO |
| 2011 | 65.6 | 64.9 | 51.1 | 66.3 | 70.8 |
| 2010 | 64.7 | 64.3 | 50.7 | 65.0 | 67.4 |
| 2009 | 62.9 | 63.2 | 49.6 | 63.7 | 63.4 |
| 2008 | 63.1 | 63.1 | 48.2 | 62.5 | 61.6 |
| 2007 | 62.9 | 63.8 | 42.8 | 61.2 | 61.0 |
| 2006 | 61.1 | 63.6 | 42.9 | 58.2 | 56.7 |
| 2005 | 61.3 | 65.6 | 45.1 | 55.0 | 49.2 |
| 2004 | 60.9 | – | 46.4 | 56.4 | – |
| 2003 | 60.7 | – | 46.2 | 53.3 | – |
| 2002 | 59.8 | – | 47.5 | 52.1 | – |
| 2001 | 56.9 | – | 45.5 | 51.2 | – |
| 2000 | 57.4 | – | – | – | – |
| 1999 | 58.8 | – | – | – | – |

| EFFECTIVE CONTINUATION PHASE TREATMENT | | | | | |
|--|------------|------|----------|----------|------|
| YEAR | COMMERCIAL | | MEDICAID | MEDICARE | |
| | HMO | PPO | HMO | HMO | PPO |
| 2011 | 49.4 | 48.8 | 34.4 | 53.3 | 58.4 |
| 2010 | 48.3 | 48.1 | 34.4 | 51.9 | 55.7 |
| 2009 | 46.2 | 46.4 | 33.0 | 50.6 | 51.0 |
| 2008 | 46.3 | 46.4 | 31.8 | 49.3 | 48.9 |
| 2007 | 46.1 | 47.6 | 27.4 | 48.7 | 48.7 |
| 2006 | 45.1 | 46.6 | 27.5 | 45.1 | 40.9 |
| 2005 | 45.0 | 48.4 | 29.7 | 41.1 | 31.1 |
| 2004 | 44.3 | – | 30.4 | 42.4 | – |
| 2003 | 44.1 | – | 29.3 | 39.2 | – |
| 2002 | 42.8 | – | 32.4 | 37.7 | – |
| 2001 | 40.1 | – | 30.0 | 36.8 | – |
| 2000 | 40.1 | – | – | – | – |
| 1999 | 42.1 | – | – | – | – |

FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS

Every year, about 20 percent of American adults experience a mental health disorder, and about 5 percent are diagnosed with a serious mental illness.¹ In 2009 there were 1.6 million hospitalizations due to mental illness.¹ Less than half of all initial appointments following a hospitalization for mental illness are kept, increasing the likelihood of rehospitalization and increased costs.³ Between 25 percent and 50 percent of patients who miss mental health appointments after hospitalization do not receive any treatment for their condition.⁴ The *Follow-Up After Hospitalization for Mental Illness* measure assesses whether children and adults who were hospitalized for treatment of selected mental health disorders were seen by a mental health provider.

- Behavioral treatments after a hospitalization for mental illness can be effective in bridging the gap between hospitalization and outpatient care.^{5,6}
- Adults who had a serious mental illness episode have higher rates of metabolic conditions like high blood pressure, asthma, diabetes, heart disease and stroke.⁷
- Half of all lifetime cases of mental illness will begin by age 14. To ensure that children and families can manage the illness, treatment should begin as soon as possible.⁹

The Case for Improvement

- Because costs for psychiatric hospitalization can exceed \$1,500 per day, interventions that reduce rates of rehospitalization for patients with psychosis could yield significant savings for the health care system.⁸
- Studies suggest that only half of all patients who are hospitalized for mental illness transition to proper follow-up care.⁵

HEDIS Measure Definition

The percentage of discharges for people 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. The measure separately identifies the percentage of people who received follow-up within 7 days and 30 days of discharge.

The Bottom Line

Patients discharged after a hospitalization for mental illness who do not have follow-up care are more likely to be rehospitalized. Proper follow-up care can improve patients' quality of life.^{6,10}

| FOLLOW-UP WITHIN 7 DAYS POST-DISCHARGE | | | | | |
|---|------------|------|----------|----------|------|
| YEAR | COMMERCIAL | | MEDICAID | MEDICARE | |
| | HMO | PPO | HMO | HMO | PPO |
| 2011 | 58.9 | 54.0 | 46.5 | 38.0 | 38.7 |
| 2010 | 59.7 | 54.2 | 44.6 | 37.4 | 39.1 |
| 2009 | 58.7 | 52.6 | 42.9 | 37.3 | 40.6 |
| 2008 | 57.2 | 49.8 | 42.6 | 38.1 | 37.3 |
| 2007 | 55.6 | 41.9 | 42.5 | 37.0 | 33.3 |
| 2006 | 56.7 | 48.3 | 39.1 | 36.9 | 38.5 |
| 2005 | 55.8 | 49.9 | 39.2 | 39.2 | 47.1 |
| 2004 | 55.9 | – | 38.0 | 40.1 | – |
| 2003 | 54.4 | – | 37.7 | 38.8 | – |
| 2002 | 52.7 | – | 37.2 | 38.7 | – |
| 2001 | 51.3 | – | 33.2 | 37.2 | – |
| 2000 | 48.2 | – | – | – | – |
| 1999 | 47.4 | – | – | – | – |

| FOLLOW-UP WITHIN 30 DAYS POST-DISCHARGE | | | | | |
|--|------------|------|----------|----------|------|
| YEAR | COMMERCIAL | | MEDICAID | MEDICARE | |
| | HMO | PPO | HMO | HMO | PPO |
| 2011 | 76.5 | 72.7 | 65.0 | 56.1 | 60.6 |
| 2010 | 77.4 | 74.1 | 63.8 | 55.4 | 61.2 |
| 2009 | 76.8 | 72.1 | 60.2 | 54.8 | 60.5 |
| 2008 | 76.1 | 71.4 | 61.7 | 56.5 | 55.5 |
| 2007 | 74.0 | 63.4 | 61.0 | 54.4 | 50.2 |
| 2006 | 75.8 | 68.1 | 57.7 | 56.3 | 58.3 |
| 2005 | 75.9 | 70.7 | 56.8 | 59.4 | 60.1 |
| 2004 | 75.9 | – | 54.9 | 60.7 | – |
| 2003 | 74.4 | – | 56.4 | 60.3 | – |
| 2002 | 73.6 | – | 56.7 | 60.6 | – |
| 2001 | 73.2 | – | 52.2 | 60.6 | – |
| 2000 | 71.2 | – | – | – | – |
| 1999 | 70.1 | – | – | – | – |

ANNUAL MONITORING FOR PATIENTS ON PERSISTENT MEDICATIONS

Millions of Americans depend on prescription medications to maintain their overall health. As many as 3 billion prescriptions are written annually.¹ More than 770,000 Americans are injured or die in hospitals each year from adverse drug events, many of which are considered preventable with appropriate monitoring.² The *Annual Monitoring for Patients on Persistent Medications* measure assesses whether adults were properly monitored for selected medications usually prescribed for long-term use.

- Up to half of patients on persistent medications receive no drug monitoring in one year.^{3,4}
- Drugs that commonly require monitoring in outpatient settings accounted for more than half of all unintentional drug overdoses that resulted in a visit to the ED. With monitoring, clinicians can adjust a patient's dosage to prevent avoidable adverse events.²
- Communication gaps between patient and provider regarding medication adherence may contribute to improper medication use.⁵
- The effects of improper medication use can be longer hospital stays, side effects and increased financial burden.²
- Adverse drug events can lead to a range of consequences for patients, from allergic reactions to death.⁷

HEDIS Measure Definition

This measure assesses the percentage of adults 18 years of age and older who received at least 180 treatment days of ambulatory medication therapy for the following therapeutic agents during the measurement year and at least one therapeutic monitoring event for the therapeutic agent in the measurement year:

The Case for Improvement

- Hospitalizations for adverse drug events cost the average U.S. hospital up to \$5.6 million each year.² Finding better ways to monitor patients taking medication for long-term use could lead to reduced hospitalizations.⁶
- An estimated 1.5 million preventable adverse drug events occur in the health care system each year.⁶
- Angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB).
- Digoxin.
- Diuretics.
- Anticonvulsants.

The Bottom Line

As Americans live longer and the use of prescription medication therapy increases, hospitalizations for adverse drug events are likely to increase.⁸

Appropriate monitoring of drug therapy is essential for patients on persistent medications, and will reduce the number of adverse drug events.⁹

MONITORING FOR PATIENTS USING ACE INHIBITORS OR ARBS

| YEAR | COMMERCIAL | | MEDICAID | | MEDICARE | |
|------|------------|------|----------|------|----------|-----|
| | HMO | PPO | HMO | HMO | PPO | PPO |
| 2011 | 82.5 | 78.8 | 85.9 | 91.3 | 91.4 | |
| 2010 | 81.6 | 78.4 | 86.0 | 90.7 | 90.8 | |
| 2009 | 80.8 | 77.6 | 85.9 | 89.6 | 89.8 | |
| 2008 | 79.4 | 76.4 | 84.8 | 86.7 | 88.8 | |
| 2007 | 77.2 | 75.6 | 82.5 | 84.8 | 87.8 | |
| 2006 | 74.8 | 66.3 | 79.9 | 82.7 | 83.9 | |

MONITORING FOR PATIENTS USING ANTICONVULSANTS

| YEAR | COMMERCIAL | | MEDICAID | | MEDICARE | |
|------|------------|------|----------|------|----------|-----|
| | HMO | PPO | HMO | HMO | PPO | PPO |
| 2011 | 60.5 | 56.9 | 65.2 | 67.4 | 68.5 | |
| 2010 | 60.4 | 57.9 | 67.7 | 68.2 | 69.1 | |
| 2009 | 62.0 | 59.2 | 68.7 | 69.7 | 68.5 | |
| 2008 | 61.7 | 59.0 | 68.7 | 67.5 | 70.0 | |
| 2007 | 59.6 | 56.3 | 65.9 | 65.1 | 66.0 | |
| 2006 | 59.4 | 49.8 | 63.6 | 63.6 | 64.9 | |

MONITORING FOR PATIENTS USING DIGOXIN

| YEAR | COMMERCIAL | | MEDICAID | | MEDICARE | |
|------|------------|------|----------|------|----------|-----|
| | HMO | PPO | HMO | HMO | PPO | PPO |
| 2011 | 85.4 | 79.2 | 90.3 | 93.4 | 93.2 | |
| 2010 | 84.6 | 79.1 | 89.7 | 93.1 | 92.7 | |
| 2009 | 83.6 | 77.9 | 88.9 | 92.0 | 92.2 | |
| 2008 | 81.9 | 76.6 | 88.5 | 90.4 | 91.1 | |
| 2007 | 79.7 | 75.7 | 84.9 | 87.9 | 90.4 | |
| 2006 | 77.3 | 64.2 | 83.0 | 86.2 | 87.1 | |

MONITORING FOR PATIENTS USING DIURETICS

| YEAR | COMMERCIAL | | MEDICAID | MEDICARE | |
|------|------------|------|----------|----------|------|
| | HMO | PPO | HMO | HMO | PPO |
| 2011 | 82.1 | 78.4 | 85.4 | 91.6 | 91.8 |
| 2010 | 81.0 | 78.1 | 85.5 | 90.9 | 91.2 |
| 2009 | 80.4 | 77.2 | 85.4 | 89.8 | 90.3 |
| 2008 | 79.1 | 76.1 | 84.2 | 87.1 | 89.1 |
| 2007 | 76.8 | 75.2 | 81.3 | 84.8 | 87.6 |
| 2006 | 74.4 | 65.7 | 79.1 | 83.0 | 84.1 |

MONITORING FOR PATIENTS ON PERSISTENT MEDICATIONS COMBINED

| YEAR | COMMERCIAL | | MEDICAID | MEDICARE | |
|------|------------|------|----------|----------|------|
| | HMO | PPO | HMO | HMO | PPO |
| 2011 | 81.9 | 78.2 | 83.9 | 90.9 | 91.2 |
| 2010 | 80.9 | 77.8 | 83.9 | 90.2 | 90.6 |
| 2009 | 80.3 | 77.0 | 83.2 | 89.2 | 89.7 |
| 2008 | 78.9 | 75.8 | 82.6 | 86.3 | 88.6 |
| 2007 | 76.6 | 74.9 | 80.1 | 84.3 | 87.2 |
| 2006 | 74.3 | 65.6 | 77.7 | 82.2 | 83.6 |

INITIATION AND ENGAGEMENT OF ALCOHOL AND OTHER DRUG DEPENDENCE TREATMENT

Alcohol and other drug (AOD) dependence is common across age groups and is one of the most preventable health conditions. More than 22 million persons 12 years of age or older in the United States were classified as abusing or being dependent on drugs or alcohol in 2010.¹ Almost 70 percent were dependent on or abused alcohol, and 19 percent were dependent on or abused illicit drugs.¹ The *Initiation and Engagement of Alcohol and Other Drug Dependence Treatment* measure monitors whether adolescents and adults with an episode of alcohol or drug dependence initiated and followed up on necessary treatment.

- Around 1 in 6 Americans has a drinking problem.¹ Alcohol abuse is on the rise, with 2009 data reporting the highest rates of abuse and dependence since 2002.¹
- The primary goals of drug abuse or addiction treatment are abstinence, relapse prevention and rehabilitation. Fewer than 20 percent of people diagnosed with substance abuse and 40 percent of people with addiction problems seek treatment.²
- People with drug or alcohol abuse and dependence conditions have higher rates of comorbid physical conditions and behavioral diagnoses.^{5,6}
- Treatment has been shown to improve quality of life by reducing AOD use, improving health and increasing productivity.^{2,7}

The Case for Improvement

- More than 10,000 people died in car crashes due to alcohol impairment in 2010, which translates to one death every 51 minutes.^{1,3}
- Costs from illicit drug use related to crime, health and loss of productivity total more than \$193 billion each year—equal to some of the most chronic health conditions, such as diabetes, in the United States.⁴

HEDIS Measure Definition

This measure assesses the percentage of adolescent and adults with a new episode of AOD dependence who received the following care.

Initiation of AOD Treatment. The percentage of people who initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of diagnosis.

Engagement of AOD Treatment. The percentage of people with a diagnosis of AOD use or dependence who initiated treatment and had 2 or more additional services within 30 days of the initiation visit.

The Bottom Line

Treatment is linked to better outcomes for people suffering from AOD dependence.^{4,7} Increased treatment can also lower economic costs for those with AOD dependence and for the health care system.

INITIATION OF AOD TREATMENT

| YEAR | COMMERCIAL | | MEDICAID | MEDICARE | |
|------|------------|------|----------|----------|------|
| | HMO | PPO | HMO | HMO | PPO |
| 2011 | 40.2 | 40.6 | 39.2 | 41.0 | 47.6 |
| 2010 | 42.7 | 40.8 | 42.9 | 44.6 | 57.4 |
| 2009 | 42.7 | 41.8 | 44.3 | 46.2 | 57.4 |
| 2008 | 42.4 | 42.6 | 44.5 | 45.9 | 49.1 |
| 2007 | 44.5 | 46.0 | 45.6 | 50.4 | 56.5 |
| 2006 | 43.2 | 49.0 | 43.3 | 50.3 | 50.0 |
| 2005 | 44.5 | 45.8 | 40.7 | 50.9 | 52.3 |
| 2004 | 45.9 | – | 45.7 | 52.6 | – |

ENGAGEMENT OF AOD TREATMENT

| YEAR | COMMERCIAL | | MEDICAID | MEDICARE | |
|------|------------|------|----------|----------|-----|
| | HMO | PPO | HMO | HMO | PPO |
| 2011 | 15.2 | 16.0 | 11.9 | 3.7 | 3.8 |
| 2010 | 15.6 | 16.0 | 14.2 | 3.7 | 4.8 |
| 2009 | 16.1 | 15.7 | 12.3 | 4.6 | 4.2 |
| 2008 | 16.2 | 16.2 | 12.4 | 4.3 | 9.4 |
| 2007 | 15.2 | 15.2 | 14.4 | 4.5 | 6.3 |
| 2006 | 13.8 | 16.0 | 11.7 | 4.5 | 7.0 |
| 2005 | 14.1 | 15.3 | 9.7 | 4.7 | 3.2 |
| 2004 | 15.5 | – | 11.9 | 7.1 | – |

WEIGHT ASSESSMENT AND COUNSELING FOR NUTRITION AND PHYSICAL ACTIVITY FOR CHILDREN/ADOLESCENTS

Childhood obesity is a growing problem that currently affects 17 percent (12.5 million) of all children and adolescents in the United States, more than triple the rate of their parents' generation.¹ There are numerous health risks associated with overweight and obese children and adolescents, many of which affect healthy growth and development and could continue and worsen as they move into adulthood.² The *Weight Assessment and Counseling for Nutrition and Physical Activity in Children/Adolescents* measure evaluates the percentage of children and adolescents who are regularly screened for weight problems and have received counseling about healthy eating and physical activity.

- Overweight and obesity are the result of consuming more calories than the body burns off during physical activity.³
- Childhood obesity commonly begins between the ages of 5 and 6 or during adolescence. Studies have shown that a child who is obese between 10 and 13 years of age has an 80 percent chance of being obese as an adult.⁴
- A variety of environmental factors contribute to the not-so-healthy choices children and parents make regarding nutrition and exercise. Such factors include increased availability and advertisements for sugar drinks and less-healthy, high-calorie food, especially on school campuses and in child care centers; limited access to affordable healthy food; increased portion sizes; lack of daily physical activity in schools and child care centers; and limited access to safe and appealing places in communities for youths to play or be active.³

The Case for Improvement

- According to a 2009 study, the cost of hospitalizations related to childhood obesity rose from \$125.9 million in 2001 to \$237.6 million in 2005. America spends as much as \$147 billion annually on the direct and indirect costs of obesity—9.1 percent of medical spending.^{5,6}
- Obesity is among the easiest medical conditions to diagnose, yet is one of the most difficult to treat. Children who are overweight or obese are at high risk for

HEDIS Measure Definition

The percentage of children and adolescents 3–17 years of age who had an outpatient visit with a primary care physician or OB/

GYN and who had evidence of BMI percentile documentation and counseling for nutrition and physical activity during the measurement year. Because BMI norms for youths vary with age and gender, this measure evaluates whether BMI percentile is assessed rather than an absolute BMI value.

The Bottom Line

It is important to monitor children's weight status and provide guidance on maintaining healthy eating and exercising habits. For an individual who is overweight or obese, adopting a healthier lifestyle involves more than just that individual, especially when it comes to children and adolescents. Children need additional help from their families, providers and communities to make long-term changes that will improve their overall health.⁷

BMI PERCENTILE ASSESSMENT (3-17 YEARS)

| YEAR | COMMERCIAL | | MEDICAID | MEDICARE | |
|------|------------|------|----------|----------|-----|
| | HMO | PPO | HMO | HMO | PPO |
| 2011 | 44.7 | 24.6 | 46.0 | - | - |
| 2010 | 35.2 | 10.9 | 37.3 | - | - |
| 2009 | 35.4 | 17.4 | 30.3 | - | - |

COUNSELING FOR NUTRITION (3-17 YEARS)

| YEAR | COMMERCIAL | | MEDICAID | MEDICARE | |
|------|------------|------|----------|----------|-----|
| | HMO | PPO | HMO | HMO | PPO |
| 2011 | 46.4 | 28.4 | 50.1 | - | - |
| 2010 | 37.4 | 11.8 | 45.6 | - | - |
| 2009 | 41.0 | 20.3 | 41.9 | - | - |

COUNSELING FOR PHYSICAL ACTIVITY (3-17 YEARS)

| YEAR | COMMERCIAL | | MEDICAID | MEDICARE | |
|------|------------|------|----------|----------|-----|
| | HMO | PPO | HMO | HMO | PPO |
| 2011 | 43.0 | 25.7 | 40.6 | - | - |
| 2010 | 35.3 | 10.5 | 36.7 | - | - |
| 2009 | 36.5 | 17.6 | 32.5 | - | - |

CHILDHOOD IMMUNIZATION STATUS

Childhood immunizations are associated with healthier children and healthier communities.¹ Because infants and toddlers are particularly vulnerable to infectious diseases, it is important to follow established immunization guidelines.^{2,3} The *Childhood Immunization Status* measure assesses whether children 2 years of age received all immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention.⁴

- Childhood immunizations have led to the lowest rates of preventable diseases in history.⁷
- Although most childhood vaccines have been proven to be highly effective, there has been a re-emergence of various vaccine-preventable diseases in recent years because of fewer children receiving immunizations.^{5,6}
- Most recently, low rates of vaccination have led to a rise in pertussis and influenza infection rates and hospitalizations among infants.⁶

The Case for Improvement

- The current childhood immunization schedule could prevent approximately 42,000 deaths and has the potential to save nearly \$69 billion in costs to the United States.^{8,9}
- When children visit the doctor to receive immunizations, they can also receive other childhood preventable services. Therefore, low rates of childhood immunizations could correspond to low rates of other preventable childhood services due to missed opportunities for doctor visits.¹⁰

HEDIS Measure Definition

The percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three H influenza type B (HiB); three hepatitis B (HepB); one chickenpox (VZV); four pneumococcal conjugate (PCV); two hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. This measure calculates a rate for each vaccine and nine separate combination rates; including a comprehensive rate.

The Bottom Line

Immunization is an important aspect of preventive care that has been proven to be effective and safe for children.² Increased immunizations rates could lead to lower costs to society and fewer health problems in children.

| DIPHTHERIA, TETANUS, ACELLULAR PERTUSSIS (DTAP/DT) | | | | | |
|--|------------|------|----------|----------|-----|
| YEAR | COMMERCIAL | | MEDICAID | MEDICARE | |
| | HMO | PPO | HMO | HMO | PPO |
| 2011 | 86.5 | 76.8 | 79.8 | - | - |
| 2010 | 86.3 | 64.7 | 80.2 | - | - |
| 2009 | 85.4 | 59.9 | 79.6 | - | - |
| 2008 | 87.2 | 47.7 | 78.6 | - | - |
| 2007 | 86.9 | 42.4 | 77.8 | - | - |
| 2006 | 87.2 | 39.2 | 79.3 | - | - |
| 2005 | 86.1 | 62.8 | 76.9 | - | - |
| 2004 | 85.9 | - | 75.6 | - | - |
| 2003 | 84.3 | - | 72.6 | - | - |
| 2002 | 80.1 | - | 69.4 | - | - |
| 2001 | 81.5 | - | 71.2 | - | - |
| 2000 | 80.4 | - | - | - | - |
| 1999 | 78.7 | - | - | - | - |

| HEPATITIS B (HEP B) | | | | | |
|---------------------|------------|------|----------|----------|-----|
| YEAR | COMMERCIAL | | MEDICAID | MEDICARE | |
| | HMO | PPO | HMO | HMO | PPO |
| 2011 | 87.9 | 74.7 | 88.8 | - | - |
| 2010 | 90.2 | 58.7 | 90.1 | - | - |
| 2009 | 90.1 | 53.7 | 89.1 | - | - |
| 2008 | 91.8 | 38.7 | 88.3 | - | - |
| 2007 | 91.3 | 35.8 | 87.2 | - | - |
| 2006 | 91.0 | 31.1 | 88.4 | - | - |
| 2005 | 90.0 | 57.7 | 85.4 | - | - |
| 2004 | 87.2 | - | 81.9 | - | - |
| 2003 | 85.8 | - | 79.5 | - | - |
| 2002 | 81.9 | - | 76.2 | - | - |
| 2001 | 79.9 | - | 75.4 | - | - |
| 2000 | 77.9 | - | - | - | - |
| 1999 | 75.5 | - | - | - | - |

| HAEMOPHILUS INFLUENZA TYPE B (HIB) | | | | | |
|---------------------------------------|------------|------|----------|----------|-----|
| YEAR | COMMERCIAL | | MEDICAID | MEDICARE | |
| | HMO | PPO | HMO | HMO | PPO |
| 2011 | 94.1 | 86.1 | 91.0 | - | - |
| 2010 | 94.3 | 75.5 | 90.3 | - | - |
| 2009 | 94.8 | 74.8 | 93.7 | - | - |
| 2008 | 94.8 | 66.3 | 93.4 | - | - |
| 2007 | 93.1 | 53.6 | 87.7 | - | - |
| 2006 | 93.4 | 49.2 | 89.1 | - | - |
| 2005 | 92.9 | 72.6 | 86.8 | - | - |
| 2004 | 87.7 | - | 79.1 | - | - |
| 2003 | 86.1 | - | 77.7 | - | - |
| 2002 | 83.2 | - | 73.8 | - | - |
| 2001 | 83.4 | - | 74.9 | - | - |
| 2000 | 82.7 | - | - | - | - |
| 1999 | 80.7 | - | - | - | - |

| INACTIVATED POLIO VIRUS (IPV) | | | | | |
|-------------------------------|------------|------|----------|----------|-----|
| YEAR | COMMERCIAL | | MEDICAID | MEDICARE | |
| | HMO | PPO | HMO | HMO | PPO |
| 2011 | 92.4 | 83.4 | 90.5 | - | - |
| 2010 | 91.8 | 71.1 | 90.8 | - | - |
| 2009 | 91.1 | 65.3 | 89.0 | - | - |
| 2008 | 92.1 | 52.6 | 87.9 | - | - |
| 2007 | 91.5 | 47.5 | 87.3 | - | - |
| 2006 | 91.4 | 43.0 | 87.9 | - | - |
| 2005 | 90.3 | 66.7 | 84.7 | - | - |
| 2004 | 90.1 | - | 84.8 | - | - |
| 2003 | 88.7 | - | 83.1 | - | - |
| 2002 | 86.0 | - | 80.3 | - | - |
| 2001 | 85.4 | - | 79.1 | - | - |
| 2000 | 84.2 | - | - | - | - |
| 1999 | 82.6 | - | - | - | - |

| MEASLES, MUMPS, RUBELLA (MMR) | | | | | |
|--------------------------------------|------------|------|----------|----------|-----|
| YEAR | COMMERCIAL | | MEDICAID | MEDICARE | |
| | HMO | PPO | HMO | HMO | PPO |
| 2011 | 91.5 | 86.9 | 90.9 | - | - |
| 2010 | 90.8 | 82.7 | 90.6 | - | - |
| 2009 | 90.6 | 80.5 | 91.2 | - | - |
| 2008 | 93.5 | 76.4 | 90.9 | - | - |
| 2007 | 93.5 | 76.3 | 90.4 | - | - |
| 2006 | 93.6 | 75.0 | 91.1 | - | - |
| 2005 | 93.0 | 86.2 | 89.6 | - | - |
| 2004 | 92.3 | - | 88.1 | - | - |
| 2003 | 91.5 | - | 87.4 | - | - |
| 2002 | 90.1 | - | 84.4 | - | - |
| 2001 | 89.4 | - | 83.7 | - | - |
| 2000 | 88.4 | - | - | - | - |
| 1999 | 87.0 | - | - | - | - |

| PNEUMOCOCCAL CONJUGATE (PCV) | | | | | |
|-------------------------------------|------------|------|----------|----------|-----|
| YEAR | COMMERCIAL | | MEDICAID | MEDICARE | |
| | HMO | PPO | HMO | HMO | PPO |
| 2011 | 87.0 | 77.7 | 79.3 | - | - |
| 2010 | 85.6 | 65.6 | 79.4 | - | - |
| 2009 | 84.6 | 60.1 | 77.6 | - | - |
| 2008 | 84.8 | 47.8 | 75.6 | - | - |
| 2007 | 83.6 | 42.3 | 73.8 | - | - |
| 2006 | 72.8 | 37.1 | 68.3 | - | - |

| VARICELLA (VZV) | | | | | |
|------------------------|------------|------|----------|----------|-----|
| YEAR | COMMERCIAL | | MEDICAID | MEDICARE | |
| | HMO | PPO | HMO | HMO | PPO |
| 2011 | 91.3 | 86.9 | 90.5 | - | - |
| 2010 | 90.8 | 82.2 | 90.0 | - | - |
| 2009 | 90.6 | 79.7 | 90.6 | - | - |
| 2008 | 92.0 | 74.8 | 89.7 | - | - |
| 2007 | 91.9 | 74.4 | 88.7 | - | - |
| 2006 | 90.9 | 72.0 | 88.9 | - | - |
| 2005 | 89.9 | 82.0 | 86.6 | - | - |
| 2004 | 87.5 | - | 84.7 | - | - |
| 2003 | 85.7 | - | 81.8 | - | - |
| 2002 | 82.0 | - | 76.4 | - | - |
| 2001 | 75.3 | - | 73.6 | - | - |
| 2000 | 70.5 | - | - | - | - |
| 1999 | 63.8 | - | - | - | - |

HEPATITIS A (HEP A)

| YEAR | COMMERCIAL | | MEDICAID | MEDICARE | |
|------|------------|------|----------|----------|-----|
| | HMO | PPO | HMO | HMO | PPO |
| 2011 | 39.0 | 32.3 | 39.2 | - | - |
| 2010 | 35.4 | 28.6 | 36.5 | - | - |

ROTAVIRUS (RV)

| YEAR | COMMERCIAL | | MEDICAID | MEDICARE | |
|------|------------|------|----------|----------|-----|
| | HMO | PPO | HMO | HMO | PPO |
| 2011 | 75.1 | 67.2 | 62.4 | - | - |
| 2010 | 63.5 | 51.9 | 57.6 | - | - |

INFLUENZA

| YEAR | COMMERCIAL | | MEDICAID | MEDICARE | |
|------|------------|------|----------|----------|-----|
| | HMO | PPO | HMO | HMO | PPO |
| 2011 | 61.1 | 57.3 | 44.8 | - | - |
| 2010 | 57.1 | 51.1 | 43.6 | - | - |

CHILDHOOD IMMUNIZATION COMBINATION 2 (DTAP, IPV, MMR, HIB, HEPATITIS B AND VZV)

| YEAR | COMMERCIAL | | MEDICAID | MEDICARE | |
|------|------------|------|----------|----------|-----|
| | HMO | PPO | HMO | HMO | PPO |
| 2011 | 78.0 | 64.8 | 74.5 | - | - |
| 2010 | 78.5 | 48.5 | 74.1 | - | - |
| 2009 | 77.7 | 43.1 | 74.3 | - | - |
| 2008 | 81.2 | 30.6 | 73.7 | - | - |
| 2007 | 80.8 | 30.1 | 72.1 | - | - |
| 2006 | 79.8 | 24.5 | 73.4 | - | - |
| 2005 | 77.7 | 54.8 | 70.5 | - | - |
| 2004 | 72.5 | - | 63.1 | - | - |
| 2003 | 69.8 | - | 58.5 | - | - |
| 2002 | 62.5 | - | 53.2 | - | - |
| 2001 | 57.6 | - | 52.5 | - | - |
| 2000 | 53.5 | - | - | - | - |
| 1999 | 47.5 | - | - | - | - |

| CHILDHOOD IMMUNIZATION COMBINATION 3 (DTAP, IPV, MMR, HIB, HEPATITIS B, VZV AND PCV) | | | | | |
|---|------------|------|----------|----------|-----|
| YEAR | COMMERCIAL | | MEDICAID | MEDICARE | |
| | HMO | PPO | HMO | HMO | PPO |
| 2011 | 75.7 | 63.1 | 70.6 | - | - |
| 2010 | 75.1 | 46.1 | 69.9 | - | - |
| 2009 | 73.4 | 40.4 | 69.4 | - | - |
| 2008 | 76.6 | 28.5 | 67.6 | - | - |
| 2007 | 75.5 | 27.6 | 65.4 | - | - |
| 2006 | 65.7 | 22.4 | 60.9 | - | - |

| CHILDHOOD IMMUNIZATION COMBINATION 10 (DTAP, IPV, MMR, HIB, HEPATITIS A, HEPATITIS B, VZV, PCV, ROTAVIRUS AND INFLUENZA) | | | | | |
|---|------------|------|----------|----------|-----|
| YEAR | COMMERCIAL | | MEDICAID | MEDICARE | |
| | HMO | PPO | HMO | HMO | PPO |
| 2011 | 22.9 | 17.0 | 17.3 | - | - |
| 2010 | 18.5 | 10.4 | 15.2 | - | - |

IMMUNIZATIONS FOR ADOLESCENTS

Immunizations are a vital component of disease prevention, protecting not only people who receive them, but also those with whom they come in contact—family, friends and the community at large.¹ Immunizations are essential for adolescents, as well, and can help ensure that they achieve and maintain well-being into and throughout adulthood.^{2,3} The *Immunizations for Adolescents* measure assesses whether adolescents were vaccinated against four vaccine-preventable diseases: meningococcal meningitis, tetanus, diphtheria and pertussis (whooping cough).

- Providing booster shots for adolescents can extend vaccine protection when childhood immunizations start to wear off.⁴ For example, the Tdap booster provides continued protection against tetanus, diphtheria and pertussis.⁵
- Prior to vaccines, the U.S. averaged approximately 500–600 cases of tetanus, 100,000–200,000 cases of diphtheria and 175,000 cases of pertussis each year.⁵ In 2009, only 19 tetanus cases, resulting in 2 deaths, were reported in the U.S., and there have been no confirmed cases of diphtheria since 2003.^{6,7}
- Adolescents who were vaccinated in early childhood, but whose immunity has waned, are common carriers of the pertussis infection and can transmit it to infants.⁸
- Although anyone can get it, adolescents are at increased risk for contracting meningococcal meningitis, a disease that infects about 1,500 Americans each year.⁹ Approximately 11 percent of people who

become infected die; of those who survive, between 11 percent and 19 percent suffer life-altering complications, including brain damage, hearing loss and amputation.⁹

The Case for Improvement

- Direct medical costs and indirect societal costs associated with vaccine-preventable diseases total more than \$10 billion each year.¹⁰
- Despite what is understood about the effectiveness of immunizations in protecting against serious, sometimes fatal, diseases, adolescent immunization rates are low.¹⁰
- Pertussis cases have increased in the U.S. over the last 30 years, especially among adolescents and infants. In 2010, 27,550 pertussis cases were reported, resulting in 26 deaths.¹¹ California reported 10 infant deaths due to a pertussis outbreak that year, the largest number of cases in 50 years.¹⁰

- Reasons frequently cited for low adolescent immunization rates are lack of regular preventive care visits that provide an opportunity for vaccination; lack of awareness of the need for immunizations; inaccurate risk assessments by parents and adolescents about vaccine-preventable diseases; and financial barriers.^{12,13}

HEDIS Measure Definition

The percentage of adolescents 13 years of age who had one dose of meningococcal vaccine and one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) or one tetanus, diphtheria toxoids vaccine (Td) by their 13th birthday. The measure calculates a rate for each vaccine and one combination rate.

The Bottom Line

Although the number of cases reported for these infectious diseases is lower than in the past, the viruses and bacteria that cause them are still common.¹¹ Immunizing adolescents prevents them from becoming infected, and also helps prevent infecting those who cannot be immunized because they are too young, cannot be vaccinated for medical reasons or do not respond to a vaccination.¹

MENINGOCOCCAL (MCV4)

| YEAR | COMMERCIAL | | MEDICAID | MEDICARE | |
|------|------------|------|----------|----------|-----|
| | HMO | PPO | HMO | HMO | PPO |
| 2011 | 61.9 | 51.4 | 63.2 | - | - |
| 2010 | 55.2 | 43.8 | 56.3 | - | - |

TETANUS, DIPHTHERIA, ACELLULAR PERTUSSIS (TDAP/TD)

| YEAR | COMMERCIAL | | MEDICAID | MEDICARE | |
|------|------------|------|----------|----------|-----|
| | HMO | PPO | HMO | HMO | PPO |
| 2011 | 77.0 | 65.4 | 75.8 | - | - |
| 2010 | 69.5 | 55.3 | 67.8 | - | - |

ADOLESCENT IMMUNIZATION COMBINATION 1 (MENINGOCOCCAL, TDAP/TD)

| YEAR | COMMERCIAL | | MEDICAID | MEDICARE | |
|------|------------|------|----------|----------|-----|
| | HMO | PPO | HMO | HMO | PPO |
| 2011 | 59.4 | 48.2 | 60.5 | - | - |
| 2010 | 51.6 | 39.4 | 52.2 | - | - |

LEAD SCREENING IN CHILDREN

Lead poisoning is highly toxic and can lead to cognitive impairment, behavioral disorders, seizures and death.^{1,2} Children are especially at risk for developing lead poisoning. Approximately 250,000 children under the age of 5 have elevated blood lead levels, as defined by the Centers for Disease Control and Prevention.³ Because low income is a risk factor for elevated blood lead levels, the *Lead Screening in Children* measure gauges the number of children covered by Medicaid who were tested for lead poisoning before they turned 2 years of age.

- The two most common methods of screening children for lead poisoning are venous blood sampling (inserting a needle into a vein) and capillary blood sampling (finger or heel stick).⁴
- Exposure to lead during childhood can impact long-term development, affecting bone and muscle growth and speech and language development or causing anemia.^{1,2,5}
- The total annual costs of environmental pollutants are estimated at \$76.6 billion. Of this, \$50.9 billion is attributable to lead poisoning.⁷
- Low-income children, non-Hispanic Black children and children living in housing built before 1950 are disproportionately affected by lead poisoning.⁸ For these populations, blood lead levels have remained consistently high, even though they have declined for the overall population by 84 percent since 1988.⁹

The Case for Improvement

- Although lead-based paints were banned for use in housing in 1978, approximately 24 million homes in the United States contain lead paint and elevated levels of lead-contaminated house dust. More than 4 million of these homes are inhabited by young children.⁶

HEDIS Measure Definition

This measure assesses the percentage of children 2 years of age who had one or more blood tests for lead poisoning by their second birthday.

The Bottom Line

Lead poisoning can cause serious harm in children, one of the most vulnerable populations. Screening is an inexpensive way to detect the presence of lead in a child's environment and reduce further exposure.

| LEAD SCREENING RATE | | | | | |
|---------------------|------------|-----|----------|----------|-----|
| YEAR | COMMERCIAL | | MEDICAID | MEDICARE | |
| | HMO | PPO | HMO | HMO | PPO |
| 2011 | - | - | 67.8 | - | - |
| 2010 | - | - | 66.2 | - | - |
| 2009 | - | - | 66.4 | - | - |
| 2008 | - | - | 66.7 | - | - |

CHLAMYDIA SCREENING IN WOMEN

Chlamydia is the most common sexually transmitted disease reported in the United States. More than 1.3 million infections were reported in 2010.¹ Although chlamydia is known as a “silent” disease, causing no symptoms at all in 75 percent of infected women, it can cause extensive and irreversible damage to reproductive organs. Chlamydia can lead to pelvic inflammatory disease (PID), infertility and cystitis, and can even increase one’s risk of becoming infected with HIV.^{1,2} The *Chlamydia Screening in Women* measure assesses whether sexually active women and adolescent girls were screened annually for chlamydia.

- With an estimated 2.8 million cases occurring in the U.S. each year, chlamydia is significantly underdiagnosed and underreported.¹ Less than half of all young, sexually active women in the U.S. are screened annually for chlamydia as recommended.^{3,4}
- Between 10 percent and 15 percent of untreated chlamydia infections result in PID, which can lead to ectopic pregnancy and infertility.¹ As many as 15 percent of women with PID will become infertile.⁵
- The lifetime medical cost of chlamydia is about \$315 per case for females (and only \$26 per case for males). If the infection leads to PID, treatment can range between \$1,060 and \$3,180 per case.⁷
- Although chlamydia is curable and can be easily diagnosed, screening remains underutilized. Obstacles affecting annual screening rates are lack of awareness, social stigma, barriers to finding and treating sexual partners of infected women and difficulty measuring chlamydia’s impact on public health.^{6,8}

The Case for Improvement

- Sexually transmitted diseases cost the U.S. health care system approximately \$17 billion each year.⁴ The annual estimated cost of chlamydia, including diagnosing and treating chlamydia-associated infertility, is approximately \$701 million.⁶

HEDIS Measure Definition

The percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.

The Bottom Line

The sooner an individual is aware of chlamydia infection, the sooner treatment can begin to prevent further health complications. If recommended annual chlamydia screening guidelines were followed, as many as 60,000 cases of PID, 8,000 cases of chronic pelvic pain and 7,500 cases of infertility could be prevented each year.⁹

| CHLAMYDIA SCREENING RATE (16–20 YEARS) | | | | | |
|---|------------|------|----------|----------|-----|
| YEAR | COMMERCIAL | | MEDICAID | MEDICARE | |
| | HMO | PPO | HMO | HMO | PPO |
| 2011 | 41.5 | 39.6 | 54.9 | – | – |
| 2010 | 40.8 | 38.1 | 54.6 | – | – |
| 2009 | 41.0 | 37.7 | 54.4 | – | – |
| 2008 | 40.1 | 36.7 | 52.7 | – | – |
| 2007 | 36.4 | 32.4 | 48.6 | – | – |
| 2006 | 36.2 | 29.4 | 50.5 | – | – |
| 2005 | 34.4 | 26.2 | 49.2 | – | – |
| 2004 | 32.6 | – | 45.9 | – | – |
| 2003 | 30.4 | – | 44.3 | – | – |
| 2002 | 26.7 | – | 40.8 | – | – |
| 2001 | 24.5 | – | 39.6 | – | – |
| 2000 | 23.6 | – | – | – | – |
| 1999 | 18.5 | – | – | – | – |

| CHLAMYDIA SCREENING RATE (21–24 YEARS) | | | | | |
|---|------------|------|----------|----------|-----|
| YEAR | COMMERCIAL | | MEDICAID | MEDICARE | |
| | HMO | PPO | HMO | HMO | PPO |
| 2011 | 48.4 | 44.9 | 63.4 | – | – |
| 2010 | 45.7 | 41.9 | 62.3 | – | – |
| 2009 | 45.4 | 41.4 | 61.6 | – | – |
| 2008 | 43.5 | 39.4 | 59.4 | – | – |
| 2007 | 39.2 | 34.9 | 54.0 | – | – |
| 2006 | 38.0 | 31.2 | 55.0 | – | – |
| 2005 | 35.2 | 27.6 | 52.5 | – | – |
| 2004 | 31.7 | – | 49.0 | – | – |
| 2003 | 29.1 | – | 46.0 | – | – |
| 2002 | 24.5 | – | 41.5 | – | – |
| 2001 | 22.1 | – | 41.1 | – | – |
| 2000 | 20.7 | – | – | – | – |
| 1999 | 16.0 | – | – | – | – |

| CHLAMYDIA SCREENING RATE (TOTAL RATE) | | | | | |
|--|------------|------|----------|----------|-----|
| YEAR | COMMERCIAL | | MEDICAID | MEDICARE | |
| | HMO | PPO | HMO | HMO | PPO |
| 2011 | 45.0 | 42.4 | 58.0 | – | – |
| 2010 | 43.1 | 40.0 | 57.5 | – | – |
| 2009 | 43.1 | 39.5 | 56.7 | – | – |
| 2008 | 41.7 | 38.0 | 54.9 | – | – |
| 2007 | 38.1 | 33.8 | 50.7 | – | – |
| 2006 | 37.3 | 30.4 | 52.4 | – | – |
| 2005 | 34.9 | 26.9 | 50.7 | – | – |
| 2004 | 32.2 | – | 47.2 | – | – |
| 2003 | 29.7 | – | 44.9 | – | – |
| 2002 | 25.4 | – | 40.9 | – | – |
| 2001 | 23.1 | – | 40.4 | – | – |

APPROPRIATE TESTING FOR CHILDREN WITH PHARYNGITIS

Pharyngitis, or sore throat, is one of the most common illnesses for which pediatricians and other primary care physicians are consulted.¹ Although most sore throats are caused by a virus, 15 percent–30 percent of all pharyngitis cases are caused by group A streptococcus bacteria.^{2,3} The *Appropriate Testing for Children With Pharyngitis* measure evaluates whether children are properly treated for pharyngitis *after* undergoing diagnostic testing, thereby avoiding antibiotic resistance resulting from using antibiotics without a confirmed diagnosis.⁴

- In the general population, acute pharyngitis accounts for 1.3 percent of all outpatient visits to health care providers in the United States. In 2006, this was 15 million patient visits.³
- Acute pharyngitis accounts for 6 percent of all ED visits and is diagnosed 10 million times annually in the ED.⁴
- Group A streptococcus is responsible for 15 percent–30 percent of pharyngitis cases in children and occurs most often among children between the ages of 5 and 15.^{2,3}
- Strep is generally overdiagnosed and overtreated with antibiotics.⁶ Appropriate use of pharyngitis tests prevent incorrect diagnosis and therefore reduce overprescribing of antibiotics and the threat of antibiotic resistance.⁴
- Infections resulting from pharyngitis can have lifestyle and productivity effects. One study found that both children and parents missed a notable number of school and work days because of pharyngitis-related treatment and management.⁷

The Case for Improvement

- Pharyngitis has a significant financial burden, costing an estimated \$224 million–\$539 million per year.⁵
- Without proper treatment with antibiotics, group A streptococcus can lead to life-threatening illnesses such as rheumatic fever and streptococcal toxic shock syndrome. Group A streptococcus contributes to 1,300 deaths every year.⁵

HEDIS Measure Definition

The percentage of children 2–18 years of age who were diagnosed with pharyngitis and dispensed an antibiotic, and who also received a group A streptococcus test for the episode. A higher rate represents better performance (i.e., appropriate testing).

The Bottom Line

Antibiotic treatment for pharyngitis is appropriate when a child tests positive for streptococcal pharyngitis. The use of a rapid strep test, also known as rapid antigen detection testing, or a throat culture should be positive before beginning antibiotic treatment.²

| APPROPRIATE TESTING RATE | | | | | |
|--------------------------|------------|------|----------|-----|-----|
| YEAR | COMMERCIAL | | MEDICAID | | |
| | HMO | PPO | HMO | HMO | PPO |
| 2011 | 80.2 | 79.3 | 66.7 | – | – |
| 2010 | 77.6 | 76.6 | 64.9 | – | – |
| 2009 | 77.4 | 75.5 | 62.3 | – | – |
| 2008 | 75.6 | 74.1 | 61.4 | – | – |
| 2007 | 74.7 | 73.5 | 58.7 | – | – |
| 2006 | 72.7 | 69.4 | 56.0 | – | – |
| 2005 | 69.7 | 64.5 | 52.0 | – | – |
| 2004 | 72.6 | – | 54.4 | – | – |

APPROPRIATE TREATMENT FOR CHILDREN WITH UPPER RESPIRATORY INFECTION

Upper respiratory infection (URI), or the common cold, is an infection that targets the lining of the throat and nose, resulting in fever, congestion, coughing and other symptoms, lasting one to two weeks. It is often caused by a virus and typically resolves without treatment.^{1,2} The *Appropriate Treatment for Children With Upper Respiratory Infection* measure evaluates whether children with URIs were properly treated by not receiving antibiotics.

- The average child has between six and eight colds a year.³ Roughly one third of all children in the U.S. are seen by a primary care provider for respiratory infections each year.⁴
- Children diagnosed with viral URIs are often prescribed antibiotics, even though antibiotics are ineffective for treating viral infections.⁵ Bacterial infections that would respond to antibiotic therapy comprise only about 2 percent of URI cases.⁶
- Children receiving an antibiotic for a URI have a higher likelihood of a return visit to the treating physician within 30 days than those not receiving an antibiotic.⁹ This places a greater burden on both clinicians and patients.

HEDIS Measure Definition

The percentage of children 3 months–18 years of age who were diagnosed with a URI and were not dispensed an antibiotic prescription.

The Case for Improvement

- Children have the highest rate of antibiotic use.⁷ Widespread overuse and inappropriate use of antibiotics in ambulatory care settings has resulted in an epidemic of resistant infections.⁸ Antibiotic-resistant infections cost more to treat and can result in longer hospital stays.⁷

The Bottom Line

The prescription of antibiotics is rarely appropriate for the treatment of URIs in children because the infections are often caused by a virus. Reducing the inappropriate use of antibiotics is vital to slowing the spread of drug-resistant microbes and reducing unnecessary health care costs.

| APPROPRIATE TESTING RATE | | | | | |
|--------------------------|------------|------|----------|-----|----------|
| YEAR | COMMERCIAL | | MEDICAID | | MEDICARE |
| | HMO | PPO | HMO | HMO | PPO |
| 2011 | 83.9 | 82.0 | 85.3 | – | – |
| 2010 | 85.1 | 83.7 | 87.2 | – | – |
| 2009 | 84.1 | 82.5 | 86.0 | – | – |
| 2008 | 83.9 | 83.3 | 85.5 | – | – |
| 2007 | 83.5 | 83.0 | 84.1 | – | – |
| 2006 | 82.8 | 82.1 | 83.4 | – | – |
| 2005 | 82.9 | 81.9 | 82.4 | – | – |
| 2004 | 82.7 | – | 79.9 | – | – |

FOLLOW-UP CARE FOR CHILDREN PRESCRIBED ADHD MEDICATION

Attention deficit/hyperactivity disorder (ADHD) is a development disorder that presents symptoms during childhood and persists into adulthood.^{1,2}

- ADHD is the most commonly diagnosed behavioral disorder among children; nearly 1 in 10 children 4–17 years of age are diagnosed with ADHD.¹
- Symptoms of ADHD include lack of attention, hyperactivity and impulsive behavior outside the normal range of a child's age and development. If left untreated, these symptoms can result in poor academic performance, family issues and behavioral problems.^{3,4}
- Studies have shown a link between untreated ADHD in adolescents and increased risk of drug-use disorders.⁹

HEDIS Measure Definition

The following two rates of this measure assess follow-up care for children prescribed an ADHD medication:

Initiation Phase

The percentage of children between 6 and 12 years of age diagnosed with ADHD who had one follow-up visit with a practitioner with prescribing authority within 30 days of their first prescription of ADHD medication.

Continuation and Maintenance Phase

The percentage of children between 6 and 12 years of age with a prescription for ADHD medication who remained on the medication for at least 210 days and had at least two follow-up visits with a practitioner in the 9 months subsequent to the Initiation Phase.

The *Follow-Up Care for Children Prescribed ADHD Medication* measure assesses whether children prescribed ADHD medication have follow-up visits.

The Case for Improvement

- Children with ADHD are more likely to also have other behavioral disorders that require more educational services.^{5,6}
- The annual cost of ADHD in the U.S. is estimated to be more than \$42 billion.⁷
- Families who have children with special care needs, such as ADHD, have increased long-term economic costs due to higher spending on medical bills and lost productivity.⁸

The Bottom Line

Medication is used to control symptoms of ADHD in children and must be monitored by a practitioner, to ensure the medication is working and to monitor side effects.

FOLLOW-UP CARE AFTER INITIATION OF TREATMENT

| YEAR | COMMERCIAL | | MEDICAID | | MEDICARE |
|------|------------|------|----------|-----|----------|
| | HMO | PPO | HMO | HMO | PPO |
| 2011 | 39.4 | 39.4 | 38.8 | – | – |
| 2010 | 38.8 | 38.1 | 38.1 | – | – |
| 2009 | 36.6 | 35.4 | 36.6 | – | – |
| 2008 | 35.8 | 34.1 | 34.4 | – | – |
| 2007 | 33.7 | 31.8 | 33.5 | – | – |
| 2006 | 33.0 | 30.6 | 31.8 | – | – |

FOLLOW-UP CARE DURING CONTINUATION OF TREATMENT

| YEAR | COMMERCIAL | | MEDICAID | | MEDICARE |
|------|------------|------|----------|-----|----------|
| | HMO | PPO | HMO | HMO | PPO |
| 2011 | 44.2 | 44.9 | 45.9 | – | – |
| 2010 | 43.4 | 43.3 | 43.9 | – | – |
| 2009 | 41.7 | 39.0 | 41.7 | – | – |
| 2008 | 40.2 | 37.1 | 39.5 | – | – |
| 2007 | 38.7 | 34.2 | 38.9 | – | – |
| 2006 | 38.1 | 30.0 | 34.0 | – | – |

CHILDREN AND ADOLESCENTS' ACCESS TO PRIMARY CARE PRACTITIONERS

Primary care is a key component for health and wellness among children and adolescents. Children and adolescents need access to primary care practitioners (PCP) to ensure their optimal health and well-being.¹ PCP guidance can promote healthy development and prevent illness.^{2,3} The *Children and Adolescents' Access to Primary Care Practitioners* measure assesses whether children and adolescents obtained medical attention from a PCP, such as a family doctor, internist, pediatrician or general practitioner.

- In 2010, nearly 4 million children 0–17 years of age had no usual source of care; this number has not improved from 2009.⁴ Compared with all age groups, adolescents are among those least likely to have health care access or to use primary care services.⁵
- More than 7 million children and adolescents had no health care visit in the past 12 months.⁴ Nearly 6 million children do not have a PCP who knows their medical history.⁶
- Although the primary care workforce increased by 35 percent between 1996 and 2006, almost 1 million children live in areas with no PCP. Children and adolescents living in rural areas are affected disproportionately.⁷
- needs.⁹ Fewer than half of children and adolescents in the United States receive the recommended amount of preventive care.¹⁰
- PCPs address care coordination, health maintenance and prevention.¹¹ In 2006, 11.6 percent of children did not have a health care visit where preventive care needs were addressed.⁹

HEDIS Measure Definition

The percentage of children and young adults 12 months–19 years of age who had a visit with a PCP. The measure reports on four separate percentages:

- Children 12–24 months who had a visit with a PCP during the measurement year.
- Children 25 months–6 years who had a visit with a PCP during the measure year.
- Children 7–11 years who had a visit with a PCP during the measure year or the year prior to the measurement year.

The Case for Improvement

- Primary care access may lower rising health care costs by reducing the need for expensive hospitalizations.⁸
- Children without a medical home are four times more likely to have unmet health care

- Adolescents 12–19 years who had a visit with a PCP during the measurement year or the year prior to the measurement year.

The Bottom Line

Access to PCPs improves use of prevention services and proper screening, and may lower unnecessary medical costs associated with emergency care. Consistent care with a provider influences better health outcomes for children and adolescents.

| ACCESS TO PRIMARY CARE CHILDREN 12–24 MONTHS | | | | | |
|---|------------|------|----------|----------|-----|
| YEAR | COMMERCIAL | | MEDICAID | MEDICARE | |
| | HMO | PPO | HMO | HMO | PPO |
| 2011 | 97.9 | 97.2 | 96.1 | – | – |
| 2010 | 97.5 | 96.9 | 96.1 | – | – |
| 2009 | 97.5 | 96.2 | 95.2 | – | – |
| 2008 | 96.7 | 95.4 | 95.0 | – | – |
| 2007 | 96.9 | 93.7 | 93.4 | – | – |
| 2006 | 97.0 | 94.2 | 94.1 | – | – |
| 2005 | 97.0 | 95.0 | 92.6 | – | – |
| 2004 | 96.8 | – | 92.3 | – | – |
| 2003 | 96.3 | – | 92.4 | – | – |
| 2002 | 95.7 | – | 91.1 | – | – |
| 2001 | 95.2 | – | 90.7 | – | – |
| 2000 | 92.5 | – | – | – | – |
| 1999 | 91.2 | – | – | – | – |

ACCESS TO PRIMARY CARE CHILDREN 25 MONTHS–6 YEARS

| YEAR | COMMERCIAL | | MEDICAID | MEDICARE | |
|------|------------|------|----------|----------|-----|
| | HMO | PPO | HMO | HMO | PPO |
| 2011 | 91.9 | 90.3 | 88.2 | – | – |
| 2010 | 91.2 | 89.1 | 88.3 | – | – |
| 2009 | 91.6 | 89.1 | 88.3 | – | – |
| 2008 | 89.7 | 87.4 | 87.2 | – | – |
| 2007 | 89.4 | 86.3 | 84.3 | – | – |
| 2006 | 89.3 | 86.3 | 84.9 | – | – |
| 2005 | 89.3 | 85.7 | 83.1 | – | – |
| 2004 | 88.1 | – | 81.9 | – | – |
| 2003 | 88.5 | – | 82.1 | – | – |
| 2002 | 87.2 | – | 80.0 | – | – |
| 2001 | 85.7 | – | 79.3 | – | – |
| 2000 | 82.4 | – | – | – | – |
| 1999 | 81.3 | – | – | – | – |

| ACCESS TO PRIMARY CARE CHILDREN 7–11 YEARS | | | | | |
|---|------------|------|----------|----------|-----|
| YEAR | COMMERCIAL | | MEDICAID | MEDICARE | |
| | HMO | PPO | HMO | HMO | PPO |
| 2011 | 91.9 | 90.1 | 89.5 | – | – |
| 2010 | 91.6 | 89.4 | 90.2 | – | – |
| 2009 | 91.4 | 89.0 | 90.3 | – | – |
| 2008 | 89.9 | 87.4 | 87.8 | – | – |
| 2007 | 89.5 | 86.8 | 85.9 | – | – |
| 2006 | 89.2 | 85.7 | 85.9 | – | – |
| 2005 | 88.6 | 83.4 | 83.4 | – | – |
| 2004 | 88.5 | – | 82.5 | – | – |
| 2003 | 88.5 | – | 82.1 | – | – |
| 2002 | 87.4 | – | 80.3 | – | – |
| 2001 | 85.8 | – | 79.3 | – | – |
| 2000 | 83.6 | – | – | – | – |
| 1999 | 82.6 | – | – | – | – |

| ACCESS TO PRIMARY CARE ADOLESCENTS 12–19 YEARS | | | | | |
|---|------------|------|----------|----------|-----|
| YEAR | COMMERCIAL | | MEDICAID | MEDICARE | |
| | HMO | PPO | HMO | HMO | PPO |
| 2011 | 89.3 | 87.3 | 87.9 | – | – |
| 2010 | 89.2 | 86.8 | 88.1 | – | – |
| 2009 | 89.0 | 86.1 | 87.9 | – | – |
| 2008 | 87.3 | 84.2 | 85.3 | – | – |
| 2007 | 86.9 | 83.4 | 82.7 | – | – |
| 2006 | 86.6 | 82.3 | 83.2 | – | – |
| 2005 | 86.1 | 79.8 | 80.9 | – | – |
| 2004 | 85.5 | – | 79.3 | – | – |
| 2003 | 85.8 | – | 79.6 | – | – |

CHILD AND ADOLESCENT WELL-CARE VISITS

Childhood and adolescence is a time of significant growth and development. In this transition to adulthood, many new physical, emotional and social challenges may affect health.¹ Well-care visits with a health care provider can identify development and behavior issues throughout this phase of life.² The *Child and Adolescent Well-Care Visits* measures assess the number of children and adolescents who had a well-care visit in the measurement year.

- Risk-taking behaviors, such as substance abuse, drunk driving, risky sexual activity and smoking, often begin in childhood or adolescence. In 2011, almost 45 percent of high school students had tried cigarettes, 87.5 percent indicated they rarely or never wore bicycle helmet and nearly 13 percent first drank alcohol before the age of 13.³ Among those who were sexually active, nearly 40 percent did not use a condom the last time they had sex.³
- Many chronic diseases seen in adults can begin during childhood, when eating habits and physical activity levels are often established.⁴ For example, 17 percent of children and adolescents between 2 and 19 years of age are obese.⁵ Without early intervention, obesity can lead to type 2 diabetes, heart disease and certain cancers.⁶
- Less than half of all children and adolescents receive the recommended number of preventive care visits. Those who get the recommended visits have lower hospital admission rates.⁷

The Case for Improvement

- Adolescents are among those least likely to have access to health care or to use primary care services.⁴ In 2008, less than 69 percent of adolescents reported a well-care visit in the past 12 months, and discussion of health behaviors with a clinician occurred in less than half of well-care visits.^{8,9}
- Health care spending for preventable health issues is a growing problem for children and adolescents. The cost of treating preventable accidents and conditions has reached \$33.5 billion each year.¹⁰ In comparison, each dollar spent on access to pediatric counseling accounts for \$9 dollars in cost savings.¹¹
- Advice from health care providers can lead to improvement in health behaviors, such as dietary habits.² Adolescents whose doctors talked to them about overweight had a higher likelihood of decreasing their food and beverage intake and attempting weight loss efforts.¹²

Well-care visits are an effective way for doctors to present health promotion advice that is timely and relevant for proper development and well-being, but nearly 10 percent of all children 18 years old and younger did not have a health care visit in the past 12 months.¹³

HEDIS Measure Definition

The percentage of enrolled children, adolescents and young adults 3–21 years of age who had at least one comprehensive well-care visit with a primary care practitioner or an OB/GYN practitioner during the measurement year.

The Bottom Line

Early life stages are a critical time in the development of healthy behaviors. Changes in physical and social circumstances can put young people at increased risk for serious and long-term health effects of risky behaviors. Annual well-care visits provide effective screening and health counseling services necessary to stay healthy.

**ADOLESCENT WELL-CARE VISITS:
AT LEAST ONE COMPREHENSIVE
WELL-CARE VISIT**

| YEAR | COMMERCIAL | | MEDICAID | MEDICARE | |
|------|------------|------|----------|----------|-----|
| | HMO | PPO | HMO | HMO | PPO |
| 2011 | 43.2 | 40.6 | 49.7 | - | - |
| 2010 | 42.7 | 39.2 | 48.1 | - | - |
| 2009 | 42.5 | 38.3 | 47.7 | - | - |
| 2008 | 42.9 | 36.2 | 45.9 | - | - |
| 2007 | 41.8 | 34.7 | 42.1 | - | - |
| 2006 | 40.3 | 34.6 | 43.6 | - | - |
| 2005 | 38.8 | 29.3 | 40.7 | - | - |
| 2004 | 38.2 | - | 40.0 | - | - |
| 2003 | 37.1 | - | 37.5 | - | - |
| 2002 | 35.8 | - | 37.1 | - | - |
| 2001 | 33.1 | - | 32.6 | - | - |
| 2000 | 30.9 | - | - | - | - |
| 1999 | 28.9 | - | - | - | - |

**WELL-CHILD VISITS (AGES 3–6 YEARS):
ONE OR MORE WELL-CHILD VISITS**

| YEAR | COMMERCIAL | | MEDICAID | MEDICARE | |
|------|------------|------|----------|----------|-----|
| | HMO | PPO | HMO | HMO | PPO |
| 2011 | 72.5 | 69.8 | 72.0 | - | - |
| 2010 | 71.6 | 67.8 | 71.9 | - | - |
| 2009 | 70.3 | 66.0 | 71.6 | - | - |
| 2008 | 69.8 | 63.6 | 69.7 | - | - |
| 2007 | 67.8 | 60.7 | 65.3 | - | - |
| 2006 | 66.7 | 61.6 | 66.8 | - | - |
| 2005 | 65.6 | 54.5 | 63.6 | - | - |
| 2004 | 64.4 | - | 62.4 | - | - |
| 2003 | 62.7 | - | 60.7 | - | - |
| 2002 | 60.4 | - | 58.2 | - | - |
| 2001 | 57.5 | - | 56.0 | - | - |
| 2000 | 54.2 | - | - | - | - |
| 1999 | 51.3 | - | - | - | - |

PRENATAL AND POSTPARTUM CARE

Each year, serious and avoidable complications, such as preterm birth, low birthweight and preeclampsia, are experienced by more than 500,000 pregnant women in the U.S.¹ The *Prenatal and Postpartum Care* and *Frequency of Ongoing Prenatal Care* measures assess whether women have access to timely and consistent prenatal and postpartum care.

- The three most common conditions reported for pregnant women are diabetes, hypertension and postpartum depression. From 2008–2009 gestational hypertension increased from 39.4 per 1,000 women to 41.2 per 1,000 women.²
- Receiving prenatal care during the first trimester improves maternal and infant survival. Connecting women with high-risk pregnancies to more adequate prenatal and neonatal care would improve birth outcomes.³
- The IOM estimates that an investment in accessible, quality prenatal care can result in decreased preterm births and lower neonatal health expenses. Every \$1 invested into proper prenatal care results in a savings of \$3.37 in neonatal care.⁴
- Obtaining proper prenatal care equates to a savings of more than \$1,000 in hospital costs.⁵ Maternal hospital stays for pregnancy-related complications can last 2.9 days for nondelivery stays or 2.7 days for delivery stays. Deliveries without complications require a hospital stay of 1.9 days, on average. Maternal hospital stays for pregnancy and delivery-related complications cost the health care system \$17.4 billion.⁸

The Case for Improvement

- Infant weight and gestational age are closely related and can predict future infant health. Most low-birthweight infants are at an increased risk for poorer health outcomes and early death.¹
- Women without prenatal care are at almost three times higher risk of giving birth to a low-birthweight infant.⁵ Healthy pregnancies occur when comprehensive, continuous prenatal care begins in early pregnancy.^{6,7}

HEDIS Measure Definition

Prenatal and Postpartum Care

The percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care:

- *Timeliness of Prenatal Care.* The percentage of deliveries that received a prenatal care visit as a member of the MCO in the first trimester or within 42 days of enrollment in the MCO.
- *Postpartum Care.* The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.

Frequency of Ongoing Prenatal Care

The percentage of Medicaid deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year that received <21 percent, 21–40 percent, 41–60 percent, 61–80 percent or ≥81 percent of the expected number of prenatal care visits, adjusted for gestational age and the month that the member enrolled in the MCO.

The Bottom Line

Adequate prenatal and postpartum care have a significant impact on the current and future health of infants. Proper maternal health before conception, during pregnancy and after birth can prevent early mortality or the development of poor health in adulthood.

| FREQUENCY OF PRENATAL CARE VISITS: <21% OF EXPECTED VISITS | | | | | |
|--|------------|-----|----------|----------|-----|
| YEAR | COMMERCIAL | | MEDICAID | MEDICARE | |
| | HMO | PPO | HMO | HMO | PPO |
| 2011 | – | – | 10.0 | – | – |
| 2010 | – | – | 10.4 | – | – |
| 2009 | – | – | 10.3 | – | – |
| 2008 | – | – | 11.9 | – | – |
| 2007 | – | – | 12.4 | – | – |
| 2006 | – | – | 13.5 | – | – |
| 2005 | – | – | 16.7 | – | – |
| 2004 | – | – | 17.9 | – | – |
| 2003 | – | – | 21.3 | – | – |
| 2002 | – | – | 27.6 | – | – |
| 2001 | – | – | 33.1 | – | – |

| FREQUENCY OF PRENATAL CARE VISITS: 21%–40% OF EXPECTED VISITS | | | | | |
|---|------------|-----|----------|----------|-----|
| YEAR | COMMERCIAL | | MEDICAID | MEDICARE | |
| | HMO | PPO | HMO | HMO | PPO |
| 2011 | – | – | 6.5 | – | – |
| 2010 | – | – | 6.9 | – | – |
| 2009 | – | – | 6.3 | – | – |
| 2008 | – | – | 6.9 | – | – |
| 2007 | – | – | 6.6 | – | – |
| 2006 | – | – | 6.0 | – | – |
| 2005 | – | – | 5.9 | – | – |
| 2004 | – | – | 6.7 | – | – |
| 2003 | – | – | 7.2 | – | – |
| 2002 | – | – | 7.9 | – | – |
| 2001 | – | – | 7.5 | – | – |

| FREQUENCY OF PRENATAL CARE VISITS: 41%–60% OF EXPECTED VISITS | | | | | |
|---|------------|-----|----------|----------|-----|
| YEAR | COMMERCIAL | | MEDICAID | MEDICARE | |
| | HMO | PPO | HMO | HMO | PPO |
| 2011 | – | – | 8.2 | – | – |
| 2010 | – | – | 8.1 | – | – |
| 2009 | – | – | 8.0 | – | – |
| 2008 | – | – | 8.6 | – | – |
| 2007 | – | – | 7.7 | – | – |
| 2006 | – | – | 7.8 | – | – |
| 2005 | – | – | 7.8 | – | – |
| 2004 | – | – | 8.0 | – | – |
| 2003 | – | – | 8.6 | – | – |
| 2002 | – | – | 9.4 | – | – |
| 2001 | – | – | 7.3 | – | – |

| FREQUENCY OF PRENATAL CARE VISITS: 61%–80% OF EXPECTED VISITS | | | | | |
|---|------------|-----|----------|----------|-----|
| YEAR | COMMERCIAL | | MEDICAID | MEDICARE | |
| | HMO | PPO | HMO | HMO | PPO |
| 2011 | – | – | 14.4 | – | – |
| 2010 | – | – | 13.6 | – | – |
| 2009 | – | – | 13.9 | – | – |
| 2008 | – | – | 14.0 | – | – |
| 2007 | – | – | 13.8 | – | – |
| 2006 | – | – | 14.1 | – | – |
| 2005 | – | – | 13.7 | – | – |
| 2004 | – | – | 14.2 | – | – |
| 2003 | – | – | 14.4 | – | – |
| 2002 | – | – | 13.8 | – | – |
| 2001 | – | – | 10.5 | – | – |

| FREQUENCY OF PRENATAL CARE VISITS: >81% OF EXPECTED VISITS | | | | | |
|--|------------|-----|----------|----------|-----|
| YEAR | COMMERCIAL | | MEDICAID | MEDICARE | |
| | HMO | PPO | HMO | HMO | PPO |
| 2011 | – | – | 60.9 | – | – |
| 2010 | – | – | 61.1 | – | – |
| 2009 | – | – | 61.6 | – | – |
| 2008 | – | – | 58.7 | – | – |
| 2007 | – | – | 59.6 | – | – |
| 2006 | – | – | 58.6 | – | – |
| 2005 | – | – | 55.8 | – | – |
| 2004 | – | – | 51.5 | – | – |
| 2003 | – | – | 48.2 | – | – |
| 2002 | – | – | 41.0 | – | – |
| 2001 | – | – | 39.2 | – | – |

| TIMELINESS OF PRENATAL CARE | | | | | |
|-----------------------------|------------|------|----------|----------|-----|
| YEAR | COMMERCIAL | | MEDICAID | MEDICARE | |
| | HMO | PPO | HMO | HMO | PPO |
| 2011 | 91.0 | 81.9 | 82.7 | - | - |
| 2010 | 91.0 | 75.7 | 83.7 | - | - |
| 2009 | 93.1 | 61.9 | 83.4 | - | - |
| 2008 | 92.4 | 55.5 | 81.9 | - | - |
| 2007 | 91.9 | 46.0 | 81.5 | - | - |
| 2006 | 90.6 | 61.9 | 81.2 | - | - |
| 2005 | 91.8 | 74.6 | 79.6 | - | - |
| 2004 | 90.8 | - | 78.2 | - | - |
| 2003 | 89.4 | - | 76.5 | - | - |
| 2002 | 86.7 | - | 70.4 | - | - |
| 2001 | 85.1 | - | 72.9 | - | - |

| POSTPARTUM CARE | | | | | |
|-----------------|------------|------|----------|----------|-----|
| YEAR | COMMERCIAL | | MEDICAID | MEDICARE | |
| | HMO | PPO | HMO | HMO | PPO |
| 2011 | 80.6 | 71.3 | 64.1 | - | - |
| 2010 | 80.7 | 65.9 | 64.4 | - | - |
| 2009 | 83.6 | 54.1 | 64.1 | - | - |
| 2008 | 82.8 | 45.8 | 62.6 | - | - |
| 2007 | 82.0 | 41.6 | 58.6 | - | - |
| 2006 | 79.9 | 46.3 | 59.1 | - | - |
| 2005 | 81.5 | 62.8 | 57.2 | - | - |
| 2004 | 80.6 | - | 56.5 | - | - |
| 2003 | 80.3 | - | 55.3 | - | - |
| 2002 | 77.0 | - | 52.1 | - | - |
| 2001 | 77.0 | - | 53.0 | - | - |

PHYSICAL ACTIVITY IN OLDER ADULTS

Physical activity in older adults is an important part of preventing and managing chronic diseases like diabetes, osteoporosis, depression and high blood pressure.¹ Physical activity is associated with maintaining or slowing decline in function, cognition and health-related quality of life among older adults, and reduces the risk of falling and fracturing bones.^{1,2,3,4} The *Physical Activity in Older Adults* measure assesses whether older adults either discussed exercise with their physician or received advice about exercise from their physician.

- Regular exercise and increased aerobic fitness are associated with a decrease in all-cause mortality and morbidity in older adults.⁵ Research suggests that older adults have more to gain from physical activity than younger adults.^{2,5} Yet, inactivity increases with age—by age 75, about 1 in 3 men and 1 in 2 women engage in no physical activity.⁶
- Many older adults have an insufficient understanding about the risks and benefits of physical activity, which could be addressed by a health care provider.⁷
- Older adults are the least physically active of any age group and are the fastest growing age group.⁹ By 2030, 70 million Americans will be 65 or older. Adults 85 and older will be the fastest-growing segment of the American population.¹⁰
- Physical inactivity among older adults is an independent risk factor for a number of chronic diseases.^{11,8}
- Regular physical activity has beneficial health effects on a variety of health outcomes for older adults, including decreased risk of early death, heart disease and diabetes; weight loss; fall prevention; reduced depression; and improved cognitive function.^{1,12,13}

The Case for Improvement

- Medical costs for inactive adults are substantially higher than for active adults, and the cost of inactivity increases with age. If inactive older adults increased their physical activity to 90 minutes per week, up to \$5,300 per person could be saved in health care costs every year.⁸

HEDIS Measure Definition

This survey-based measure assesses the percentage of Medicare adults 65 years of age and older who had a doctor's visit in the past 12 months and who:

- Were asked by their health provider about their level of exercise or physical activity.
- Received advice to start, increase or maintain their level of exercise or physical activity.

The Bottom Line

There is strong evidence that physical activity reduces the risk of developing chronic diseases and maintaining function. Counseling older adults about physical activity should be a priority for preventing and treating disease and disability in older adults.¹²

PHYSICAL ACTIVITY DISCUSSION

| YEAR | COMMERCIAL | | MEDICAID | | MEDICARE | |
|------|------------|-----|----------|------|----------|--|
| | HMO | PPO | HMO | HMO | PPO | |
| 2011 | - | - | - | 53.0 | 53.7 | |
| 2010 | - | - | - | 52.3 | 53.9 | |
| 2009 | - | - | - | 51.3 | 54.4 | |
| 2008 | - | - | - | 51.5 | 54.0 | |
| 2007 | - | - | - | 51.1 | 53.0 | |
| 2006 | - | - | - | 50.3 | 53.6 | |
| 2005 | - | - | - | 50.6 | 53.7 | |

PHYSICAL ACTIVITY ADVICE

| YEAR | COMMERCIAL | | MEDICAID | | MEDICARE | |
|------|------------|-----|----------|------|----------|--|
| | HMO | PPO | HMO | HMO | PPO | |
| 2011 | - | - | - | 48.7 | 47.6 | |
| 2010 | - | - | - | 47.9 | 47.6 | |
| 2009 | - | - | - | 46.9 | 47.8 | |
| 2008 | - | - | - | 47.0 | 47.1 | |
| 2007 | - | - | - | 46.1 | 46.7 | |
| 2006 | - | - | - | 45.2 | 48.8 | |
| 2005 | - | - | - | 43.7 | 46.3 | |

PNEUMOCOCCAL VACCINATION STATUS FOR OLDER ADULTS

Pneumococcal infection is a common illness and cause of death in the elderly and in persons with certain underlying conditions.¹ The *Pneumococcal Vaccination Status for Older Adults* survey measure asks patients 65 years of age and older if they have ever received a pneumococcal vaccination (also referred to as a pneumonia shot). The current ACIP guideline recommends that people 65 years of age and older receive a pneumococcal vaccination if it has been more than five years since their previous vaccination.

- There are approximately 43,500 cases of pneumococcal infection each year, and 5,000 deaths.¹
- Older adults have higher rates of pneumococcal infection than other groups. The presence of underlying health conditions puts older adults at further risk of infection.²
- Improved rates of vaccination would lessen the burden associated with medical conditions that arise from pneumococcal infection and would lessen the cost of care associated with avoidable hospitalizations.⁵

HEDIS Measure Definition

The percentage of adults 65 years of age and older who ever received a pneumococcal vaccination.

The Case for Improvement

- Availability of the pneumococcal vaccination over the past 20 years has been associated with decreased mortality from pneumonia, especially for older adults.³
- Among the Hispanic population, rates of pneumococcal vaccination are 21 percent lower than in the White population; for Asian/Pacific Islanders and Blacks, rates are 17 percent lower.⁴
- Survey Question: "Have you ever had a pneumonia shot? This shot is usually given only once or twice in a person's lifetime and is different from the flu shot. It is also called the pneumococcal vaccine."

The Bottom Line

Older adults are at increased risk of death and complications due to pneumonia, and infections can be prevented with vaccination.

| PNEUMONIA VACCINE FOR OLDER ADULTS | | | | | |
|------------------------------------|------------|-----|----------|----------|------|
| YEAR | COMMERCIAL | | MEDICAID | MEDICARE | |
| | HMO | PPO | HMO | HMO | PPO |
| 2011 | - | - | - | 69.4 | 71.7 |
| 2010 | - | - | - | 69.0 | 70.0 |
| 2009 | - | - | - | 65.4 | 66.7 |
| 2008 | - | - | - | 63.8 | 66.5 |
| 2007 | - | - | - | 65.1 | 65.6 |
| 2006 | - | - | - | 66.1 | 66.0 |
| 2005 | - | - | - | 70.7 | 66.4 |
| 2004 | - | - | - | 68.7 | - |
| 2003 | - | - | - | 68.4 | - |
| 2002 | - | - | - | 67.6 | - |
| 2001 | - | - | - | 66.8 | - |

MEASURES TARGETED TOWARD OLDER ADULTS

GLAUCOMA SCREENING IN OLDER ADULTS

Glaucoma, the second leading cause of blindness, represents a family of diseases commonly associated with optic nerve damage and changes in the visual field (narrowing of the eyes' usual scope of vision). Disease development is gradual, starting with "blind spots" and progressing to complete blindness, with little or no warning signs or symptoms until the disease is at an advanced stage.¹ Elevated eye pressure and older age are key risk factors. With an aging population, the prevalence and incidence of glaucoma continue to rise.^{2,3,4} The *Glaucoma Screening in Older Adults* measure assesses whether older adults received a biennial eye exam to check for this condition.

- Untreated glaucoma is the second leading cause of irreversible blindness in the U.S.^{1,2}
- Minorities have higher rates of glaucoma. Among African Americans, glaucoma is the leading cause of blindness—African Americans are five to eight times more likely than Caucasians to have glaucoma.^{3,4,5}
- Mexican Americans and Asian Americans also face an increased risk.⁴ It is expected that by 2050 the largest demographic of glaucoma patients will be Hispanic men, and the per capita rates will double in Texas, Florida and New Mexico.⁶
- Glaucoma accounts for more than 10 million visits to physicians each year.⁸
- Glaucoma-associated visual impairment affects quality of life and the ability to function independently, hampering basic daily activities. Vision loss among the elderly has been shown to result in social isolation, family stress and a greater tendency to experience other health conditions.^{2,3}

HEDIS Measure Definition

The percentage of Medicare adults, 65 years and older, without a prior diagnosis of glaucoma or glaucoma suspect, who received a glaucoma eye exam by an eye-care professional for the early identification of glaucomatous conditions.

The Case for Improvement

- Managed care organizations spend approximately \$1 billion (\$2,000 per patient) annually to treat glaucoma. Treatment costs increase significantly as the disease progresses.⁷

The Bottom Line

Glaucoma's asymptomatic progression points to the importance of early detection and treatment, which can prevent, slow or stop vision loss.^{7,8}

| GLAUCOMA SCREENING RATE | | | | | |
|-------------------------|------------|-----|----------|----------|------|
| YEAR | COMMERCIAL | | MEDICAID | MEDICARE | |
| | HMO | PPO | HMO | HMO | PPO |
| 2011 | - | - | - | 65.8 | 66.6 |
| 2010 | - | - | - | 63.8 | 65.1 |
| 2009 | - | - | - | 62.3 | 63.7 |
| 2008 | - | - | - | 59.8 | 62.2 |
| 2007 | - | - | - | 59.5 | 62.6 |
| 2006 | - | - | - | 62.2 | 63.3 |
| 2005 | - | - | - | 61.5 | 64.5 |

FALL RISK MANAGEMENT

Falls among older adults are a growing national concern because of the financial and societal costs associated with falls and the expanding body of evidence that falling is a public health problem that can be prevented.^{1,2,3} The *Fall Risk Management* measure assesses whether adults over 65 years of age who are at risk of falling discussed their problem with their practitioner and received an appropriate intervention, if necessary.

- Among adults 65 and older, falls are the leading cause of injury and death—each year, 1 in 3 adults experiences a fall.^{2,5} Falls are also the most common cause of nonfatal injuries and hospital admissions for trauma.³ The chances of falling, and of being seriously injured in a fall, increase with age.^{2,3}
- Most falls result in fractures.^{3,4} Falls are also the most common cause of traumatic brain injuries.³
- and loss of physical fitness, which in turn increases their actual risk of falling.^{3,7}
- In 2008, 82 percent of fall-related deaths were among people 65 and older.³
- Multifaceted fall intervention programs for adults 65 and older (exercise, medication adjustment and behavioral interventions) can save an average of \$2,000 in health care costs per person and reduce the total number of falls among those at high risk of falling.⁶

The Case for Improvement

- Direct medical costs of falls total more than \$19.3 billion—\$349 million for fatal falls and \$19 billion for nonfatal fall injuries.⁵ Hospitalizations and visits to the ED make up more than 80 percent of the costs. By 2020, the annual direct and indirect cost of fall injuries is expected to reach \$54.9 billion (in 2007 dollars).^{5,6}
- Many older adults who fall develop a fear of falling that may cause them to limit their activities, leading to reduced mobility

HEDIS Measure Definition

The two components of this survey measure assess different facets of fall risk management.

The percentage of adults 75 years of age and older, or adults 65–74 years of age with balance or walking problems or a fall in the past 12 months, who were seen by a practitioner in the past 12 months and who discussed falls or problems with balance or walking with their current practitioner.

The percentage of adults 65 years of age and older who had a fall or had problems with balance or walking in the past 12 months, who were seen by a practitioner in the past 12 months and who received fall risk intervention from their current practitioner.

The Bottom Line

A discussion between provider and patient regarding falls identifies risk factors related to vision, muscle strength and reflexes—important information for developing an appropriate intervention plan.^{2,3,5}

| FALL RISK DISCUSSION | | | | | |
|----------------------|------------|-----|----------|----------|------|
| YEAR | COMMERCIAL | | MEDICAID | MEDICARE | |
| | HMO | PPO | HMO | HMO | PPO |
| 2011 | – | – | – | 32.8 | 30.7 |
| 2010 | – | – | – | 32.8 | 31.1 |
| 2009 | – | – | – | 31.1 | 30.3 |
| 2008 | – | – | – | 31.3 | 30.7 |
| 2007 | – | – | – | 29.4 | 28.1 |
| 2006 | – | – | – | 27.5 | 26.9 |

| FALL RISK INTERVENTION | | | | | |
|------------------------|------------|-----|----------|----------|------|
| YEAR | COMMERCIAL | | MEDICAID | MEDICARE | |
| | HMO | PPO | HMO | HMO | PPO |
| 2011 | – | – | – | 60.2 | 54.6 |
| 2010 | – | – | – | 60.1 | 55.3 |
| 2009 | – | – | – | 57.7 | 54.7 |
| 2008 | – | – | – | 57.8 | 54.6 |
| 2007 | – | – | – | 55.8 | 53.4 |
| 2006 | – | – | – | 56.0 | 54.2 |

MANAGEMENT OF URINARY INCONTINENCE IN OLDER ADULTS

Urinary incontinence (UI) is involuntary loss of urine. It can affect people of all ages, although it is more common in older adults and women.^{1,2,3} Possible causes of UI in older adults include declining mobility, cognitive impairment, medication side-effects, involuntary bladder contractions and stress incontinence.^{1,4} The *Management of Urinary Incontinence in Older Adults* measure assesses whether adults over 65 years of age were asked by their health care provider about UI symptoms.

- UI disproportionately affects adults 65 and older. More than 65 percent of adults have been found to be incontinent upon admission to a long-term care facility, whereas 39 percent of elderly women and 21 percent of elderly men in the community-dwelling population have UI.^{1,4}
- Very few patients report UI to their providers or seek help for their symptoms, partly due to embarrassment or the belief that it is an inevitable part of aging and there are limited treatment options.⁵ One study found that 74 percent of women with UI symptoms waited one year before seeking help, and 46 percent waited three years.^{5,6}
- Given a rapidly aging population, the incidence and prevalence of UI continues to be a major problem. Among homebound elderly, it ranges from 15 percent–33 percent.^{8,9}
- UI puts older adults at further risk for falls, fractures and functional impairment. It is associated with poor self-rated health, diminished quality of life, social isolation, depressive symptoms and dependence on caregivers.¹⁰

HEDIS Measure Definition

The percentage of Medicare adults 65 and older who reported having a problem with urine leakage in the past six months and discussed the problem with their current practitioner.

The Case for Improvement

- The estimated annual cost of UI is about \$32 billion, or approximately \$3,565 per individual with UI. The largest components are management costs and expenses associated with nursing home admissions attributable to UI.⁷

The Bottom Line

Routinely asking older patients about their symptoms is the first step toward providing appropriate treatment, which is associated with minimal adverse outcomes, decreasing symptoms for many patients and possible prevention of medical or surgical intervention.¹⁰

| URINARY INCONTINENCE DISCUSSION | | | | | |
|---------------------------------|------------|-----|----------|----------|------|
| YEAR | COMMERCIAL | | MEDICAID | MEDICARE | |
| | HMO | PPO | HMO | HMO | PPO |
| 2011 | - | - | - | 57.3 | 56.9 |
| 2010 | - | - | - | 58.2 | 57.9 |
| 2009 | - | - | - | 57.1 | 58.2 |
| 2008 | - | - | - | 57.3 | 58.0 |
| 2007 | - | - | - | 57.8 | 57.7 |
| 2006 | - | - | - | 56.8 | 57.3 |
| 2005 | - | - | - | 56.0 | 55.8 |

OSTEOPOROSIS TESTING IN OLDER WOMEN

Osteoporosis, which affects mostly women, is a disease characterized by low bone mass and structural deterioration of bone tissue, leading to bone fragility and an increased susceptibility to fractures. While any bone can be affected, the spine, wrists and hips are most vulnerable to osteoporosis-related fractures. The disease develops gradually, progressing without symptoms until a low-energy fall or minor activity fractures a bone.¹ The *Osteoporosis Testing in Older Women* measure assesses whether women over the age of 65 reported receiving a bone density test.

- About 12 million Americans have osteoporosis, and approximately 52.4 million over 50 years of age have low bone density—which puts them at increased risk for developing the disease. About 80 percent of those affected are women.^{1,2}
- Half of the women over 50 will have an osteoporosis-related fracture in their lifetime, most commonly of the hip, wrist or spine.^{1,2}
- Osteoporosis is responsible for more than 1.5 million fractures each year, and results in 500,000 hospital admissions, 800,000 ED visits, 2.6 million physician visits and 180,000 nursing home admissions annually.^{4,5}
- Despite being a covered service under Medicare with no out-of-pocket costs, bone density tests are underutilized by elderly women. In 2005 only an estimated 30 percent of female Medicare enrollees received a bone density test.⁵

The Case for Improvement

- In 2008 the annual direct medical costs of osteoporosis and fractures ranged from \$17 billion–\$22 billion. By 2025, annual fractures and costs are expected to rise by almost 50 percent. The most rapid growth is estimated to be for people 65–74 years of age.^{3,4} Total health care costs for fractures are highest for the older female population.⁶

HEDIS Measure Definition

This survey-based measure assesses the percentage of Medicare women 65 years of age and older who report ever having received a bone density test to check for osteoporosis.

The Bottom Line

Osteoporosis-related fractures are associated with high total medical and hospitalization costs in the U.S.⁶ Bone density screenings are an important strategy for reducing the rate of fractures among women over 65.^{7,8}

| BONE DENSITY TESTING RATE | | | | | |
|---------------------------|------------|-----|----------|----------|------|
| YEAR | COMMERCIAL | | MEDICAID | MEDICARE | |
| | HMO | PPO | HMO | HMO | PPO |
| 2011 | - | - | - | 71.0 | 75.0 |
| 2010 | - | - | - | 68.5 | 73.4 |
| 2009 | - | - | - | 68.0 | 72.8 |
| 2008 | - | - | - | 66.7 | 72.0 |
| 2007 | - | - | - | 65.7 | 70.3 |
| 2006 | - | - | - | 64.4 | 71.3 |

OSTEOPOROSIS MANAGEMENT IN WOMEN WHO HAD A FRACTURE

Osteoporosis is a weakening of the bones that puts patients at risk for bone fracture.¹ Fractures, like those caused by osteoporosis, are associated with chronic pain and bone fragility.^{1,2} In 2011 an estimated 52 million adults had low bone density; of these, more than 12 million 50 years of age and older had osteoporosis. The *Osteoporosis Management in Women Who Had a Fracture* measure assesses whether women over 67 years of age who had one or more bone fractures received a bone density test to determine if osteoporosis was the underlying cause of the fracture, or received appropriate prevention or treatment for osteoporosis.

- Women lose bone density with age, and a woman over 50 has a much greater chance of having an osteoporosis-related fracture in her lifetime.^{3,4} Once a woman is near or past menopause and has a fracture, her chances of having another fracture are increased.⁴
- Because osteoporosis is asymptomatic in the early stages of the disease, most people are not aware that they have the condition, and therefore it is underdiagnosed and undertreated. A fracture may be the first indicator of the presence of osteoporosis.⁴ Only one-third of patients with fractures receive appropriate testing and treatment for osteoporosis.⁵
- A bone mineral density test is the most effective method for determining bone health, and can identify osteoporosis, predict fracture risk and assess response to osteoporosis treatment.⁴ Osteoporosis therapy has the potential to reduce the risk of fracture by nearly 50 percent.⁶

The Case for Improvement

- More than 1.5 million fractures are caused by osteoporosis each year. Almost half of these are fractures to the spine (700,000) and hip (300,000). 14 percent of hip fractures will result in death within 1 year of the fracture.⁷
- Osteoporosis treatment costs \$17 billion annually.⁷ Direct medical costs are predicted to increase to \$25.3 billion annually by 2025.^{8,9} Each year, fractures result in 500,000 hospitalizations, 800,000 ED visits, 2.6 million doctor visits and 180,000 nursing home placements.¹⁰

HEDIS Measure Definition

The percentage of women 67 years of age and older who suffered a fracture and who had either a bone mineral density test or prescription for a drug to treat or prevent osteoporosis in the six months after the fracture.

The Bottom Line

Osteoporosis may lead to painful bone fractures that limit mobility and put patients at risk for other adverse health conditions. Appropriate prevention or treatment of osteoporosis can reduce the risk of fractures for older women and improve health outcomes.⁹

| TESTING/TREATMENT RATE IN WOMEN WHO HAD A FRACTURE | | | | | |
|--|------------|-----|----------|----------|------|
| YEAR | COMMERCIAL | | MEDICAID | MEDICARE | |
| | HMO | PPO | HMO | HMO | PPO |
| 2011 | - | - | - | 22.8 | 19.3 |
| 2010 | - | - | - | 20.7 | 18.5 |
| 2009 | - | - | - | 20.7 | 18.1 |
| 2008 | - | - | - | 20.7 | 18.0 |
| 2007 | - | - | - | 20.4 | 17.8 |

MEDICATION IN THE ELDERLY

Optimal drug use in the elderly is a topic of increasing importance as the population ages and the use of prescription drugs increases.¹ Elderly people are more likely to experience an adverse drug event than younger adults, and are seven times more likely to be hospitalized due to an adverse drug event.² The *Use of High-Risk Medications in the Elderly* measure assesses how often elderly individuals are exposed to potentially harmful drugs. The *Potentially Harmful Drug-Disease Interaction in the Elderly* measure assess how often patients with a specific diagnosis are prescribed medications that could interact negatively with their condition or disease.

- In the United States, 88 percent of persons aged 65 years and over consume at least one prescription medication.³ In the ambulatory care setting, 27 percent of adverse drug events are preventable. Most problems occur at the prescribing and monitoring stages of care.⁴
- Common medication side effects can pose extra risks to elderly people with multiple chronic conditions.^{5,6}
- In a study that measured potentially inappropriate medication use in the elderly, 40 percent of the population filled at least one prescription for a potentially inappropriate medication and 13 percent filled two or more prescriptions.⁶

The Case for Improvement

- Exposure to high-risk medications increases health care costs, including medication costs, which are an estimated \$7.2 billion annually.⁷
- The use of high-risk medications increases the risk for hospitalization, death and general adverse health outcomes in general.^{2,8}
- One study found that 49 percent of patients 65 or older admitted to the hospital were prescribed at least one potentially high-risk medication.⁹
- The elderly population's exposure to drugs that harm them puts them at risk for further complications, including falls, fractures and illnesses of longer duration.^{2,5,10}

HEDIS Measure Definition

The measures assess two different dimensions of high-risk medication use in the Medicare population 65 years of age and older.

Potentially Harmful Drug-Disease Interactions in the Elderly

The percentage of adults 65 and older who have evidence of an underlying disease, condition or health concern (history of falls, dementia or chronic renal failure) and who were prescribed a contraindicated medication, concurrent with or after the diagnosis.

Use of High-Risk Medications in the Elderly

This measure assesses the percentage of Medicare adults 65 years of age and older who received at least one high-risk medication and the percentage of Medicare adults 65 years of age and older who received at least two different high-risk medications. A combined rate is also reported. Lower rates represent better performance.

The Bottom Line

Even with broad medical consensus that certain medications increase the risk of harm to the elderly, have limited effectiveness and should be avoided, those medications are often prescribed for the elderly population.¹⁰

Collaboration between prescribers, pharmacists and patients is essential to identify safe pharmacological alternatives and

nonpharmacological therapy that could be substituted for high-risk medications.¹⁰

| POTENTIALLY INAPPROPRIATE MEDICATIONS FOR PATIENTS WITH CHRONIC RENAL FAILURE* | | | | | |
|--|------------|-----|----------|----------|------|
| YEAR | COMMERCIAL | | MEDICAID | MEDICARE | |
| | HMO | PPO | HMO | HMO | PPO |
| 2011 | - | - | - | 11.7 | 10.0 |
| 2010 | - | - | - | 11.6 | 11.7 |
| 2009 | - | - | - | 11.5 | 11.5 |
| 2008 | - | - | - | 11.7 | 9.9 |
| 2007 | - | - | - | 10.5 | 12.2 |

| POTENTIALLY INAPPROPRIATE MEDICATIONS FOR PATIENTS WITH DEMENTIA* | | | | | |
|---|------------|-----|----------|----------|------|
| YEAR | COMMERCIAL | | MEDICAID | MEDICARE | |
| | HMO | PPO | HMO | HMO | PPO |
| 2011 | - | - | - | 27.0 | 25.6 |
| 2010 | - | - | - | 28.7 | 27.3 |
| 2009 | - | - | - | 28.6 | 27.3 |
| 2008 | - | - | - | 28.2 | 27.0 |
| 2007 | - | - | - | 27.3 | 26.1 |

*Lower rates signify better performance.

**POTENTIALLY INAPPROPRIATE
MEDICATIONS FOR
PATIENTS WITH FALLS***

| YEAR | COMMERCIAL | | MEDICAID | MEDICARE | |
|------|------------|-----|----------|----------|------|
| | HMO | PPO | HMO | HMO | PPO |
| 2011 | – | – | – | 15.6 | 15.3 |
| 2010 | – | – | – | 17.1 | 16.3 |
| 2009 | – | – | – | 16.7 | 16.6 |
| 2008 | – | – | – | 16.2 | 16.9 |
| 2007 | – | – | – | 16.2 | 18.0 |

OVERALL RATE*

| YEAR | COMMERCIAL | | MEDICAID | MEDICARE | |
|------|------------|-----|----------|----------|------|
| | HMO | PPO | HMO | HMO | PPO |
| 2011 | – | – | – | 21.7 | 20.6 |
| 2010 | – | – | – | 23.3 | 21.8 |
| 2009 | – | – | – | 23.2 | 21.8 |
| 2008 | – | – | – | 23.0 | 21.7 |
| 2007 | – | – | – | 21.8 | 21.5 |

**USE OF HIGH-RISK MEDICATIONS
IN THE ELDERLY: AT LEAST ONE
HIGH-RISK MEDICATION***

| YEAR | COMMERCIAL | | MEDICAID | MEDICARE | |
|------|------------|-----|----------|----------|------|
| | HMO | PPO | HMO | HMO | PPO |
| 2011 | – | – | – | 18.5 | 18.5 |
| 2010 | – | – | – | 22.1 | 21.9 |
| 2009 | – | – | – | 23.0 | 22.3 |
| 2008 | – | – | – | 23.4 | 22.1 |
| 2007 | – | – | – | 23.2 | 22.1 |
| 2006 | – | – | – | 23.1 | 23.1 |

**USE OF HIGH-RISK MEDICATIONS
IN THE ELDERLY: AT LEAST TWO
HIGH-RISK MEDICATIONS***

| YEAR | COMMERCIAL | | MEDICAID | MEDICARE | |
|------|------------|-----|----------|----------|-----|
| | HMO | PPO | HMO | HMO | PPO |
| 2011 | – | – | – | 3.6 | 3.5 |
| 2010 | – | – | – | 5.1 | 5.1 |
| 2009 | – | – | – | 5.7 | 5.3 |
| 2008 | – | – | – | 6.0 | 5.4 |
| 2007 | – | – | – | 6.0 | 5.3 |
| 2006 | – | – | – | 5.9 | 6.5 |

*Lower rates signify better performance.

RELATIVE RESOURCE USE

Relative Resource Use (RRU) measures indicate how health plans use health care resources (e.g., doctor visits, hospital stays, surgical procedures and medications), compared with other plans (at both the national and regional levels) and adjusted for the population of patients served. When combined with HEDIS quality measures, RRU measures reveal *value* by relating use of health care services to quality.

RRU measures help purchasers identify health plans that deliver high-quality care while managing associated resources. The table below is a hypothetical example of RRU results for plans in one region for patients with diabetes. Scores above 1.0 indicate higher-than-average use; scores below 1.0 indicate lower-than-average use. In this example, Plan D is highlighted because it offers an appealing combination of above-average quality and below-average resource use.

NCQA collects RRU data for five chronic conditions that account for a major portion of all health spending: asthma, cardiovascular disease, COPD, diabetes and hypertension.

To allow fair comparison of plans, RRU measures feature risk adjustment and price standardization of services. The goal of risk adjustment is to eliminate sources of variation that neither health plans nor providers can control. Factors used in risk adjustment include age, gender and the presence of serious health conditions. Standardized prices are assigned to each unit of service delivered to patients covered by health plans and reported

by service category (e.g., inpatient hospital care, evaluation and management, surgery and other procedures, diagnostic lab and imaging, prescription drugs) for each of the five conditions.

Looking at quality and resource use scores together, purchasers should be most interested in plans that are high in quality and low in resource use. As depicted in the following scatterplots, scores that place health plans in the upper left quadrant are generally considered desirable (above-average quality, below-average resource use). Health plans in the lower right quadrant are less desirable (below-average quality, above-average resource use). Overall, RRU results reveal that the amount of services used to treat people often has little correlation to the quality of care.

This report focuses on the three RRU measures where discrepancies between plans' resource use and resulting quality are most pronounced: hypertension, diabetes and certain cardiovascular conditions.

Refinements to RRU*Updated risk-adjustment approach*

For 2012, NCQA moved to a new risk-adjustment approach that was adapted from the CMS Hierarchical Condition Category (HCC) case-mix adjustment approach. The new approach considers disease severity and number of comorbidities, in addition to other factors that inform the cost of care delivered to patients covered by health plans.

Additional services

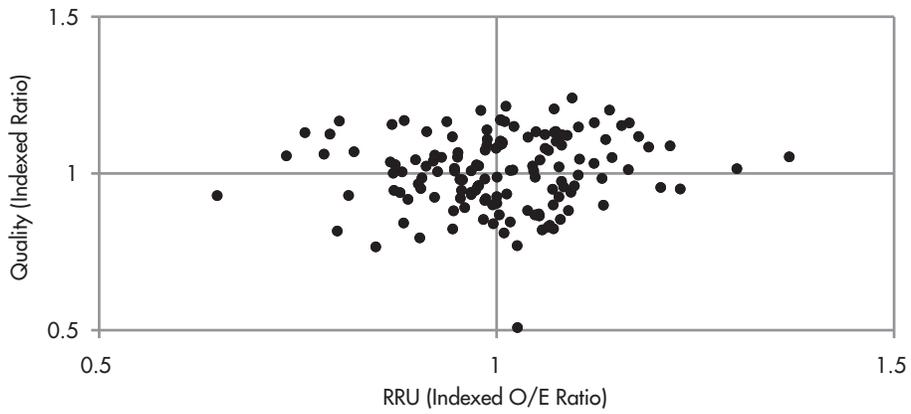
For 2012 NCQA added diagnostic laboratory and diagnostic imaging to the list of services captured by RRU measure specifications.

Medications

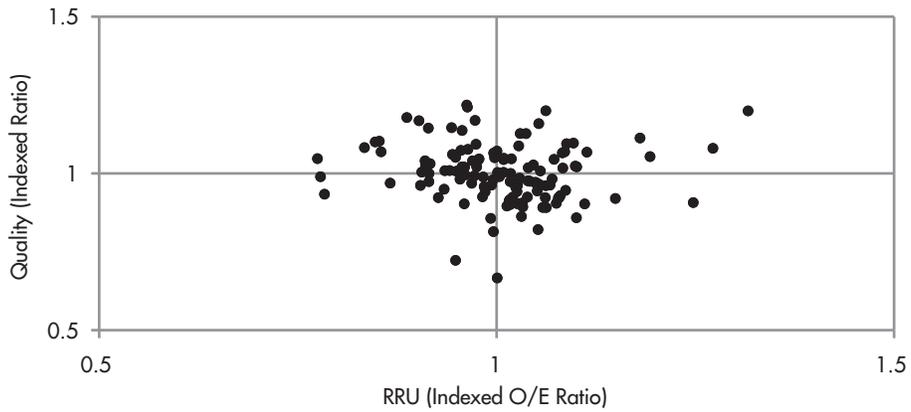
RRU results now include pharmacy utilization reported by generic and name-brand use. Health plan results are stratified by the number of generic medications used by patients covered by the plan, compared with the number of name-brand medications used.

The scatterplots shown in this report are a sample of the RRU data available in NCQA's Quality Compass.

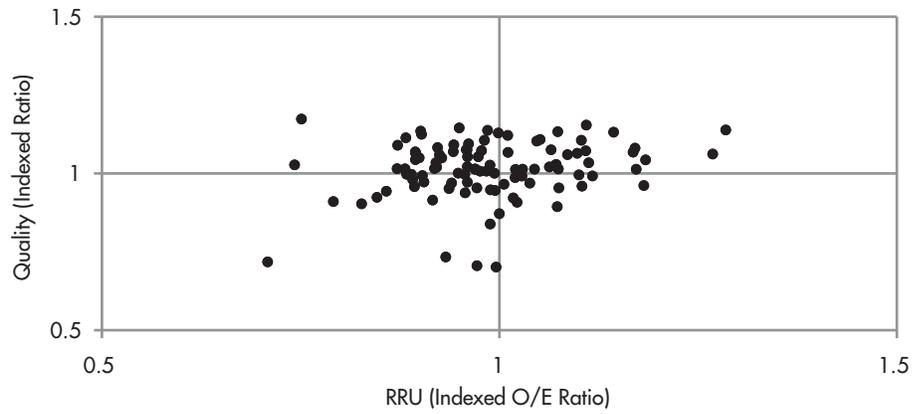
COMMERCIAL HMOS: DIABETES



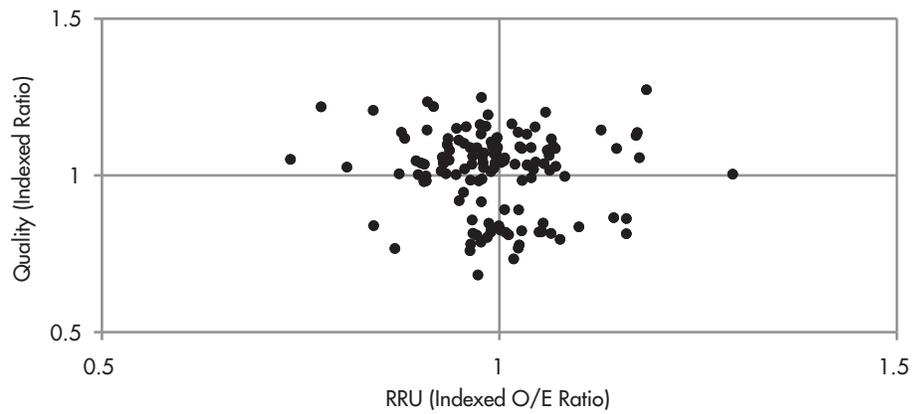
COMMERCIAL PPOS: DIABETES



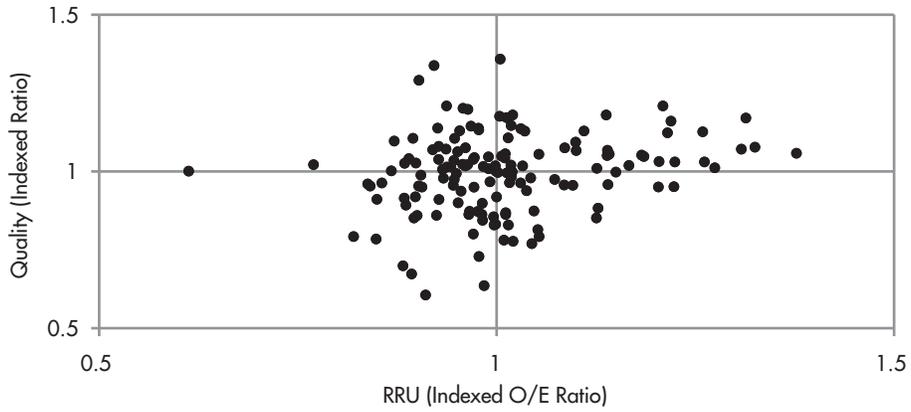
COMMERCIAL HMOS: CARDIOVASCULAR



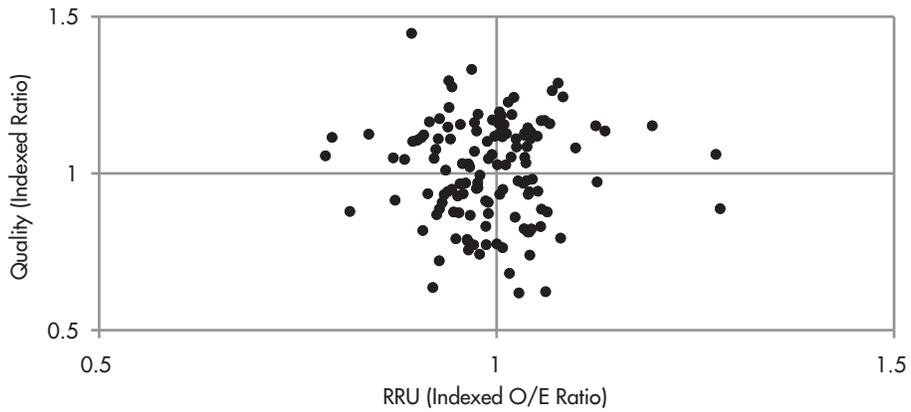
COMMERCIAL PPOS: CARDIOVASCULAR



COMMERCIAL HMOS: HYPERTENSION

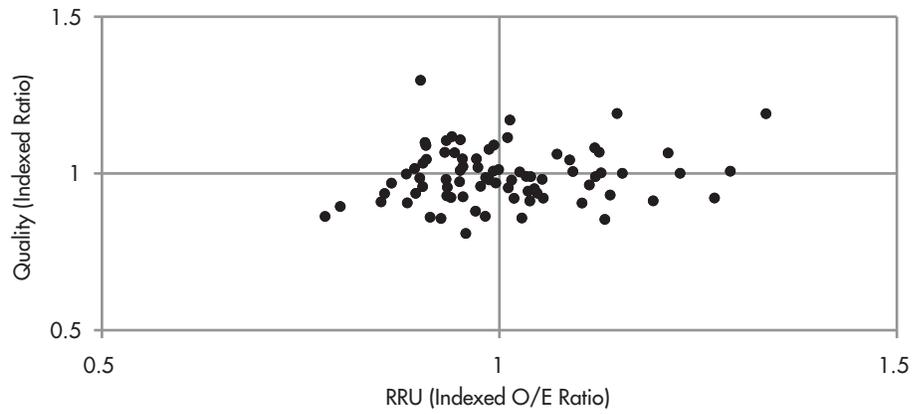


COMMERCIAL PPOS: HYPERTENSION

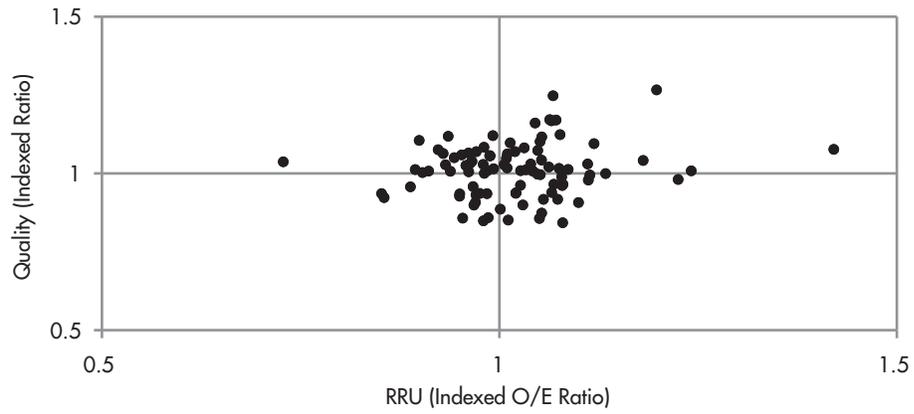


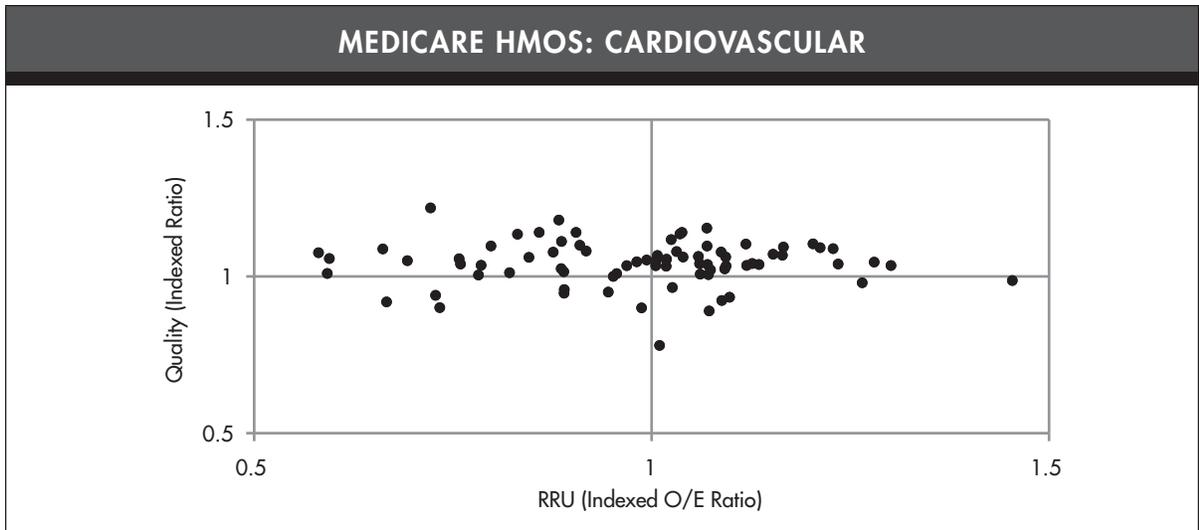
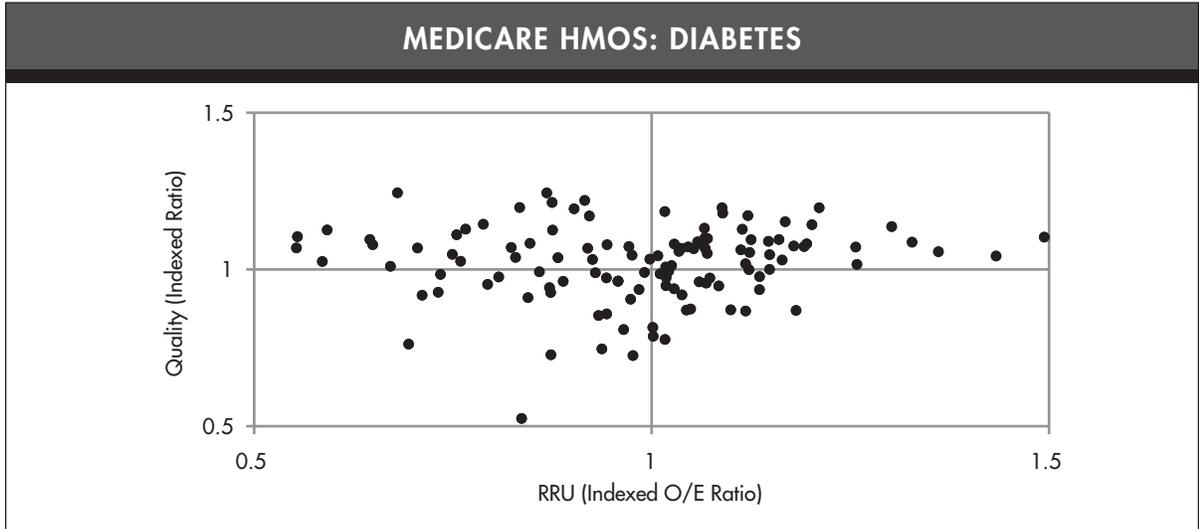
MEASURES OF VALUE AND UTILIZATION

COMMERCIAL HMOS: COPD



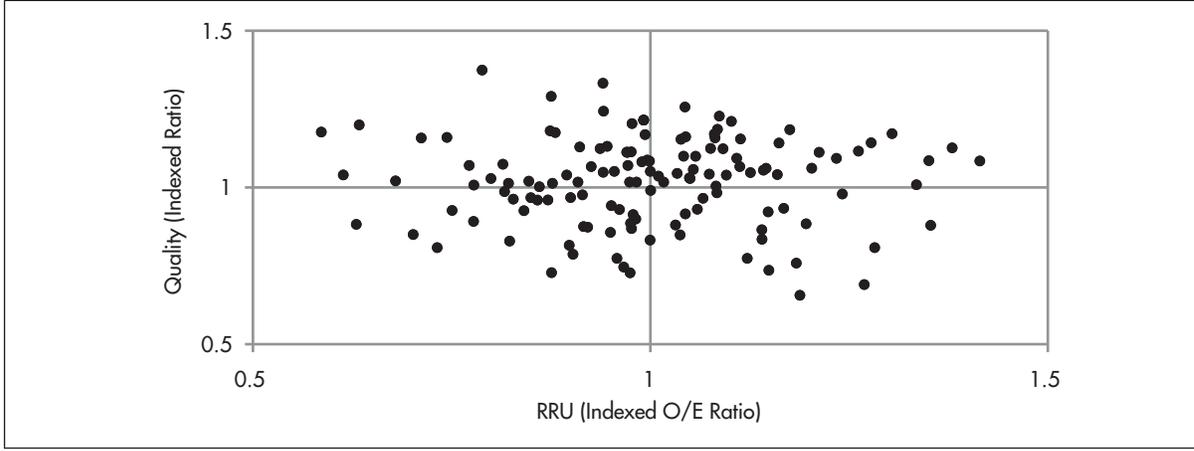
COMMERCIAL PPOS: COPD



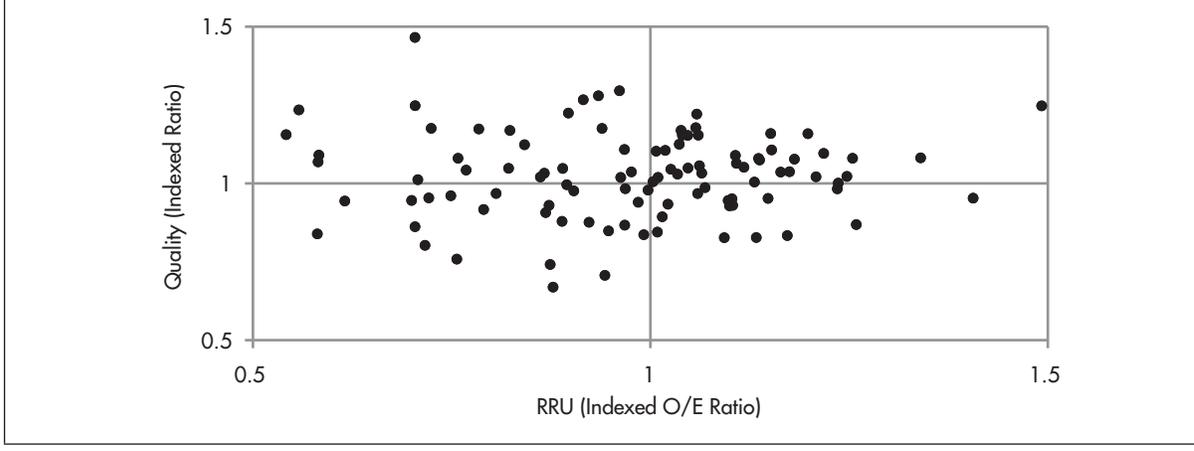


MEASURES OF VALUE AND UTILIZATION

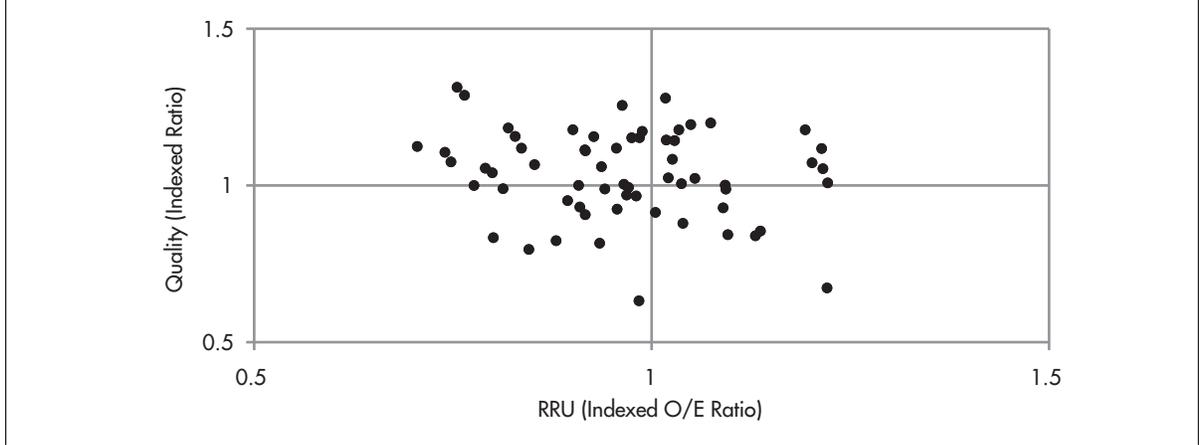
MEDICARE HMOS: HYPERTENSION



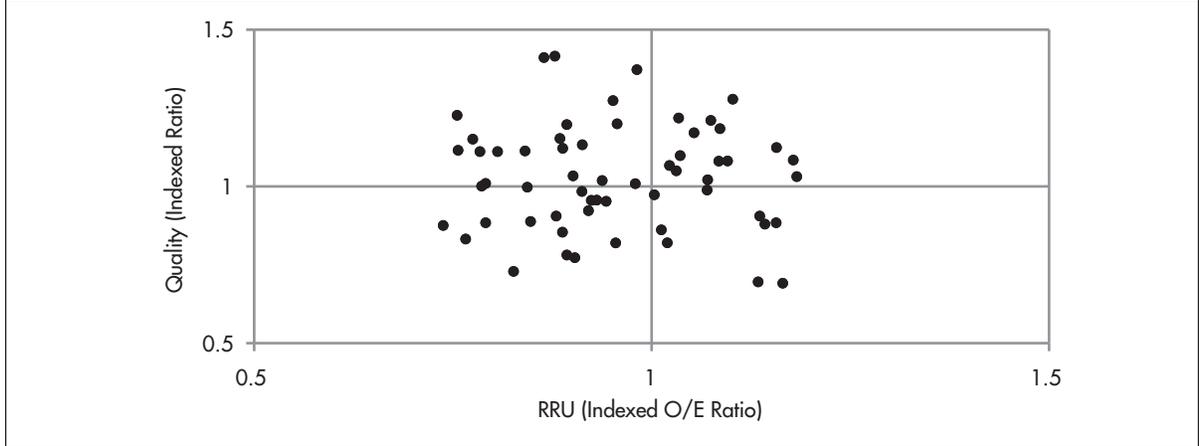
MEDICARE HMOS: COPD



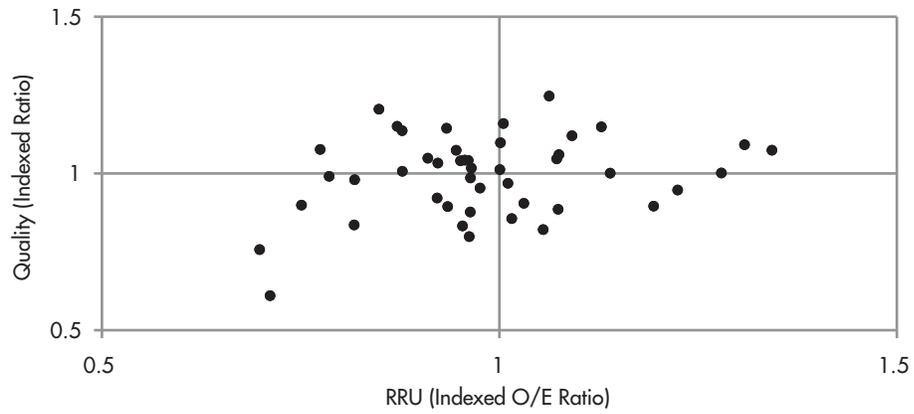
MEDICAID HMOS: DIABETES



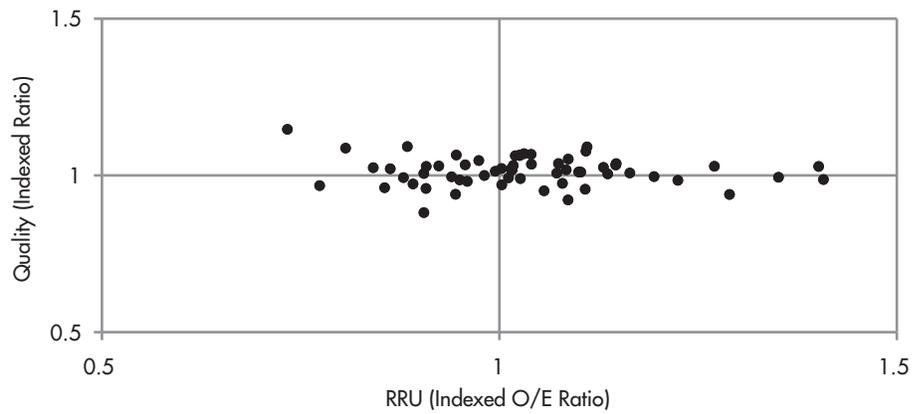
MEDICAID HMOS: HYPERTENSION



MEDICAID HMOS: COPD



MEDICAID HMOS: ASTHMA



PLAN ALL-CAUSE READMISSIONS

A readmission is when a patient is discharged from the hospital and then admitted back into the hospital within a short period of time. Readmissions are associated with increased comorbidity and wasted expenditures.^{1,2} They occur because patients develop complications related to their initial diagnosis or acquire new disease conditions after leaving the hospital. Although not all readmissions can be avoided, many are preventable.

- Avoiding unnecessary readmissions begins in the hospital and carries over into the discharge period and the period immediately after discharge.³ Some factors that contribute to potentially preventable readmissions are medical errors or substandard care during the initial hospitalization, poor discharge planning and inadequate follow-up care.⁴ With effective discharge planning and care coordination post-discharge, health plans can play an important role in improving services to members in order to reduce readmissions.
- Each year, approximately 20 percent of Medicare patients are readmitted within 30 days.² Avoidable readmission rates depend on the definition of the concept of “avoidable.”⁵ One study estimated that 23 percent of Medicare readmissions can be considered avoidable.¹
- In 2004 the total cost to Medicare of unplanned readmissions was \$17.4 billion; in 2005 the average payment for a potentially preventable readmission was approximately \$7,200.^{2,3,4}

The Case for Improvement

- A study of Medicare patients with heart failure found that readmission rates have increased over the past 14 years.⁶
- Among plans and states, there is wide variation in hospital readmission rates after controlling for disease-specific and severity-related differences in patients, particularly for congestive heart failure.^{3,7} In one study, more than half of patients readmitted to the hospital within 30 days of discharge had no evidence of a follow-up visit of any kind between discharge and readmission.²

HEDIS Measure Definition

The rate of adult acute inpatient stays that were followed by an acute readmission for any diagnosis within 30 days after discharge. As well as reporting observed rates, NCCA also specifies that plans report a predicted probability of readmission in order to account for, among other things, the prior and current health of the member.

The Bottom Line

Some readmissions can be prevented through improved quality of care, comprehensive discharge planning and care coordination among a patient's providers and caregivers.³

READMISSION RATE (18–64 YEARS)*

| YEAR | COMMERCIAL | | MEDICAID | | MEDICARE |
|------|------------|------|----------|-----|----------|
| | HMO | PPO | HMO | HMO | PPO |
| 2011 | 0.81 | 0.80 | – | – | – |

**READMISSION RATE
(65 YEARS AND OLDER)***

| YEAR | COMMERCIAL | | MEDICAID | | MEDICARE |
|------|------------|-----|----------|------|----------|
| | HMO | PPO | HMO | HMO | PPO |
| 2011 | – | – | – | 0.91 | 0.88 |

*Lower rates signify better performance.

CONSUMER AND PATIENT ENGAGEMENT AND EXPERIENCE

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) program is a public/private initiative to develop standardized surveys of patients' experiences with ambulatory and facility-level care in commercial and Medicaid plans. Surveys were developed with the Agency for Healthcare Research and Quality (AHRQ). CAHPS data address areas such as patient ease of obtaining information from a health plan; timeliness of service; and speed and accuracy of claim processing.

CAHPS results offer an indication of how well health care organizations meet member expectations.

Rating of Health Plan

Respondents were asked to give their health plan an overall rating, with 0 equaling "worst health plan possible" and 10 equaling "best health plan possible." The tables below represent the percentage of respondents who rated their health plan either 9 or 10.

| RATING OF HEALTH PLAN: RATING OF 8, 9 OR 10 | | | | | |
|--|------------|------|----------|----------|------|
| YEAR | COMMERCIAL | | MEDICAID | MEDICARE | |
| | HMO | PPO | HMO | HMO | PPO |
| 2011 | 66.1 | 58.4 | 73.5 | 88.5 | 87.7 |
| 2010 | 64.2 | 58.6 | 72.4 | 87.5 | 86.6 |
| 2009 | 62.7 | 57.3 | 70.7 | 84.4 | 81.9 |
| 2008 | 64.3 | 59.7 | 72.7 | 85.5 | 83.8 |
| 2007 | 61.9 | 56.8 | 70.7 | 85.9 | 82.6 |
| 2006 | 63.0 | 59.5 | 70.1 | 86.7 | 84.1 |
| 2005 | 65.2 | 67.1 | 71.9 | 87.7 | 84.2 |
| 2004 | 64.1 | – | 71.2 | 85.2 | – |
| 2003 | 61.8 | – | 69.9 | 81.4 | – |
| 2002 | 61.3 | – | 69.3 | 85.9 | – |
| 2001 | 61.8 | – | 51.4 | 86.6 | – |
| 2000 | 59.3 | – | – | – | – |

| RATING OF HEALTH PLAN: RATING OF 9 OR 10 | | | | | |
|---|------------|------|----------|----------|------|
| YEAR | COMMERCIAL | | MEDICAID | MEDICARE | |
| | HMO | PPO | HMO | HMO | PPO |
| 2011 | 42.1 | 33.9 | 55.6 | 63.9 | 58.5 |
| 2010 | 40.3 | 33.7 | 54.7 | 62.7 | 56.9 |
| 2009 | 38.3 | 32.4 | 52.5 | 59.0 | 52.2 |
| 2008 | 39.1 | 34.2 | 55.3 | 60.7 | 53.4 |
| 2007 | 37.1 | 31.8 | 53.3 | 61.1 | 52.9 |
| 2006 | 38.0 | 35.9 | 52.4 | 61.7 | 53.9 |
| 2005 | 39.8 | 43.1 | 54.0 | 61.3 | 54.2 |
| 2004 | 38.4 | – | 52.3 | 57.5 | – |
| 2003 | 36.7 | – | 51.7 | 53.3 | – |
| 2002 | 36.0 | – | 51.5 | 60.5 | – |
| 2001 | 37.4 | – | 69.1 | 62.4 | – |
| 2000 | 34.7 | – | – | – | – |
| 1999 | 32.6 | – | – | – | – |

Rating of Health Care

Respondents were asked to give their health care an overall rating, with 0 equaling “worst health care possible” and 10 equaling “best health care possible.” The tables below represent the percentage of respondents who rated their health care either 9 or 10.

| RATING OF HEALTH CARE: RATING OF 8, 9 OR 10 | | | | | |
|--|------------|------|----------|----------|------|
| YEAR | COMMERCIAL | | MEDICAID | MEDICARE | |
| | HMO | PPO | HMO | HMO | PPO |
| 2011 | 77.6 | 76.2 | 69.9 | 86.5 | 89.3 |
| 2010 | 76.6 | 75.6 | 68.9 | 86.2 | 88.9 |
| 2009 | 74.9 | 74.3 | 67.3 | 84.2 | 87.0 |
| 2008 | 75.2 | 75.0 | 68.2 | 84.6 | 87.2 |
| 2007 | 73.8 | 73.6 | 67.1 | 84.4 | 86.2 |
| 2006 | 73.6 | 75.1 | 65.6 | 87.2 | 89.3 |
| 2005 | 77.9 | 80.8 | 72.8 | 92.5 | 95.2 |
| 2004 | 77.6 | – | 72.6 | 91.8 | – |
| 2003 | 76.2 | – | 72.1 | 91.0 | – |
| 2002 | 75.2 | – | 71.6 | 91.6 | – |
| 2001 | 73.2 | – | 52.6 | 91.6 | – |
| 2000 | 72.0 | – | – | – | – |

| RATING OF HEALTH CARE: RATING OF 9 OR 10 | | | | | |
|---|------------|------|----------|----------|------|
| YEAR | COMMERCIAL | | MEDICAID | MEDICARE | |
| | HMO | PPO | HMO | HMO | PPO |
| 2011 | 51.9 | 49.0 | 49.7 | 60.9 | 62.6 |
| 2010 | 50.7 | 48.1 | 48.8 | 60.3 | 61.8 |
| 2009 | 48.7 | 46.6 | 47.0 | 56.2 | 57.4 |
| 2008 | 48.7 | 46.7 | 48.1 | 56.2 | 56.4 |
| 2007 | 47.2 | 45.8 | 46.8 | 55.9 | 55.0 |
| 2006 | 47.0 | 48.3 | 46.2 | 62.0 | 62.7 |
| 2005 | 53.4 | 55.6 | 54.1 | 69.1 | 72.2 |
| 2004 | 52.1 | – | 53.5 | 68.7 | – |
| 2003 | 51.5 | – | 52.8 | 67.5 | – |
| 2002 | 49.4 | – | 53.0 | 67.8 | – |
| 2001 | 47.5 | – | 71.3 | 68.8 | – |
| 2000 | 45.6 | – | – | – | – |
| 1999 | 44.1 | – | – | – | – |

Getting Needed Care

The *Getting Needed Care* composite measures members’ perception of how easy it was to get care from their doctor and from specialists in the last 12 months. Members were asked how often they were able to:

- See a specialist when they needed one.
- Obtain the care, tests or treatment they believed were necessary.

Responses were “Never,” “Sometimes,” “Usually” and “Always.” The rates displayed represent the average percentage of health plan members nationwide who responded “Always.”

| GETTING NEEDED CARE: USUALLY OR ALWAYS | | | | | |
|---|------------|------|----------|----------|------|
| YEAR | COMMERCIAL | | MEDICAID | MEDICARE | |
| | HMO | PPO | HMO | HMO | PPO |
| 2011 | 85.5 | 86.2 | 75.5 | 89.4 | 92.6 |
| 2010 | 86.2 | 86.6 | 76.0 | 89.9 | 92.8 |
| 2009 | 85.4 | 86.3 | 75.0 | 89.1 | 91.3 |
| 2008 | 85.3 | 86.4 | 75.7 | 88.6 | 90.8 |
| 2007 | 84.2 | 85.3 | 75.2 | 88.8 | 91.0 |
| 2006 | 84.2 | 85.3 | 74.2 | 89.3 | 91.7 |

| GETTING NEEDED CARE: ALWAYS | | | | | |
|-----------------------------|------------|------|----------|----------|------|
| YEAR | COMMERCIAL | | MEDICAID | MEDICARE | |
| | HMO | PPO | HMO | HMO | PPO |
| 2011 | 54.1 | 53.8 | 50.4 | 64.1 | 66.6 |
| 2010 | 53.9 | 53.9 | 50.1 | 63.9 | 66.2 |
| 2009 | 52.9 | 52.7 | 48.5 | 63.6 | 64.4 |
| 2008 | 52.6 | 52.6 | 49.4 | 62.4 | 61.9 |
| 2007 | 50.4 | 49.5 | 48.7 | 62.0 | 63.4 |
| 2006 | 50.1 | 51.2 | 46.7 | 62.6 | 64.6 |
| 2005 | 80.1 | 84.7 | 73.4 | 95.9 | 97.0 |
| 2004 | 79.3 | – | 73.8 | 95.7 | – |
| 2003 | 78.4 | – | 72.1 | 94.9 | – |
| 2002 | 76.9 | – | 72.3 | 94.8 | – |
| 2001 | 76.7 | – | 75.4 | 94.9 | – |
| 2000 | 75.4 | – | – | – | – |

Getting Care Quickly

The *Getting Care Quickly* composite measures members' perception of how quickly they received care when it was sought in the last 12 months. Members were asked how often they were able to:

- Receive needed care right away.
- Get an appointment for health care at a doctor's office or clinic as soon as they thought care was needed.

Responses were "Never," "Sometimes," "Usually" and "Always." The rates displayed represent the average percentage of health plan members nationwide who responded "Always."

| GETTING CARE QUICKLY: USUALLY OR ALWAYS | | | | | |
|--|------------|------|----------|----------|------|
| YEAR | COMMERCIAL | | MEDICAID | MEDICARE | |
| | HMO | PPO | HMO | HMO | PPO |
| 2011 | 86.2 | 87.0 | 80.3 | 87.8 | 90.1 |
| 2010 | 86.5 | 87.1 | 80.6 | 88.1 | 90.6 |
| 2009 | 86.4 | 87.3 | 79.5 | 86.7 | 88.4 |
| 2008 | 86.3 | 87.2 | 80.1 | 86.3 | 88.9 |
| 2007 | 85.9 | 87.0 | 80.2 | 86.7 | 88.5 |
| 2006 | 86.1 | 87.1 | 78.7 | 87.2 | 89.5 |
| 2005 | 79.6 | 80.4 | 71.8 | 84.5 | 85.4 |
| 2004 | 79.3 | – | 72.3 | 84.2 | – |
| 2003 | 78.6 | – | 70.8 | 83.4 | – |
| 2002 | 77.6 | – | 71.9 | 81.9 | – |
| 2001 | 79.7 | – | 77.2 | 87.2 | – |
| 2000 | 78.3 | – | – | – | – |

| GETTING CARE QUICKLY: ALWAYS | | | | | |
|------------------------------|------------|------|----------|----------|------|
| YEAR | COMMERCIAL | | MEDICAID | MEDICARE | |
| | HMO | PPO | HMO | HMO | PPO |
| 2011 | 58.7 | 58.0 | 57.2 | 65.6 | 67.5 |
| 2010 | 58.2 | 57.7 | 56.2 | 65.4 | 68.2 |
| 2009 | 57.8 | 57.4 | 54.7 | 64.0 | 64.7 |
| 2008 | 57.6 | 56.2 | 55.7 | 63.7 | 64.6 |
| 2007 | 56.0 | 55.6 | 55.6 | 63.5 | 65.0 |
| 2006 | 56.8 | 57.5 | 53.4 | 65.4 | 67.0 |
| 2005 | 46.5 | 46.2 | 44.5 | 58.7 | 60.2 |
| 2004 | 45.5 | – | 44.2 | 58.5 | – |
| 2003 | 45.0 | – | 42.6 | 57.2 | – |
| 2002 | 43.9 | – | 44.1 | 55.8 | – |
| 2001 | 44.8 | – | 46.5 | 60.0 | – |
| 2000 | 45.8 | – | – | – | – |

How Well Doctors Communicate

The *How Well Doctors Communicate* composite measures members’ perception of the quality of communication with their personal doctor in the last 12 months. Members were asked how often their doctor:

- Explained things in a way that was easy to understand.
- Listened carefully to them.
- Showed respect for what they had to say.
- Spent enough time with them.

Responses were “Never,” “Sometimes,” “Usually” and “Always.” The rates displayed represent the average percentage of health plan members nationwide who responded “Always.”

| DOCTOR COMMUNICATION: USUALLY OR ALWAYS | | | | | |
|--|------------|------|----------|----------|------|
| | COMMERCIAL | | MEDICAID | MEDICARE | |
| YEAR | HMO | PPO | HMO | HMO | PPO |
| 2011 | 94.0 | 94.6 | 87.8 | 94.2 | 95.5 |
| 2010 | 93.9 | 94.6 | 87.8 | 94.2 | 95.5 |
| 2009 | 93.4 | 94.2 | 87.0 | 93.5 | 94.6 |
| 2008 | 93.2 | 94.0 | 87.2 | 93.6 | 94.5 |
| 2007 | 92.8 | 93.8 | 86.7 | 93.6 | 94.9 |
| 2006 | 92.8 | 93.7 | 86.3 | 93.5 | 95.0 |
| 2005 | 92.1 | 92.8 | 85.9 | 94.0 | 95.4 |
| 2004 | 92.0 | – | 86.2 | 93.7 | – |
| 2003 | 91.5 | – | 85.7 | 93.3 | – |
| 2002 | 91.0 | – | 85.7 | 93.2 | – |
| 2001 | 90.7 | – | 85.8 | 93.1 | – |
| 2000 | 89.9 | – | – | – | – |

| DOCTOR COMMUNICATION: ALWAYS | | | | | |
|---------------------------------|------------|------|----------|----------|------|
| | COMMERCIAL | | MEDICAID | MEDICARE | |
| YEAR | HMO | PPO | HMO | HMO | PPO |
| 2011 | 74.2 | 73.8 | 70.0 | 76.3 | 77.3 |
| 2010 | 73.5 | 73.5 | 69.1 | 75.6 | 76.9 |
| 2009 | 72.0 | 71.7 | 67.5 | 74.7 | 74.8 |
| 2008 | 71.1 | 70.7 | 68.0 | 75.3 | 74.8 |
| 2007 | 70.2 | 70.1 | 67.7 | 74.6 | 75.7 |
| 2006 | 70.3 | 71.5 | 66.7 | 75.0 | 76.2 |
| 2005 | 61.3 | 58.8 | 61.5 | 69.5 | 71.6 |
| 2004 | 60.2 | – | 60.8 | 69.0 | – |
| 2003 | 59.4 | – | 59.1 | 68.6 | – |
| 2002 | 57.7 | – | 59.9 | 68.0 | – |
| 2001 | 57.1 | – | 60.4 | 68.5 | – |
| 2000 | 58.4 | – | – | – | – |

Rating of Personal Doctor

Respondents were asked to give their personal doctor an overall rating, with 0 equaling “worst personal doctor possible” and 10 equaling “best personal doctor possible.” The tables below represent the percentage of respondents who rated their personal doctor either 9 or 10.

| PERSONAL DOCTOR RATING OF 8, 9 OR 10 | | | | | |
|--------------------------------------|------------|------|----------|----------|------|
| YEAR | COMMERCIAL | | MEDICAID | MEDICARE | |
| | HMO | PPO | HMO | HMO | PPO |
| 2011 | 83.9 | 83.2 | 77.1 | 92.9 | 94.1 |
| 2010 | 83.2 | 82.8 | 76.4 | 92.6 | 94.0 |
| 2009 | 82.2 | 81.9 | 75.6 | 92.0 | 93.1 |
| 2008 | 81.9 | 82.0 | 76.2 | 92.3 | 93.2 |
| 2007 | 81.0 | 82.0 | 75.8 | 92.0 | 93.1 |
| 2006 | 81.1 | 83.0 | 75.6 | 92.4 | 93.9 |
| 2005 | 77.1 | 78.8 | 77.2 | 91.7 | 94.5 |
| 2004 | 77.0 | – | 77.0 | 91.1 | – |
| 2003 | 76.2 | – | 76.8 | 90.3 | – |
| 2002 | 75.0 | – | 76.0 | 90.2 | – |
| 2001 | 74.6 | – | 59.4 | 90.0 | – |
| 2000 | 74.3 | – | – | – | – |

| PERSONAL DOCTOR RATING OF 9 OR 10 | | | | | |
|-----------------------------------|------------|------|----------|----------|------|
| YEAR | COMMERCIAL | | MEDICAID | MEDICARE | |
| | HMO | PPO | HMO | HMO | PPO |
| 2011 | 66.0 | 63.7 | 61.8 | 74.6 | 76.1 |
| 2010 | 65.0 | 62.8 | 61.1 | 75.1 | 76.5 |
| 2009 | 63.2 | 61.2 | 60.1 | 73.3 | 73.9 |
| 2008 | 63.3 | 61.9 | 61.1 | 73.6 | 73.3 |
| 2007 | 62.1 | 61.7 | 60.4 | 73.6 | 73.8 |
| 2006 | 62.3 | 63.2 | 60.3 | 73.8 | 75.0 |
| 2005 | 52.8 | 54.0 | 59.2 | 67.8 | 70.9 |
| 2004 | 51.7 | – | 58.4 | 67.5 | – |
| 2003 | 51.9 | – | 58.9 | 66.4 | – |
| 2002 | 49.7 | – | 58.0 | 65.2 | – |
| 2001 | 50.5 | – | 76.5 | 65.8 | – |
| 2000 | 48.3 | – | – | – | – |
| 1999 | 47.0 | – | – | – | – |

Rating of Specialist

Respondents were asked to give their specialist an overall rating, with 0 equaling “worst specialist possible” and 10 equaling “best specialist possible.” The tables below represent the percentage of respondents who rated their specialist either 9 or 10.

| SPECIALIST RATING OF 8, 9 OR 10 | | | | | |
|---------------------------------|------------|------|----------|----------|------|
| YEAR | COMMERCIAL | | MEDICAID | MEDICARE | |
| | HMO | PPO | HMO | HMO | PPO |
| 2011 | 83.2 | 82.1 | 77.7 | 91.3 | 92.7 |
| 2010 | 82.3 | 81.6 | 76.9 | 90.9 | 92.8 |
| 2009 | 80.9 | 80.9 | 76.4 | 89.8 | 91.9 |
| 2008 | 81.0 | 81.0 | 76.4 | 89.8 | 91.7 |
| 2007 | 80.4 | 80.7 | 75.8 | 89.7 | 91.6 |
| 2006 | 79.9 | 81.0 | 75.2 | 90.6 | 92.7 |
| 2005 | 78.1 | 80.3 | 76.2 | 90.4 | 93.1 |
| 2004 | 77.8 | – | 76.0 | 89.5 | – |
| 2003 | 77.1 | – | 75.1 | 89.4 | – |
| 2002 | 76.0 | – | 74.1 | 89.6 | – |
| 2001 | 76.3 | – | 58.7 | 89.7 | – |
| 2000 | 76.3 | – | – | – | – |

| SPECIALIST RATING OF 9 OR 10 | | | | | |
|------------------------------|------------|------|----------|----------|------|
| YEAR | COMMERCIAL | | MEDICAID | MEDICARE | |
| | HMO | PPO | HMO | HMO | PPO |
| 2011 | 65.2 | 62.7 | 62.1 | 70.5 | 73.6 |
| 2010 | 64.1 | 61.9 | 61.3 | 71.9 | 74.1 |
| 2009 | 61.8 | 60.4 | 60.5 | 69.3 | 70.8 |
| 2008 | 62.3 | 60.5 | 60.7 | 68.9 | 69.9 |
| 2007 | 61.7 | 60.5 | 60.8 | 69.2 | 70.2 |
| 2006 | 60.7 | 62.4 | 59.3 | 70.7 | 73.0 |
| 2005 | 57.2 | 59.1 | 60.2 | 67.7 | 71.7 |
| 2004 | 56.2 | – | 59.2 | 67.5 | – |
| 2003 | 55.8 | – | 58.3 | 67.7 | – |
| 2002 | 54.4 | – | 57.8 | 67.7 | – |
| 2001 | 54.6 | – | 75.3 | 68.5 | – |
| 2000 | 53.7 | – | – | – | – |
| 1999 | 51.8 | – | – | – | – |

Customer Service

The *Customer Service* composite measures members' perception of the usefulness and quality of customer service they experienced in the last 12 months (for those who tried to get information or help from their plan's customer service). Members were asked how often their health plan's customer service:

- Gave them the information or help they needed.
- Treated them with courtesy and respect.

Responses were "Never," "Sometimes," "Usually" and "Always." The rates displayed represent the average percentage of health plan members nationwide who responded "Always."

| CUSTOMER SERVICE: SPECIALIST RATING OF 9 OR 10 | | | | | |
|---|------------|------|----------|----------|------|
| YEAR | COMMERCIAL | | MEDICAID | MEDICARE | |
| | HMO | PPO | HMO | HMO | PPO |
| 2011 | 86.1 | 82.2 | 80.4 | 88.3 | 88.5 |
| 2010 | 84.5 | 83.0 | 79.7 | 88.5 | 88.7 |
| 2009 | 84.2 | 82.4 | 79.5 | 86.5 | – |
| 2008 | 83.8 | 82.6 | 80.1 | 86.6 | 90.0 |
| 2007 | 82.7 | 80.7 | 79.1 | 86.7 | 84.5 |
| 2006 | 81.2 | 80.3 | 75.1 | – | – |

| CUSTOMER SERVICE USUALLY OR ALWAYS | | | | | |
|---------------------------------------|------------|------|----------|----------|------|
| YEAR | COMMERCIAL | | MEDICAID | MEDICARE | |
| | HMO | PPO | HMO | HMO | PPO |
| 2011 | 62.1 | 54.8 | 60.9 | 68.9 | 68.3 |
| 2010 | 59.4 | 55.5 | 59.5 | 68.4 | 67.3 |
| 2009 | 57.9 | 54.5 | 57.9 | 66.4 | – |
| 2008 | 57.2 | 53.5 | 59.0 | 66.6 | 64.3 |
| 2007 | 55.4 | 50.7 | 57.3 | 66.5 | 62.5 |
| 2006 | 54.2 | 53.9 | 49.7 | – | – |
| 2005 | 71.2 | 69.7 | 68.6 | 91.5 | 87.7 |
| 2004 | 71.0 | – | 69.8 | 94.8 | – |
| 2003 | 70.8 | – | 69.7 | 94.5 | – |
| 2002 | 70.4 | – | 67.4 | 94.3 | – |
| 2001 | 67.2 | – | 67.5 | 94.8 | – |
| 2000 | 66.6 | – | – | – | – |

METHODOLOGY OVERVIEW

General Methods

Data in this report are from HEDIS year 2012, which is measure year 2011 (January 1–December 31, 2011). Unless otherwise noted, all references to “years” in charts and tables are to measure years, not HEDIS years.

Because *The State of Health Care Quality* Report focuses on health plan performance, summary tables are not weighted for the size of eligible populations. Most tables and appendices provide mean rates separately for each measure, or for each indicator in a measure.

In most tables and appendices, rate means are provided side-by-side for commercial, Medicare and Medicaid product lines. Results for HMO and PPO plans are shown in separate tables. HMO plans include HMOs, HMO/POS combined, HMO/PPO/POS combined, HMO/PPO combined and POS. Only plans with the sole designation of “PPO” are shown as PPOs in tables.

Some reporting periods are limited. For example, PPOs have reported substantial HEDIS data only since measure year 2005; Medicare and Medicaid performance data are reported only as far back as measure year 2001.

Best States

Identification of high-performing state cohorts is based on the state means of five measures: Diabetes (seven indicators), Hypertension (one indicator), Persistence of Beta-Blockers After a Heart Attack (one indicator) and Cholesterol Management for Patients With Cardiovascular Conditions (two indicators).

The unweighted average of all indicators across all plans in a state is calculated for each state. No distinction is made among plans with respect to product line or reporting type. The composite means are ranked in descending order. The top 10 states compose the “Best” cohort. In the Diabetes quality composite, the Poor Glycemic Control indicator is inverted before calculating the composite so that higher performance is indicated by a higher rate.

Composite Measure Means by Region

Analysis provides mean rates for several composite measures by U.S. Census region. The Childhood and Adolescent Immunizations summary rate comprises the rates for vaccinations appropriate to each age group. Childhood vaccinations included in the composite are DTaP/

DT, hepatitis A, hepatitis B, Hib, IPV, MMR, pneumococcal conjugate and chicken pox vaccines, rotavirus, influenza and combinations. Adolescent vaccinations included in the composite are meningococcal, Tdap/Td and combinations.

Consumer Experience is a summary of the following indicators: Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Claims Processing, Customer Service, Rating of Personal Doctor, Rating of Specialist, Rating of All Health Care and Rating of Plan.

All rating summaries reflect ratings of 9 or 10 and all composites correspond to responses of "Always." The Diabetes composite summarizes the mean for the following indicators: Blood Pressure Control (<140/90 mm Hg), Eye Exams, HbA1c Screening, Poor Glycemic Control (>9%), LDL Cholesterol Screening, LDL Cholesterol Control (<100 mg/dL) and Medical Attention for Nephropathy.

The Heart Disease composite summarizes performance on the following indicators: Persistence of Beta-Blockers After a Heart Attack; Controlling High Blood Pressure; Cholesterol Screening; and Management for Patients With Cardiovascular Conditions.

The final rates presented are the unweighted averages of all indicators in the composites defined above, across all plans (by product line and reporting type) in each U.S. Census region. Plans that operate in more than one region are counted in each region summary. For example, a plan that operates in the Mountain and Pacific regions contributed data to the composite mean once for the Mountain region and once for the Pacific region.

Relative Resource Use

Health plans report case mix-adjusted measures of resource use related to five chronic illnesses: asthma, cardiovascular conditions, COPD, diabetes and hypertension. These measures incorporate cost and service frequency for each eligible member during the measurement year.

All services administered to members identified with one of these conditions are attributed to the RRU measure for that condition. Each of the five RRU measures summarizes a health plan's utilization of several service categories:

- Inpatient Facility.
- Evaluation and Management (E&M—Inpatient and Outpatient).
- Procedure and Surgery (Inpatient and Outpatient).
- Diagnostic Imaging Services.
- Diagnostic Laboratory Services.
- Ambulatory Pharmacy Services.

NCQA calculates an observed-to-expected (O/E) ratio for resource use for each health plan, as well as a quality composite. In order to facilitate comparison within regions and among reporting types, NCQA reports indexed O/E ratios (each health plan's O/E ratio is divided by the average O/E for all plans of the same type in a given region). The quality composite is also indexed in the same way (each plan's composite rate is divided by the average composite for plans of the same reporting type in the same region). The O/E ratio is a plan's actual resource use (the "observed"), divided by an estimate of the resource use the plan would have if its population was the same as the average population of all other plans submitting data to NCQA (the "expected").

For the resource use index, shown as the horizontal axis on RRU scatter plots, a value of 1.00 represents the average resource utilization for all HMOs or PPOs nationally. A value greater than 1.00 represents higher-than-expected use; a value less than 1.00 represents lower-than-expected use.

For the quality index, otherwise known as the Effectiveness of Care index and shown as the vertical axis on RRU scatter plots, an index greater than 1.00 represents better-than-expected performance; an index less than 1.00 represents lower-than-expected performance. For example, a PPO with an index of 1.12 for quality and 1.15 for resource use delivered quality that was 12 percent better than the average PPO serving similar patients, and used 15 percent more resources than the PPO average.

Descriptive statistics are provided for composites with up to 10 indicators. With the exception of the COPD quality RRU composite, the summary statistics for composite measures are the simple, unweighted average of all measures and indicators in the composite. Since 2 of the 3 COPD indicators describe the same dimension of care (Pharmacotherapy Management), each indicator receives a weight of 1/2.

APPENDIX 1A: VARIATION IN PLAN PERFORMANCE: THE 90TH PERCENTILE VS. THE 10TH PERCENTILE: COMMERCIAL HMOS

| HEDIS EFFECTIVENESS OF CARE AND UTILIZATION MEASURES COMMERCIAL HMO STATISTICS—2011 | | | |
|---|--------------------|--------------------|------------|
| MEASURE | 90TH PERCENTILE | 10TH PERCENTILE | DIFFERENCE |
| Overuse and Appropriateness | | | |
| Imaging Studies for Low Back Pain | 82.2 | 66.5 | 15.7 |
| Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis | 33.0 | 15.5 | 17.5 |
| Screening, Prevention and Wellness | | | |
| Adult BMI Assessment | 82.4 | 2.0 | 80.5 |
| Medical Assistance With Smoking and Tobacco Use Cessation: Advising Smokers and Tobacco Users to Quit | 86.8 | 68.8 | 18.0 |
| Medical Assistance With Smoking and Tobacco Use Cessation: Discussing Cessation Strategies | 62.1 | 36.8 | 25.3 |
| Medical Assistance With Smoking and Tobacco Use Cessation: Discussing Cessation Medications | 66.9 | 43.1 | 23.8 |
| Flu Shots for Adults | 62.1 | 44.2 | 17.9 |
| Breast Cancer Screening | 79.0 | 63.6 | 15.4 |
| Cervical Cancer Screening | 82.9 | 69.9 | 13.0 |
| Colorectal Cancer Screening | 73.7 | 49.9 | 23.8 |
| Chlamydia Screening in Women: 16–20 Years | 56.0 | 29.8 | 26.2 |
| Chlamydia Screening in Women: 21–24 Years | 65.2 | 34.1 | 31.1 |
| Chlamydia Screening in Women: Total Rate | 60.3 | 32.0 | 28.4 |
| Chronic Condition Management | | | |
| Aspirin Use and Discussion: Aspirin Use | 54.3 | 39.1 | 15.2 |
| Persistence of Beta-Blocker Treatment After a Heart Attack | 91.2 | 68.8 | 22.5 |
| Comprehensive Diabetes Care: Blood Pressure Control (<140/80 mm Hg) | 58.9 | 33.1 | 25.8 |
| Comprehensive Diabetes Care: Blood Pressure Control (<140/90 mm Hg) | 79.7 | 51.3 | 28.4 |
| Comprehensive Diabetes Care: Eye Exams | 73.7 | 37.8 | 35.9 |
| Comprehensive Diabetes Care: HbA1c Screening | 94.7 | 85.5 | 9.2 |
| Comprehensive Diabetes Care: Good Glycemic Control (HbA1c <7% for a Selected Population) | 49.8 | 33.9 | 15.9 |
| Comprehensive Diabetes Care: Good Glycemic Control (HbA1c <8%) | 70.8 | 51.0 | 19.8 |
| Comprehensive Diabetes Care: Poor Glycemic Control (HbA1c >9%)— Lower rates signify better performance | 18.2 | 39.3 | 21.1 |
| Comprehensive Diabetes Care: LDL Cholesterol Screening | 90.9 | 80.0 | 10.8 |
| Comprehensive Diabetes Care: LDL Cholesterol Control (<100 mg/dL) | 58.4 | 38.2 | 20.2 |
| Comprehensive Diabetes Care: Medical Attention for Nephropathy | 90.4 | 77.5 | 12.9 |
| Controlling High Blood Pressure | 76.2 | 54.2 | 21.9 |

HEDIS EFFECTIVENESS OF CARE AND UTILIZATION MEASURES COMMERCIAL HMO STATISTICS—2011

| MEASURE | 90TH PERCENTILE | 10TH PERCENTILE | DIFFERENCE |
|--|--------------------|--------------------|------------|
| Cholesterol Management for Patients With Cardiovascular Conditions: LDL Cholesterol Screening | 93.8 | 82.2 | 11.5 |
| Cholesterol Management for Patients With Cardiovascular Conditions: LDL Control (<100 mg/dL) | 73.1 | 47.8 | 25.3 |
| Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis | 93.5 | 81.4 | 12.1 |
| Use of Appropriate Medications for People With Asthma: 5–11 Years | 99.1 | 94.1 | 5.0 |
| Use of Appropriate Medications for People With Asthma: 12–18 Years | 97.1 | 88.3 | 8.8 |
| Use of Appropriate Medications for People With Asthma: 19–50 Years | 93.8 | 84.0 | 9.9 |
| Use of Appropriate Medications for People With Asthma: 51–64 Years | 96.6 | 88.7 | 7.9 |
| Use of Appropriate Medications for People With Asthma: Overall Rate | 95.2 | 88.9 | 6.3 |
| Use of Spirometry Testing in the Assessment and Diagnosis of COPD | 56.0 | 30.9 | 25.1 |
| Pharmacotherapy Management of COPD: Bronchodilators | 87.8 | 72.7 | 15.0 |
| Pharmacotherapy Management of COPD: Systemic Corticosteroids | 80.7 | 62.8 | 17.9 |
| Annual Monitoring for Patients on Persistent Medications: ACE Inhibitors or ARBs | 87.4 | 78.1 | 9.4 |
| Annual Monitoring for Patients on Persistent Medications: Anticonvulsants | 69.6 | 51.3 | 18.3 |
| Annual Monitoring for Patients on Persistent Medications: Digoxin | 93.5 | 75.9 | 17.6 |
| Annual Monitoring for Patients on Persistent Medications: Diuretics | 87.0 | 77.7 | 9.3 |
| Annual Monitoring for Patients on Persistent Medications: Combined | 86.9 | 77.5 | 9.3 |
| Antidepressant Medication Management: Acute Phase | 73.4 | 57.9 | 15.6 |
| Antidepressant Medication Management: Continuation Phase | 57.7 | 41.1 | 16.7 |
| Follow-Up After Hospitalization for Mental Illness: Within 7 Days Post-Discharge | 76.2 | 41.6 | 34.6 |
| Follow-Up After Hospitalization for Mental Illness: Within 30 Days Post-Discharge | 89.2 | 61.6 | 27.6 |
| Alcohol and Other Drug Dependence Treatment: Initiation | 48.7 | 31.1 | 17.5 |
| Alcohol and Other Drug Dependence Treatment: Engagement | 22.1 | 8.6 | 13.6 |
| Measures Targeted Toward Children and Adolescents | | | |
| Appropriate Testing for Children With Pharyngitis | 92.1 | 67.3 | 24.8 |
| Appropriate Treatment for Children With Upper Respiratory Infection | 94.2 | 72.0 | 22.2 |
| Childhood Immunization Status: DTaP/DT | 92.9 | 80.3 | 12.7 |
| Childhood Immunization Status: Hepatitis B | 94.8 | 81.3 | 13.5 |
| Childhood Immunization Status: HiB | 97.8 | 90.0 | 7.8 |
| Childhood Immunization Status: IPV | 97.3 | 87.5 | 9.8 |
| Childhood Immunization Status: MMR | 95.4 | 87.1 | 8.3 |
| Childhood Immunization Status: Pneumococcal Conjugate (PCV) | 93.3 | 80.3 | 13.0 |

HEDIS EFFECTIVENESS OF CARE AND UTILIZATION MEASURES COMMERCIAL HMO STATISTICS—2011

| MEASURE | 90TH PERCENTILE | 10TH PERCENTILE | DIFFERENCE |
|---|-----------------|-----------------|------------|
| Childhood Immunization Status: VZV | 95.1 | 87.5 | 7.6 |
| Childhood Immunization Status: Hepatitis A | 55.8 | 25.0 | 30.8 |
| Childhood Immunization Status: Rotavirus | 84.7 | 66.1 | 18.6 |
| Childhood Immunization Status: Influenza | 74.9 | 47.0 | 27.9 |
| Childhood Immunization Status: Combination 2 (DTaP, IPV, MMR, HiB, Hepatitis B and VZV) | 87.0 | 68.6 | 18.4 |
| Childhood Immunization Status: Combination 3 (DTaP, IPV, MMR, HiB, Hepatitis B, VZV and PCV) | 84.9 | 65.6 | 19.3 |
| Childhood Immunization Status: Combination 10 (DTaP, IPV, MMR, HiB, Hepatitis A, Hepatitis B, VZV, PCV, Rotavirus and Influenza) | 36.7 | 12.4 | 24.3 |
| Immunizations for Adolescents: Meningococcal | 80.9 | 42.3 | 38.6 |
| Immunizations for Adolescents: Tdap/Td | 93.8 | 55.2 | 38.6 |
| Immunizations for Adolescents: Combination 1 (Meningococcal, Tdap/Td) | 79.9 | 39.4 | 40.5 |
| Follow-Up Care for Children Prescribed ADHD Medication: Initiation | 50.0 | 29.4 | 20.6 |
| Follow-Up Care for Children Prescribed ADHD Medication: Continuation | 57.5 | 31.9 | 25.6 |
| Weight Assessment and Counseling for Nutrition and Physical Activity in Children and Adolescents: BMI Percentile (3–17 Years) | 83.0 | 0.8 | 82.2 |
| Weight Assessment and Counseling for Nutrition and Physical Activity in Children and Adolescents: Counseling for Nutrition (3–17 Years) | 76.4 | 0.4 | 76.0 |
| Weight Assessment and Counseling for Nutrition and Physical Activity in Children and Adolescents: Counseling for Physical Activity (3–17 Years) | 72.7 | 0.0 | 72.7 |
| Well-Child Visits (Ages 0–15 Months): Six or More Well-Child Visits | 90.6 | 64.5 | 26.1 |
| Well-Child Visits (Ages 3–6 Years): One or More Well-Child Visits | 86.2 | 57.9 | 28.3 |
| Adolescent Well-Care Visits: At Least One Comprehensive Well-Care Visit | 61.5 | 29.7 | 31.8 |
| Children and Adolescents' Access to Primary Care Practitioners: Children 12–24 Months | 99.6 | 96.2 | 3.4 |
| Children and Adolescents' Access to Primary Care Practitioners: Children 25 Months–6 Years | 96.3 | 86.9 | 9.4 |
| Children and Adolescents' Access to Primary Care Practitioners: Children 7–11 Years | 97.3 | 87.1 | 10.2 |
| Children and Adolescents' Access to Primary Care Practitioners: Adolescents 12–19 Years | 95.4 | 84.4 | 11.0 |
| Other Access and Utilization | | | |
| Prenatal and Postpartum Care: Timeliness of Prenatal Care | 97.9 | 80.0 | 17.9 |
| Prenatal and Postpartum Care: Postpartum Visit Between 21 and 56 Days After Delivery | 91.5 | 63.6 | 27.9 |
| Plan All-Cause Readmissions: 18–64 Years—Lower rates signify better performance* | 0.67 | 0.97 | 0.30 |

*This indicator is expressed as the ratio of the observed readmission rate to the expected (adjusted for case-mix) readmission rate. Ratios less than 1.0 indicate lower-than-expected readmission rates, whereas ratios greater than 1.0 indicate higher-than-expected readmission rates.

APPENDIX 1B: VARIATION IN PLAN PERFORMANCE: THE 90TH PERCENTILE VS. THE 10TH PERCENTILE: COMMERCIAL HMOS

| CAHPS MEMBER SATISFACTION MEASURES COMMERCIAL HMO STATISTICS—2011 | | | |
|--|--------------------|--------------------|------------|
| MEASURE | 90TH PERCENTILE | 10TH PERCENTILE | DIFFERENCE |
| Consumer and Patient Engagement and Experience | | | |
| Rating of Health Plan: Rating of 8, 9 or 10 | 78.2 | 52.5 | 25.7 |
| Rating of Health Plan: Rating of 9 or 10 | 58.1 | 28.8 | 29.4 |
| Rating of Health Care: Rating of 8, 9 or 10 | 83.9 | 70.4 | 13.5 |
| Rating of Health Care: Rating of 9 or 10 | 60.5 | 43.8 | 16.8 |
| Getting Needed Care: Usually or Always | 90.0 | 80.4 | 9.5 |
| Getting Needed Care: Always | 61.2 | 47.2 | 14.0 |
| Getting Care Quickly: Usually or Always | 90.4 | 80.9 | 9.4 |
| Getting Care Quickly: Always | 64.9 | 52.9 | 12.0 |
| How Well Doctors Communicate: Usually or Always | 96.4 | 91.5 | 4.9 |
| How Well Doctors Communicate: Always | 78.8 | 69.1 | 9.7 |
| Rating of Personal Doctor: Rating of 8, 9 or 10 | 89.0 | 78.9 | 10.0 |
| Rating of Personal Doctor: Rating of 9 or 10 | 72.9 | 58.6 | 14.3 |
| Rating of Specialist: Rating of 8, 9 or 10 | 87.5 | 77.7 | 9.8 |
| Rating of Specialist: Rating of 9 or 10 | 72.6 | 57.8 | 14.8 |
| Customer Service: Usually or Always | 92.4 | 80.9 | 11.4 |
| Customer Service: Always | 71.7 | 53.7 | 18.0 |
| Claims Processing: Usually or Always | 94.2 | 83.5 | 10.7 |
| Claims Processing: Always | 66.5 | 45.5 | 20.9 |

APPENDIX 2A: VARIATION IN PLAN PERFORMANCE: THE 90TH PERCENTILE VS. THE 10TH PERCENTILE: COMMERCIAL PPOS

| HEDIS EFFECTIVENESS OF CARE AND UTILIZATION MEASURES COMMERCIAL PPO STATISTICS—2011 | | | |
|---|--------------------|--------------------|------------|
| MEASURE | 90TH PERCENTILE | 10TH PERCENTILE | DIFFERENCE |
| Overuse and Appropriateness | | | |
| Imaging Studies for Low Back Pain | 81.3 | 66.4 | 15.0 |
| Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis | 28.6 | 16.4 | 12.2 |
| Screening, Prevention and Wellness | | | |
| Adult BMI Assessment | 64.0 | 1.4 | 62.7 |
| Medical Assistance With Smoking and Tobacco Use Cessation: Advising Smokers and Tobacco Users to Quit | 79.2 | 67.3 | 11.9 |
| Medical Assistance With Smoking and Tobacco Use Cessation: Discussing Cessation Strategies | 49.6 | 32.9 | 16.7 |
| Medical Assistance With Smoking and Tobacco Use Cessation: Discussing Cessation Medications | 56.9 | 40.4 | 16.5 |
| Flu Shots for Adults | 59.3 | 42.8 | 16.5 |
| Breast Cancer Screening | 72.1 | 61.6 | 10.6 |
| Cervical Cancer Screening | 79.1 | 69.3 | 9.7 |
| Colorectal Cancer Screening | 64.4 | 43.4 | 21.1 |
| Chlamydia Screening in Women: 16–20 Years | 50.0 | 31.6 | 18.4 |
| Chlamydia Screening in Women: 21–24 Years | 58.9 | 33.6 | 25.3 |
| Chlamydia Screening in Women: Total Rate | 54.5 | 32.9 | 21.6 |
| Chronic Condition Management | | | |
| Aspirin Use and Discussion: Aspirin Use | 56.0 | 42.2 | 13.8 |
| Persistence of Beta-Blocker Treatment After a Heart Attack | 86.1 | 67.8 | 18.3 |
| Comprehensive Diabetes Care: Blood Pressure Control (<140/80 mm Hg) | 45.7 | 30.7 | 15.0 |
| Comprehensive Diabetes Care: Blood Pressure Control (<140/90 mm Hg) | 69.6 | 49.5 | 20.1 |
| Comprehensive Diabetes Care: Eye Exams | 61.0 | 33.2 | 27.8 |
| Comprehensive Diabetes Care: HbA1c Screening | 92.1 | 81.3 | 10.8 |
| Comprehensive Diabetes Care: Good Glycemic Control (HbA1c <7% for a Selected Population) | 45.6 | 12.0 | 33.6 |
| Comprehensive Diabetes Care: Good Glycemic Control (HbA1c <8%) | 66.2 | 45.7 | 20.5 |
| Comprehensive Diabetes Care: Poor Glycemic Control (HbA1c >9%)— Lower rates signify better performance | 22.4 | 45.9 | 23.5 |
| Comprehensive Diabetes Care: LDL Cholesterol Screening | 86.8 | 73.5 | 13.3 |
| Comprehensive Diabetes Care: LDL Cholesterol Control (<100 mg/dL) | 51.1 | 32.4 | 18.7 |
| Comprehensive Diabetes Care: Medical Attention for Nephropathy | 85.2 | 70.1 | 15.1 |
| Controlling High Blood Pressure | 68.2 | 45.5 | 22.8 |

HEDIS EFFECTIVENESS OF CARE AND UTILIZATION MEASURES

COMMERCIAL PPO STATISTICS – 2011

| MEASURE | 90TH PERCENTILE | 10TH PERCENTILE | DIFFERENCE |
|--|--------------------|--------------------|------------|
| Cholesterol Management for Patients With Cardiovascular Conditions: LDL Cholesterol Screening | 89.6 | 74.1 | 15.4 |
| Cholesterol Management for Patients With Cardiovascular Conditions: LDL Control (<100 mg/dL) | 65.8 | 25.8 | 40.0 |
| Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis | 92.7 | 80.5 | 12.2 |
| Use of Appropriate Medications for People With Asthma: 5–11 Years | 98.6 | 94.6 | 4.0 |
| Use of Appropriate Medications for People With Asthma: 12–18 Years | 96.6 | 89.7 | 6.9 |
| Use of Appropriate Medications for People With Asthma: 19–50 Years | 91.9 | 83.9 | 8.0 |
| Use of Appropriate Medications for People With Asthma: 51–64 Years | 95.8 | 89.4 | 6.4 |
| Use of Appropriate Medications for People With Asthma: Overall Rate | 93.9 | 89.0 | 4.9 |
| Use of Spirometry Testing in the Assessment and Diagnosis of COPD | 48.8 | 32.0 | 16.7 |
| Pharmacotherapy Management of COPD: Bronchodilators | 86.5 | 66.4 | 20.2 |
| Pharmacotherapy Management of COPD: Systemic Corticosteroids | 80.0 | 58.9 | 21.1 |
| Annual Monitoring for Patients on Persistent Medications: ACE Inhibitors or ARBs | 83.2 | 73.7 | 9.5 |
| Annual Monitoring for Patients on Persistent Medications: Anticonvulsants | 63.7 | 50.0 | 13.7 |
| Annual Monitoring for Patients on Persistent Medications: Digoxin | 87.3 | 69.3 | 17.9 |
| Annual Monitoring for Patients on Persistent Medications: Diuretics | 82.9 | 73.0 | 9.9 |
| Annual Monitoring for Patients on Persistent Medications: Combined | 82.5 | 72.8 | 9.7 |
| Antidepressant Medication Management: Acute Phase | 70.4 | 59.1 | 11.3 |
| Antidepressant Medication Management: Continuation Phase | 55.4 | 42.6 | 12.8 |
| Follow-Up After Hospitalization for Mental Illness: Within 7 Days Post-Discharge | 67.5 | 38.3 | 29.2 |
| Follow-Up After Hospitalization for Mental Illness: Within 30 Days Post-Discharge | 83.8 | 59.7 | 24.1 |
| Alcohol and Other Drug Dependence Treatment: Initiation | 46.9 | 34.2 | 12.7 |
| Alcohol and Other Drug Dependence Treatment: Engagement | 21.6 | 10.6 | 11.1 |
| Measures Targeted Toward Children and Adolescents | | | |
| Appropriate Testing for Children With Pharyngitis | 89.4 | 66.5 | 22.9 |
| Appropriate Treatment for Children With Upper Respiratory Infection | 91.0 | 70.1 | 20.9 |
| Childhood Immunization Status: DTaP/DT | 90.0 | 50.6 | 39.4 |
| Childhood Immunization Status: Hepatitis B | 92.9 | 27.8 | 65.1 |
| Childhood Immunization Status: HiB | 96.4 | 65.4 | 30.9 |
| Childhood Immunization Status: IPV | 95.1 | 59.8 | 35.4 |
| Childhood Immunization Status: MMR | 93.2 | 77.8 | 15.4 |
| Childhood Immunization Status: Pneumococcal Conjugate (PCV) | 90.4 | 54.5 | 35.9 |

HEDIS EFFECTIVENESS OF CARE AND UTILIZATION MEASURES COMMERCIAL PPO STATISTICS—2011

| MEASURE | 90TH PERCENTILE | 10TH PERCENTILE | DIFFERENCE |
|---|-----------------|-----------------|------------|
| Childhood Immunization Status: VZV | 93.6 | 78.2 | 15.5 |
| Childhood Immunization Status: Hepatitis A | 42.2 | 23.3 | 19.0 |
| Childhood Immunization Status: Rotavirus | 81.8 | 49.6 | 32.2 |
| Childhood Immunization Status: Influenza | 71.6 | 42.3 | 29.3 |
| Childhood Immunization Status: Combination 2 (DTaP, IPV, MMR, HiB, Hepatitis B and VZV) | 83.3 | 23.3 | 59.9 |
| Childhood Immunization Status: Combination 3 (DTaP, IPV, MMR, HiB, Hepatitis B, VZV and PCV) | 79.7 | 22.4 | 57.3 |
| Childhood Immunization Status: Combination 10 (DTaP, IPV, MMR, HiB, Hepatitis A, Hepatitis B, VZV, PCV, Rotavirus and Influenza) | 27.5 | 6.4 | 21.1 |
| Immunizations for Adolescents: Meningococcal | 73.4 | 33.4 | 40.0 |
| Immunizations for Adolescents: Tdap/Td | 87.1 | 41.7 | 45.4 |
| Immunizations for Adolescents: Combination 1 (Meningococcal, Tdap/Td) | 69.6 | 30.4 | 39.2 |
| Follow-Up Care for Children Prescribed ADHD Medication: Initiation | 49.4 | 32.3 | 17.1 |
| Follow-Up Care for Children Prescribed ADHD Medication: Continuation | 54.9 | 35.1 | 19.9 |
| Weight Assessment and Counseling for Nutrition and Physical Activity in Children and Adolescents: BMI Percentile (3–17 Years) | 65.3 | 0.2 | 65.1 |
| Weight Assessment and Counseling for Nutrition and Physical Activity in Children and Adolescents: Counseling for Nutrition (3–17 Years) | 69.8 | 0.3 | 69.5 |
| Weight Assessment and Counseling for Nutrition and Physical Activity in Children and Adolescents: Counseling for Physical Activity (3–17 Years) | 65.5 | 0.0 | 65.4 |
| Well-Child Visits (Ages 0–15 Months): Six or More Well-Child Visits | 86.2 | 64.6 | 21.6 |
| Well-Child Visits (Ages 3–6 Years): One or More Well-Child Visits | 85.1 | 53.6 | 31.5 |
| Adolescent Well-Care Visits: At Least One Comprehensive Well-Care Visit | 60.3 | 26.3 | 34.0 |
| Children and Adolescents' Access to Primary Care Practitioners: Children 12–24 Months | 98.9 | 95.1 | 3.8 |
| Children and Adolescents' Access to Primary Care Practitioners: Children 25 Months–6 Years | 95.4 | 83.5 | 11.9 |
| Children and Adolescents' Access to Primary Care Practitioners: Children 7–11 Years | 96.3 | 83.4 | 13.0 |
| Children and Adolescents' Access to Primary Care Practitioners: Adolescents 12–19 Years | 94.5 | 81.1 | 13.4 |
| Other Access and Utilization | | | |
| Prenatal and Postpartum Care: Timeliness of Prenatal Care | 96.7 | 48.6 | 48.1 |
| Prenatal and Postpartum Care: Postpartum Visit Between 21 and 56 Days After Delivery | 88.0 | 42.6 | 45.4 |
| Plan All-Cause Readmissions: 18–64 Years— Lower rates signify better performance* | 0.69 | 0.90 | 0.21 |

*This indicator is expressed as the ratio of the observed readmission rate to the expected (adjusted for case-mix) readmission rate. Ratios less than 1.0 indicate lower-than-expected readmission rates, whereas ratios greater than 1.0 indicate higher-than-expected readmission rates.

APPENDIX 2B: VARIATION IN PLAN PERFORMANCE: THE 90TH PERCENTILE VS. THE 10TH PERCENTILE: COMMERCIAL PPOS

| CAHPS MEMBER SATISFACTION MEASURES COMMERCIAL PPO STATISTICS—2011 | | | |
|--|--------------------|--------------------|------------|
| MEASURE | 90TH PERCENTILE | 10TH PERCENTILE | DIFFERENCE |
| Consumer and Patient Engagement and Experience | | | |
| Rating of Health Plan: Rating of 8, 9 or 10 | 67.3 | 49.0 | 18.3 |
| Rating of Health Plan: Rating of 9 or 10 | 43.0 | 25.6 | 17.4 |
| Rating of Health Care: Rating of 8, 9 or 10 | 81.2 | 71.3 | 10.0 |
| Rating of Health Care: Rating of 9 or 10 | 55.0 | 42.9 | 12.2 |
| Getting Needed Care: Usually or Always | 89.7 | 82.5 | 7.3 |
| Getting Needed Care: Always | 59.5 | 47.7 | 11.8 |
| Getting Care Quickly: Usually or Always | 90.1 | 83.4 | 6.7 |
| Getting Care Quickly: Always | 62.9 | 53.7 | 9.2 |
| How Well Doctors Communicate: Usually or Always | 96.3 | 92.9 | 3.4 |
| How Well Doctors Communicate: Always | 77.3 | 69.9 | 7.4 |
| Rating of Personal Doctor: Rating of 8, 9 or 10 | 87.4 | 78.9 | 8.5 |
| Rating of Personal Doctor: Rating of 9 or 10 | 69.3 | 58.4 | 10.8 |
| Rating of Specialist: Rating of 8, 9 or 10 | 86.1 | 77.8 | 8.3 |
| Rating of Specialist: Rating of 9 or 10 | 69.0 | 56.8 | 12.2 |
| Customer Service: Usually or Always | 87.9 | 77.4 | 10.4 |
| Customer Service: Always | 62.6 | 48.8 | 13.8 |
| Claims Processing: Usually or Always | 92.3 | 83.3 | 9.0 |
| Claims Processing: Always | 57.6 | 42.5 | 15.2 |

APPENDIX 3A: VARIATION IN PLAN PERFORMANCE: THE 90TH PERCENTILE VS. THE 10TH PERCENTILE: MEDICAID HMOS

| HEDIS EFFECTIVENESS OF CARE AND UTILIZATION MEASURES MEDICAID HMO STATISTICS – 2011 | | | |
|---|--------------------|--------------------|------------|
| MEASURE | 90TH PERCENTILE | 10TH PERCENTILE | DIFFERENCE |
| Overuse and Appropriateness | | | |
| Imaging Studies for Low Back Pain | 82.0 | 69.5 | 12.5 |
| Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis | 33.3 | 16.5 | 16.9 |
| Screening, Prevention and Wellness | | | |
| Adult BMI Assessment | 78.4 | 4.4 | 73.9 |
| Medical Assistance With Smoking and Tobacco Use Cessation: Advising Smokers and Tobacco Users to Quit | 81.4 | 65.5 | 15.9 |
| Medical Assistance With Smoking and Tobacco Use Cessation: Discussing Cessation Strategies | 50.7 | 31.3 | 19.4 |
| Medical Assistance With Smoking and Tobacco Use Cessation: Discussing Cessation Medications | 56.6 | 32.9 | 23.7 |
| Breast Cancer Screening | 62.8 | 36.8 | 26.0 |
| Cervical Cancer Screening | 78.5 | 51.9 | 26.7 |
| Chlamydia Screening in Women: 16–20 Years | 67.4 | 42.9 | 24.4 |
| Chlamydia Screening in Women: 21–24 Years | 72.7 | 52.4 | 20.2 |
| Chlamydia Screening in Women: Total Rate | 68.8 | 47.6 | 21.2 |
| Chronic Condition Management | | | |
| Persistence of Beta-Blocker Treatment After a Heart Attack | 91.2 | 66.7 | 24.5 |
| Comprehensive Diabetes Care: Blood Pressure Control (<140/80 mm Hg) | 55.0 | 27.3 | 27.7 |
| Comprehensive Diabetes Care: Blood Pressure Control (<140/90 mm Hg) | 75.4 | 47.0 | 28.4 |
| Comprehensive Diabetes Care: Eye Exams | 69.7 | 36.3 | 33.5 |
| Comprehensive Diabetes Care: HbA1c Screening | 91.1 | 74.9 | 16.2 |
| Comprehensive Diabetes Care: Good Glycemic Control (HbA1c <7% for a Selected Population) | 44.0 | 25.4 | 18.6 |
| Comprehensive Diabetes Care: Good Glycemic Control (HbA1c <8%) | 59.4 | 35.0 | 24.3 |
| Comprehensive Diabetes Care: Poor Glycemic Control (HbA1c >9%)— Lower rates signify better performance | 29.0 | 58.2 | 29.3 |
| Comprehensive Diabetes Care: LDL Cholesterol Screening | 83.5 | 64.4 | 19.1 |
| Comprehensive Diabetes Care: LDL Cholesterol Control (<100 mg/dL) | 46.4 | 23.1 | 23.4 |
| Comprehensive Diabetes Care: Medical Attention for Nephropathy | 86.9 | 68.4 | 18.5 |
| Controlling High Blood Pressure | 69.1 | 42.2 | 26.9 |
| Cholesterol Management for Patients With Cardiovascular Conditions: LDL Cholesterol Screening | 88.8 | 76.0 | 12.8 |
| Cholesterol Management for Patients With Cardiovascular Conditions: LDL Control (<100 mg/dL) | 55.6 | 28.4 | 27.2 |

HEDIS EFFECTIVENESS OF CARE AND UTILIZATION MEASURES MEDICAID HMO STATISTICS – 2011

| MEASURE | 90TH PERCENTILE | 10TH PERCENTILE | DIFFERENCE |
|---|-----------------|-----------------|------------|
| Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis | 81.0 | 57.4 | 23.5 |
| Use of Appropriate Medications for People With Asthma: 5–11 Years | 95.4 | 85.0 | 10.5 |
| Use of Appropriate Medications for People With Asthma: 12–18 Years | 92.3 | 81.0 | 11.3 |
| Use of Appropriate Medications for People With Asthma: 19–50 Years | 84.4 | 63.8 | 20.6 |
| Use of Appropriate Medications for People With Asthma: 51–64 Years | 85.6 | 58.1 | 27.5 |
| Use of Appropriate Medications for People With Asthma: Overall Rate | 90.6 | 79.7 | 10.8 |
| Use of Spirometry Testing in the Assessment and Diagnosis of COPD | 44.0 | 20.5 | 23.5 |
| Pharmacotherapy Management of COPD: Bronchodilators | 88.1 | 71.3 | 16.8 |
| Pharmacotherapy Management of COPD: Systemic Corticosteroids | 76.3 | 48.8 | 27.4 |
| Annual Monitoring for Patients on Persistent Medications: ACE Inhibitors or ARBs | 91.3 | 80.2 | 11.2 |
| Annual Monitoring for Patients on Persistent Medications: Anticonvulsants | 74.7 | 53.7 | 21.0 |
| Annual Monitoring for Patients on Persistent Medications: Digoxin | 95.6 | 83.3 | 12.2 |
| Annual Monitoring for Patients on Persistent Medications: Diuretics | 91.3 | 78.5 | 12.8 |
| Annual Monitoring for Patients on Persistent Medications: Combined | 88.6 | 78.5 | 10.1 |
| Antidepressant Medication Management: Acute Phase | 61.6 | 43.4 | 18.2 |
| Antidepressant Medication Management: Continuation Phase | 42.9 | 26.7 | 16.2 |
| Follow-Up After Hospitalization for Mental Illness: Within 7 Days Post-Discharge | 69.6 | 24.0 | 45.5 |
| Follow-Up After Hospitalization for Mental Illness: Within 30 Days Post-Discharge | 84.3 | 36.0 | 48.2 |
| Alcohol and Other Drug Dependence Treatment: Initiation | 49.4 | 29.9 | 19.5 |
| Alcohol and Other Drug Dependence Treatment: Engagement | 21.2 | 2.4 | 18.8 |
| Measures Targeted Toward Children and Adolescents | | | |
| Appropriate Testing for Children With Pharyngitis | 83.9 | 50.0 | 33.9 |
| Appropriate Treatment for Children With Upper Respiratory Infection | 93.2 | 77.4 | 15.8 |
| Childhood Immunization Status: DTaP/DT | 88.5 | 71.5 | 16.9 |
| Childhood Immunization Status: Hepatitis B | 95.4 | 80.0 | 15.3 |
| Childhood Immunization Status: HiB | 96.1 | 85.1 | 11.0 |
| Childhood Immunization Status: IPV | 95.9 | 84.0 | 11.8 |
| Childhood Immunization Status: MMR | 95.4 | 85.6 | 9.8 |
| Childhood Immunization Status: Pneumococcal Conjugate (PCV) | 87.7 | 71.6 | 16.1 |
| Childhood Immunization Status: VZV | 95.1 | 85.6 | 9.5 |
| Childhood Immunization Status: Hepatitis A | 52.8 | 25.8 | 27.0 |
| Childhood Immunization Status: Rotavirus | 74.1 | 46.3 | 27.8 |
| Childhood Immunization Status: Influenza | 59.7 | 24.6 | 35.1 |

HEDIS EFFECTIVENESS OF CARE AND UTILIZATION MEASURES MEDICAID HMO STATISTICS – 2011

| MEASURE | 90TH PERCENTILE | 10TH PERCENTILE | DIFFERENCE |
|---|-----------------|-----------------|------------|
| Childhood Immunization Status: Combination 2 (DTaP, IPV, MMR, HiB, Hepatitis B and VZV) | 84.2 | 64.2 | 20.0 |
| Childhood Immunization Status: Combination 3 (DTaP, IPV, MMR, HiB, Hepatitis B, VZV and PCV) | 82.5 | 58.9 | 23.6 |
| Childhood Immunization Status: Combination 10 (DTaP, IPV, MMR, HiB, Hepatitis A, Hepatitis B, VZV, PCV, Rotavirus and Influenza) | 27.5 | 8.1 | 19.4 |
| Immunizations for Adolescents: Meningococcal | 82.8 | 42.9 | 40.0 |
| Immunizations for Adolescents: Tdap/Td | 90.3 | 53.5 | 36.7 |
| Immunizations for Adolescents: Combination 1 (Meningococcal, Tdap/Td) | 80.9 | 39.8 | 41.1 |
| Follow-Up Care for Children Prescribed ADHD Medication: Initiation | 52.5 | 23.0 | 29.5 |
| Follow-Up Care for Children Prescribed ADHD Medication: Continuation | 63.1 | 21.8 | 41.3 |
| Lead Screening in Children | 86.6 | 39.2 | 47.3 |
| Weight Assessment and Counseling for Nutrition and Physical Activity in Children and Adolescents: BMI Percentile (3–17 Years) | 77.1 | 1.5 | 75.6 |
| Weight Assessment and Counseling for Nutrition and Physical Activity in Children and Adolescents: Counseling for Nutrition (3–17 Years) | 77.6 | 0.8 | 76.8 |
| Weight Assessment and Counseling for Nutrition and Physical Activity in Children and Adolescents: Counseling for Physical Activity (3–17 Years) | 64.9 | 0.2 | 64.7 |
| Well-Child Visits (Ages 0–15 Months): Six or More Well-Child Visits | 77.3 | 43.8 | 33.5 |
| Well-Child Visits (Ages 3–6 Years): One or More Well-Child Visits | 83.0 | 61.1 | 22.0 |
| Adolescent Well-Care Visits: At Least One Comprehensive Well-Care Visit | 64.7 | 35.5 | 29.2 |
| Children and Adolescents' Access to Primary Care Practitioners: Children 12–24 Months | 98.4 | 93.1 | 5.3 |
| Children and Adolescents' Access to Primary Care Practitioners: Children 25 Months–6 Years | 92.6 | 83.2 | 9.5 |
| Children and Adolescents' Access to Primary Care Practitioners: Children 7–11 Years | 94.5 | 83.4 | 11.1 |
| Children and Adolescents' Access to Primary Care Practitioners: Adolescents 12–19 Years | 93.0 | 81.8 | 11.2 |
| Other Access and Utilization | | | |
| Frequency of Prenatal Care Visits: <21% of Expected Visits | 19.1 | 2.4 | 16.7 |
| Frequency of Prenatal Care Visits: 21–40% of Expected Visits | 13.1 | 2.0 | 11.1 |
| Frequency of Prenatal Care Visits: 41–60% of Expected Visits | 14.0 | 3.9 | 10.1 |
| Frequency of Prenatal Care Visits: 61–80% of Expected Visits | 21.4 | 8.1 | 13.3 |
| Frequency of Prenatal Care Visits: ≥81% of Expected Visits | 82.7 | 39.4 | 43.3 |
| Prenatal and Postpartum Care: Timeliness of Prenatal Care | 93.3 | 72.0 | 21.3 |
| Prenatal and Postpartum Care: Postpartum Visit Between 21 and 56 Days After Delivery | 74.7 | 52.4 | 22.3 |

APPENDIX 3B: VARIATION IN PLAN PERFORMANCE: THE 90TH PERCENTILE VS. THE 10TH PERCENTILE: MEDICAID HMOS

| CAHPS MEMBER SATISFACTION MEASURES | | | |
|---|-----------------|-----------------|------------|
| MEDICAID HMO STATISTICS – 2011 | | | |
| MEASURE | 90TH PERCENTILE | 10TH PERCENTILE | DIFFERENCE |
| Consumer and Patient Engagement and Experience | | | |
| Rating of Health Plan: Rating of 8, 9 or 10 | 81.2 | 65.3 | 15.9 |
| Rating of Health Plan: Rating of 9 or 10 | 63.9 | 46.3 | 17.6 |
| Rating of Health Care: Rating of 8, 9 or 10 | 76.2 | 62.5 | 13.7 |
| Rating of Health Care: Rating of 9 or 10 | 56.4 | 42.3 | 14.1 |
| Getting Needed Care: Usually or Always | 84.4 | 65.5 | 18.9 |
| Getting Needed Care: Always | 59.0 | 42.4 | 16.6 |
| Getting Care Quickly: Usually or Always | 85.5 | 74.3 | 11.3 |
| Getting Care Quickly: Always | 63.1 | 49.9 | 13.2 |
| How Well Doctors Communicate: Usually or Always | 91.9 | 83.9 | 7.9 |
| How Well Doctors Communicate: Always | 75.9 | 62.8 | 13.1 |
| Rating of Personal Doctor: Rating of 8, 9 or 10 | 82.8 | 71.6 | 11.2 |
| Rating of Personal Doctor: Rating of 9 or 10 | 68.0 | 54.8 | 13.2 |
| Rating of Specialist: Rating of 8, 9 or 10 | 83.1 | 72.5 | 10.5 |
| Rating of Specialist: Rating of 9 or 10 | 67.8 | 56.0 | 11.8 |
| Customer Service: Usually or Always | 86.7 | 74.3 | 12.4 |
| Customer Service: Always | 68.2 | 53.2 | 15.0 |

APPENDIX 4A: VARIATION IN PLAN PERFORMANCE: THE 90TH PERCENTILE VS. THE 10TH PERCENTILE: MEDICARE HMOS

| HEDIS EFFECTIVENESS OF CARE AND UTILIZATION MEASURES MEDICARE HMO STATISTICS – 2011 | | | |
|---|--------------------|--------------------|------------|
| MEASURE | 90TH PERCENTILE | 10TH PERCENTILE | DIFFERENCE |
| Screening, Prevention and Wellness | | | |
| Adult BMI Assessment | 88.6 | 48.0 | 40.6 |
| Medical Assistance With Smoking and Tobacco Use Cessation: Advising Smokers and Tobacco Users to Quit | 89.2 | 72.7 | 16.4 |
| Flu Shots for Older Adults | 78.7 | 58.9 | 19.8 |
| Pneumonia Vaccine for Older Adults | 83.1 | 52.8 | 30.3 |
| Breast Cancer Screening | 80.6 | 56.8 | 23.8 |
| Colorectal Cancer Screening | 76.0 | 44.0 | 32.0 |
| Chronic Condition Management | | | |
| Persistence of Beta-Blocker Treatment After a Heart Attack | 94.3 | 80.0 | 14.3 |
| Comprehensive Diabetes Care: Blood Pressure Control (<140/80 mm Hg) | 63.0 | 34.8 | 28.2 |
| Comprehensive Diabetes Care: Blood Pressure Control (<140/90 mm Hg) | 76.6 | 49.0 | 27.7 |
| Comprehensive Diabetes Care: Eye Exams | 80.8 | 49.3 | 31.5 |
| Comprehensive Diabetes Care: HbA1c Screening | 95.6 | 85.8 | 9.8 |
| Comprehensive Diabetes Care: Good Glycemic Control (HbA1c <8%) | 79.5 | 48.0 | 31.5 |
| Comprehensive Diabetes Care: Poor Glycemic Control (HbA1c >9%)— Lower rates signify better performance | 11.7 | 45.5 | 33.8 |
| Comprehensive Diabetes Care: LDL Cholesterol Screening | 94.4 | 81.9 | 12.4 |
| Comprehensive Diabetes Care: LDL Cholesterol Control (<100 mg/dL) | 66.4 | 38.7 | 27.7 |
| Comprehensive Diabetes Care: Medical Attention for Nephropathy | 94.2 | 85.2 | 9.0 |
| Controlling High Blood Pressure | 75.5 | 50.2 | 25.4 |
| Cholesterol Management for Patients With Cardiovascular Conditions: LDL Cholesterol Screening | 94.9 | 82.2 | 12.7 |
| Cholesterol Management for Patients With Cardiovascular Conditions: LDL Control (<100 mg/dL) | 72.5 | 39.7 | 32.9 |
| Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis | 84.9 | 59.4 | 25.5 |
| Use of Spirometry Testing in the Assessment and Diagnosis of COPD | 51.4 | 23.5 | 27.9 |
| Pharmacotherapy Management of COPD: Bronchodilators | 87.5 | 67.4 | 20.0 |
| Pharmacotherapy Management of COPD: Systemic Corticosteroids | 77.0 | 55.9 | 21.1 |
| Annual Monitoring for Patients on Persistent Medications: ACE Inhibitors or ARBs | 95.2 | 87.4 | 7.8 |
| Annual Monitoring for Patients on Persistent Medications: Anticonvulsants | 79.5 | 54.2 | 25.3 |
| Annual Monitoring for Patients on Persistent Medications: Digoxin | 97.1 | 88.9 | 8.2 |
| Annual Monitoring for Patients on Persistent Medications: Diuretics | 95.5 | 87.8 | 7.6 |
| Annual Monitoring for Patients on Persistent Medications: Combined | 94.9 | 86.8 | 8.1 |

HEDIS EFFECTIVENESS OF CARE AND UTILIZATION MEASURES

MEDICARE HMO STATISTICS – 2011

| MEASURE | 90TH PERCENTILE | 10TH PERCENTILE | DIFFERENCE |
|--|-----------------|-----------------|------------|
| Antidepressant Medication Management: Acute Phase | 79.4 | 51.5 | 27.9 |
| Antidepressant Medication Management: Continuation Phase | 68.1 | 36.6 | 31.5 |
| Follow-Up After Hospitalization for Mental Illness: Within 7 Days Post-Discharge | 64.9 | 15.7 | 49.3 |
| Follow-Up After Hospitalization for Mental Illness: Within 30 Days Post-Discharge | 80.2 | 31.6 | 48.6 |
| Alcohol and Other Drug Dependence Treatment: Initiation | 58.5 | 20.9 | 37.6 |
| Alcohol and Other Drug Dependence Treatment: Engagement | 7.0 | 0.8 | 6.2 |
| Measures Targeted Toward Older Adults | | | |
| Fall Risk Management: Discussion | 45.1 | 25.4 | 19.7 |
| Fall Risk Management: Management | 71.0 | 51.8 | 19.1 |
| Potentially Harmful Drug-Disease Interactions in the Elderly: Chronic Renal Failure and NSAIDs or Cox-2 Selective NSAIDs— Lower rates signify better performance | 3.8 | 21.8 | 18.0 |
| Potentially Harmful Drug-Disease Interactions in the Elderly: Dementia and Tricyclic Antidepressants or Anticholinergic Agents— Lower rates signify better performance | 17.4 | 37.8 | 20.4 |
| Potentially Harmful Drug-Disease Interactions in the Elderly: Falls and Tricyclic Antidepressants, Antipsychotics and Sleep Agents— Lower rates signify better performance | 10.6 | 20.7 | 10.2 |
| Potentially Harmful Drug-Disease Interactions in the Elderly: Overall Rate— Lower rates signify better performance | 14.3 | 30.8 | 16.5 |
| Use of High-Risk Medications in the Elderly: At Least One Medication— Lower rates signify better performance | 11.0 | 27.7 | 16.7 |
| Use of High-Risk Medications in the Elderly: At Least Two Medications— Lower rates signify better performance | 1.1 | 7.1 | 6.0 |
| Management of Urinary Incontinence: Discussion | 64.5 | 51.3 | 13.1 |
| Physical Activity in Older Adults: Discussion | 61.1 | 45.6 | 15.5 |
| Physical Activity in Older Adults: Advice | 55.9 | 41.7 | 14.2 |
| Osteoporosis Testing in Older Women | 82.9 | 57.6 | 25.3 |
| Osteoporosis Management in Women Who Had a Fracture | 38.0 | 12.0 | 26.0 |
| Glaucoma Screening in Older Adults | 78.6 | 52.2 | 26.5 |
| Other Access and Utilization | | | |
| Plan All-Cause Readmissions: 65 Years And Older— Lower rates signify better performance* | 0.71 | 1.11 | 0.41 |

*This indicator is expressed as the ratio of the observed readmission rate to the expected (adjusted for case-mix) readmission rate. Ratios less than 1.0 indicate lower-than-expected readmission rates, whereas ratios greater than 1.0 indicate higher-than-expected readmission rates.

APPENDIX 4B: VARIATION IN PLAN PERFORMANCE: THE 90TH PERCENTILE VS. THE 10TH PERCENTILE: MEDICARE HMOS

| CAHPS MEMBER SATISFACTION MEASURES MEDICARE HMO STATISTICS – 2011 | | | |
|--|--------------------|--------------------|------------|
| MEASURE | 90TH PERCENTILE | 10TH PERCENTILE | DIFFERENCE |
| Consumer and Patient Engagement and Experience | | | |
| Rating of Health Plan: Rating of 8, 9 or 10 | 94.6 | 82.5 | 12.1 |
| Rating of Health Plan: Rating of 9 or 10 | 75.8 | 52.4 | 23.4 |
| Rating of Health Care: Rating of 8, 9 or 10 | 93.1 | 78.1 | 15.0 |
| Rating of Health Care: Rating of 9 or 10 | 70.5 | 50.2 | 20.3 |
| Getting Needed Care: Usually or Always | 95.3 | 81.3 | 14.0 |
| Getting Needed Care: Always | 72.5 | 54.1 | 18.5 |
| Getting Care Quickly: Usually or Always | 93.2 | 81.0 | 12.1 |
| Getting Care Quickly: Always | 72.9 | 57.9 | 15.0 |
| How Well Doctors Communicate: Usually or Always | 97.1 | 90.4 | 6.7 |
| How Well Doctors Communicate: Always | 81.3 | 70.3 | 11.0 |
| Rating of Personal Doctor: Rating of 8, 9 or 10 | 96.4 | 88.3 | 8.1 |
| Rating of Personal Doctor: Rating of 9 or 10 | 82.8 | 66.2 | 16.6 |
| Rating of Specialist: Rating of 8, 9 or 10 | 95.4 | 86.5 | 8.9 |
| Rating of Specialist: Rating of 9 or 10 | 79.2 | 59.6 | 19.6 |
| Customer Service: Usually or Always | 94.9 | 81.0 | 13.9 |
| Customer Service: Always | 80.1 | 59.0 | 21.1 |

APPENDIX 5A: VARIATION IN PLAN PERFORMANCE: THE 90TH PERCENTILE VS. THE 10TH PERCENTILE: MEDICARE PPOS

| HEDIS EFFECTIVENESS OF CARE AND UTILIZATION MEASURES MEDICARE PPO STATISTICS—2011 | | | |
|---|--------------------|--------------------|------------|
| MEASURE | 90TH PERCENTILE | 10TH PERCENTILE | DIFFERENCE |
| Screening, Prevention and Wellness | | | |
| Adult BMI Assessment | 81.3 | 44.2 | 37.1 |
| Medical Assistance With Smoking and Tobacco Use Cessation: Advising Smokers and Tobacco Users to Quit | 88.2 | 69.4 | 18.8 |
| Flu Shots for Older Adults | 77.2 | 61.8 | 15.3 |
| Pneumonia Vaccine for Older Adults | 79.3 | 65.0 | 14.3 |
| Breast Cancer Screening | 76.6 | 51.8 | 24.8 |
| Colorectal Cancer Screening | 69.8 | 40.6 | 29.3 |
| Chronic Condition Management | | | |
| Persistence of Beta-Blocker Treatment After a Heart Attack | 93.2 | 78.3 | 15.0 |
| Comprehensive Diabetes Care: Blood Pressure Control (<140/80 mm Hg) | 57.6 | 36.6 | 21.0 |
| Comprehensive Diabetes Care: Blood Pressure Control (<140/90 mm Hg) | 72.6 | 48.2 | 24.4 |
| Comprehensive Diabetes Care: Eye Exams | 78.1 | 49.2 | 28.9 |
| Comprehensive Diabetes Care: HbA1c Screening | 95.4 | 87.4 | 8.0 |
| Comprehensive Diabetes Care: Good Glycemic Control (HbA1c <8%) | 76.3 | 49.8 | 26.5 |
| Comprehensive Diabetes Care: Poor Glycemic Control (HbA1c >9%)— Lower rates signify better performance | 14.4 | 42.9 | 28.6 |
| Comprehensive Diabetes Care: LDL Cholesterol Screening | 92.9 | 79.8 | 13.1 |
| Comprehensive Diabetes Care: LDL Cholesterol Control (<100 mg/dL) | 62.2 | 38.2 | 24.0 |
| Comprehensive Diabetes Care: Medical Attention for Nephropathy | 91.7 | 83.7 | 8.0 |
| Controlling High Blood Pressure | 70.9 | 49.1 | 21.7 |
| Cholesterol Management for Patients With Cardiovascular Conditions: LDL Cholesterol Screening | 93.5 | 82.2 | 11.3 |
| Cholesterol Management for Patients With Cardiovascular Conditions: LDL Control (<100 mg/dL) | 70.5 | 42.0 | 28.5 |
| Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis | 85.3 | 68.2 | 17.1 |
| Use of Spirometry Testing in the Assessment and Diagnosis of COPD | 46.2 | 24.6 | 21.5 |
| Pharmacotherapy Management of COPD: Bronchodilators | 86.0 | 66.3 | 19.7 |
| Pharmacotherapy Management of COPD: Systemic Corticosteroids | 77.1 | 59.7 | 17.4 |
| Annual Monitoring for Patients on Persistent Medications: ACE Inhibitors or ARBs | 93.7 | 87.9 | 5.8 |
| Annual Monitoring for Patients on Persistent Medications: Anticonvulsants | 81.1 | 57.4 | 23.7 |
| Annual Monitoring for Patients on Persistent Medications: Digoxin | 97.2 | 89.3 | 8.0 |
| Annual Monitoring for Patients on Persistent Medications: Diuretics | 94.3 | 88.5 | 5.8 |
| Annual Monitoring for Patients on Persistent Medications: Combined | 93.5 | 87.6 | 6.0 |

HEDIS EFFECTIVENESS OF CARE AND UTILIZATION MEASURES MEDICARE PPO STATISTICS—2011

| MEASURE | 90TH PERCENTILE | 10TH PERCENTILE | DIFFERENCE |
|--|-----------------|-----------------|------------|
| Antidepressant Medication Management: Acute Phase | 82.1 | 58.7 | 23.4 |
| Antidepressant Medication Management: Continuation Phase | 69.1 | 47.8 | 21.3 |
| Follow-Up After Hospitalization for Mental Illness: Within 7 Days Post-Discharge | 53.1 | 25.8 | 27.3 |
| Follow-Up After Hospitalization for Mental Illness: Within 30 Days Post-Discharge | 73.9 | 45.1 | 28.8 |
| Alcohol and Other Drug Dependence Treatment: Initiation | 59.2 | 35.3 | 23.9 |
| Alcohol and Other Drug Dependence Treatment: Engagement | 6.7 | 1.0 | 5.7 |
| Measures Targeted Toward Older Adults | | | |
| Fall Risk Management: Discussion | 39.3 | 24.1 | 15.3 |
| Fall Risk Management: Management | 65.2 | 46.7 | 18.5 |
| Potentially Harmful Drug-Disease Interactions in the Elderly: Chronic Renal Failure and NSAIDs or Cox-2 Selective NSAIDs— Lower rates signify better performance | 4.7 | 18.2 | 13.5 |
| Potentially Harmful Drug-Disease Interactions in the Elderly: Dementia and Tricyclic Antidepressants or Anticholinergic Agents— Lower rates signify better performance | 16.9 | 34.9 | 17.9 |
| Potentially Harmful Drug-Disease Interactions in the Elderly: Falls and Tricyclic Antidepressants, Antipsychotics and Sleep Agents— Lower rates signify better performance | 10.5 | 20.6 | 10.1 |
| Potentially Harmful Drug-Disease Interactions in the Elderly: Overall Rate— Lower rates signify better performance | 14.5 | 27.7 | 13.2 |
| Use of High-Risk Medications in the Elderly: At Least One Medication— Lower rates signify better performance | 11.8 | 26.2 | 14.4 |
| Use of High-Risk Medications in the Elderly: At Least Two Medications— Lower rates signify better performance | 1.4 | 6.4 | 4.9 |
| Management of Urinary Incontinence: Discussion | 64.0 | 50.0 | 14.0 |
| Physical Activity in Older Adults: Discussion | 60.8 | 45.6 | 15.1 |
| Physical Activity in Older Adults: Advice | 53.0 | 39.8 | 13.2 |
| Osteoporosis Testing in Older Women | 84.4 | 63.4 | 21.0 |
| Osteoporosis Management in Women Who Had a Fracture | 27.7 | 12.8 | 14.8 |
| Glaucoma Screening in Older Adults | 79.0 | 55.9 | 23.0 |
| Other Access and Utilization | | | |
| Plan All-Cause Readmissions: 65 Years And Older— Lower rates signify better performance* | 0.63 | 1.05 | 0.41 |

*This indicator is expressed as the ratio of the observed readmission rate to the expected (adjusted for case-mix) readmission rate. Ratios less than 1.0 indicate lower-than-expected readmission rates, whereas ratios greater than 1.0 indicate higher-than-expected readmission rates.

APPENDIX 5B: VARIATION IN PLAN PERFORMANCE: THE 90TH PERCENTILE VS. THE 10TH PERCENTILE: MEDICARE PPOS

| CAHPS MEMBER SATISFACTION MEASURES MEDICARE PPO STATISTICS – 2011 | | | |
|--|--------------------|--------------------|------------|
| MEASURE | 90TH PERCENTILE | 10TH PERCENTILE | DIFFERENCE |
| Consumer and Patient Engagement and Experience | | | |
| Rating of Health Plan: Rating of 8, 9 or 10 | 92.7 | 83.2 | 9.5 |
| Rating of Health Plan: Rating of 9 or 10 | 67.4 | 51.3 | 16.2 |
| Rating of Health Care: Rating of 8, 9 or 10 | 92.5 | 84.8 | 7.7 |
| Rating of Health Care: Rating of 9 or 10 | 68.1 | 57.1 | 11.0 |
| Getting Needed Care: Usually or Always | 95.4 | 89.2 | 6.1 |
| Getting Needed Care: Always | 71.2 | 60.7 | 10.5 |
| Getting Care Quickly: Usually or Always | 93.5 | 84.3 | 9.2 |
| Getting Care Quickly: Always | 73.0 | 60.8 | 12.2 |
| How Well Doctors Communicate: Usually or Always | 97.3 | 93.1 | 4.1 |
| How Well Doctors Communicate: Always | 80.8 | 73.4 | 7.4 |
| Rating of Personal Doctor: Rating of 8, 9 or 10 | 96.4 | 91.2 | 5.1 |
| Rating of Personal Doctor: Rating of 9 or 10 | 79.9 | 71.9 | 8.0 |
| Rating of Specialist: Rating of 8, 9 or 10 | 95.5 | 89.6 | 5.9 |
| Rating of Specialist: Rating of 9 or 10 | 78.5 | 68.0 | 10.5 |
| Customer Service: Usually or Always | 94.7 | 82.6 | 12.1 |
| Customer Service: Always | 79.5 | 59.1 | 20.4 |

APPENDIX 6A: HEDIS EFFECTIVENESS OF CARE AND UTILIZATION MEASURES: 2011 NATIONAL HMO AVERAGES

| HEDIS EFFECTIVENESS OF CARE AND UTILIZATION MEASURES NATIONAL HMO AVERAGES—2011 | | | |
|---|------------|----------|----------|
| MEASURE | COMMERCIAL | MEDICARE | MEDICAID |
| Overuse and Appropriateness | | | |
| Imaging Studies for Low Back Pain | 74.4 | – | 75.8 |
| Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis | 23.5 | – | 24.3 |
| Screening, Prevention and Wellness | | | |
| Adult BMI Assessment | 55.4 | 68.2 | 52.6 |
| Medical Assistance With Smoking and Tobacco Use Cessation: Advising Smokers and Tobacco Users to Quit | 77.6 | 81.5 | 74.6 |
| Medical Assistance With Smoking and Tobacco Use Cessation: Discussing Cessation Strategies | 47.6 | – | 40.3 |
| Medical Assistance With Smoking and Tobacco Use Cessation: Discussing Cessation Medications | 53.1 | – | 44.3 |
| Flu Shots for Adults | 53.3 | – | – |
| Flu Shots for Older Adults | – | 68.8 | – |
| Pneumonia Vaccine for Older Adults | – | 69.4 | – |
| Breast Cancer Screening | 70.5 | 68.9 | 50.4 |
| Cervical Cancer Screening | 76.5 | – | 66.7 |
| Colorectal Cancer Screening | 62.4 | 60.0 | – |
| Chlamydia Screening in Women: 16–20 Years | 41.5 | – | 54.9 |
| Chlamydia Screening in Women: 21–24 Years | 48.4 | – | 63.4 |
| Chlamydia Screening in Women: Total Rate | 45.0 | – | 58.0 |
| Chronic Condition Management | | | |
| Aspirin Use and Discussion: Aspirin Use | 46.9 | – | – |
| Persistence of Beta-Blocker Treatment After a Heart Attack | 81.3 | 87.3 | 80.5 |
| Comprehensive Diabetes Care: Blood Pressure Control (<140/80 mm Hg) | 44.2 | 48.2 | 39.4 |
| Comprehensive Diabetes Care: Blood Pressure Control (<140/90 mm Hg) | 65.8 | 63.1 | 60.9 |
| Comprehensive Diabetes Care: Eye Exams | 56.9 | 66.0 | 53.3 |
| Comprehensive Diabetes Care: HbA1c Screening | 90.0 | 91.0 | 82.5 |
| Comprehensive Diabetes Care: Good Glycemic Control (HbA1c <7% for a Selected Population) | 42.2 | – | 35.4 |
| Comprehensive Diabetes Care: Good Glycemic Control (HbA1c <8%) | 61.2 | 65.2 | 48.1 |
| Comprehensive Diabetes Care: Poor Glycemic Control (HbA1c >9%)— Lower rates signify better performance | 28.3 | 26.5 | 43.0 |
| Comprehensive Diabetes Care: LDL Cholesterol Screening | 85.3 | 88.3 | 75.0 |
| Comprehensive Diabetes Care: LDL Cholesterol Control (<100 mg/dL) | 48.1 | 52.5 | 35.2 |
| Comprehensive Diabetes Care: Medical Attention for Nephropathy | 83.8 | 89.9 | 77.8 |

HEDIS EFFECTIVENESS OF CARE AND UTILIZATION MEASURES NATIONAL HMO AVERAGES – 2011

| MEASURE | COMMERCIAL | MEDICARE | MEDICAID |
|---|------------|----------|----------|
| Controlling High Blood Pressure | 65.4 | 64.0 | 56.8 |
| Cholesterol Management for Patients With Cardiovascular Conditions: LDL Cholesterol Screening | 88.1 | 88.8 | 82.0 |
| Cholesterol Management for Patients With Cardiovascular Conditions: LDL Control (<100 mg/dL) | 59.8 | 56.5 | 42.1 |
| Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis | 87.6 | 72.7 | 68.9 |
| Use of Appropriate Medications for People With Asthma: 5–11 Years | 96.0 | – | 90.5 |
| Use of Appropriate Medications for People With Asthma: 12–18 Years | 92.7 | – | 86.6 |
| Use of Appropriate Medications for People With Asthma: 19–50 Years | 89.1 | – | 74.7 |
| Use of Appropriate Medications for People With Asthma: 51–64 Years | 93.2 | – | 72.9 |
| Use of Appropriate Medications for People With Asthma: Overall Rate | 91.9 | – | 85.0 |
| Use of Spirometry Testing in the Assessment and Diagnosis of COPD | 42.9 | 36.3 | 32.0 |
| Pharmacotherapy Management of COPD: Bronchodilators | 79.9 | 78.4 | 80.4 |
| Pharmacotherapy Management of COPD: Systemic Corticosteroids | 71.3 | 66.8 | 64.1 |
| Annual Monitoring for Patients on Persistent Medications: ACE Inhibitors or ARBs | 82.5 | 91.3 | 85.9 |
| Annual Monitoring for Patients on Persistent Medications: Anticonvulsants | 60.5 | 67.4 | 65.2 |
| Annual Monitoring for Patients on Persistent Medications: Digoxin | 85.4 | 93.4 | 90.3 |
| Annual Monitoring for Patients on Persistent Medications: Diuretics | 82.1 | 91.6 | 85.4 |
| Annual Monitoring for Patients on Persistent Medications: Combined | 81.9 | 90.9 | 83.9 |
| Antidepressant Medication Management: Acute Phase | 65.6 | 66.3 | 51.1 |
| Antidepressant Medication Management: Continuation Phase | 49.4 | 53.3 | 34.4 |
| Follow-Up After Hospitalization for Mental Illness: Within 7 Days Post-Discharge | 58.9 | 38.0 | 46.5 |
| Follow-Up After Hospitalization for Mental Illness: Within 30 Days Post-Discharge | 76.5 | 56.1 | 65.0 |
| Alcohol and Other Drug Dependence Treatment: Initiation | 40.2 | 41.0 | 39.2 |
| Alcohol and Other Drug Dependence Treatment: Engagement | 15.2 | 3.7 | 11.9 |
| Measures Targeted Toward Children and Adolescents | | | |
| Appropriate Testing for Children With Pharyngitis | 80.2 | – | 66.7 |
| Appropriate Treatment for Children With Upper Respiratory Infection | 83.9 | – | 85.3 |
| Childhood Immunization Status: DTaP/DT | 86.5 | – | 79.8 |
| Childhood Immunization Status: Hepatitis B | 87.9 | – | 88.8 |
| Childhood Immunization Status: HiB | 94.1 | – | 91.0 |
| Childhood Immunization Status: IPV | 92.4 | – | 90.5 |
| Childhood Immunization Status: MMR | 91.5 | – | 90.9 |
| Childhood Immunization Status: Pneumococcal Conjugate (PCV) | 87.0 | – | 79.3 |

HEDIS EFFECTIVENESS OF CARE AND UTILIZATION MEASURES NATIONAL HMO AVERAGES—2011

| MEASURE | COMMERCIAL | MEDICARE | MEDICAID |
|---|------------|----------|----------|
| Childhood Immunization Status: VZV | 91.3 | – | 90.5 |
| Childhood Immunization Status: Hepatitis A | 39.0 | – | 39.2 |
| Childhood Immunization Status: Rotavirus | 75.1 | – | 62.4 |
| Childhood Immunization Status: Influenza | 61.1 | – | 44.8 |
| Childhood Immunization Status: Combination 2 (DTaP, IPV, MMR, HiB, Hepatitis B and VZV) | 78.0 | – | 74.5 |
| Childhood Immunization Status: Combination 3 (DTaP, IPV, MMR, HiB, Hepatitis B, VZV and PCV) | 75.7 | – | 70.6 |
| Childhood Immunization Status: Combination 10 (DTaP, IPV, MMR, HiB, Hepatitis A, Hepatitis B, VZV, PCV, Rotavirus and Influenza) | 22.9 | – | 17.3 |
| Immunizations for Adolescents: Meningococcal | 61.9 | – | 63.2 |
| Immunizations for Adolescents: Tdap/Td | 77.0 | – | 75.8 |
| Immunizations for Adolescents: Combination 1 (Meningococcal, Tdap/Td) | 59.4 | – | 60.5 |
| Follow-Up Care for Children Prescribed ADHD Medication: Initiation | 39.4 | – | 38.8 |
| Follow-Up Care for Children Prescribed ADHD Medication: Continuation | 44.2 | – | 45.9 |
| Lead Screening in Children | – | – | 67.8 |
| Weight Assessment and Counseling for Nutrition and Physical Activity in Children and Adolescents: BMI Percentile (3–17 Years) | 44.7 | – | 46.0 |
| Weight Assessment and Counseling for Nutrition and Physical Activity in Children and Adolescents: Counseling for Nutrition (3–17 Years) | 46.4 | – | 50.1 |
| Weight Assessment and Counseling for Nutrition and Physical Activity in Children and Adolescents: Counseling for Physical Activity (3–17 Years) | 43.0 | – | 40.6 |
| Well-Child Visits (Ages 0–15 Months): Six or More Well-Child Visits | 78.0 | – | 61.8 |
| Well-Child Visits (Ages 3–6 Years): One or More Well-Child Visits | 72.5 | – | 72.0 |
| Adolescent Well-Care Visits: At Least One Comprehensive Well-Care Visit | 43.2 | – | 49.7 |
| Children and Adolescents' Access to Primary Care Practitioners: Children 12–24 Months | 97.9 | – | 96.1 |
| Children and Adolescents' Access to Primary Care Practitioners: Children 25 Months–6 Years | 91.9 | – | 88.2 |
| Children and Adolescents' Access to Primary Care Practitioners: Children 7–11 Years | 91.9 | – | 89.5 |
| Children and Adolescents' Access to Primary Care Practitioners: Adolescents 12–19 Years | 89.3 | – | 87.9 |
| Measures Targeted Toward Older Adults | | | |
| Fall Risk Management: Discussion | – | 32.8 | – |
| Fall Risk Management: Management | – | 60.2 | – |
| Potentially Harmful Drug-Disease Interactions in the Elderly: Chronic Renal Failure and NSAIDs or Cox-2 Selective NSAIDs— Lower rates signify better performance | – | 11.7 | – |

HEDIS EFFECTIVENESS OF CARE AND UTILIZATION MEASURES

NATIONAL HMO AVERAGES—2011

| MEASURE | COMMERCIAL | MEDICARE | MEDICAID |
|--|------------|----------|----------|
| Potentially Harmful Drug-Disease Interactions in the Elderly: Dementia and Tricyclic Antidepressants or Anticholinergic Agents— Lower rates signify better performance | – | 27.0 | – |
| Potentially Harmful Drug-Disease Interactions in the Elderly: Falls and Tricyclic Antidepressants, Antipsychotics and Sleep Agents— Lower rates signify better performance | – | 15.6 | – |
| Potentially Harmful Drug-Disease Interactions in the Elderly: Overall Rate— Lower rates signify better performance | – | 21.7 | – |
| Use of High-Risk Medications in the Elderly: At Least One Medication— Lower rates signify better performance | – | 18.5 | – |
| Use of High-Risk Medications in the Elderly: At Least Two Medications— Lower rates signify better performance | – | 3.6 | – |
| Management of Urinary Incontinence: Discussion | – | 57.3 | – |
| Physical Activity in Older Adults: Discussion | – | 53.0 | – |
| Physical Activity in Older Adults: Advice | – | 48.7 | – |
| Osteoporosis Testing in Older Women | – | 71.0 | – |
| Osteoporosis Management in Women Who Had a Fracture | – | 22.8 | – |
| Glaucoma Screening in Older Adults | – | 65.8 | – |
| Other Access and Utilization | | | |
| Frequency of Prenatal Care Visits: <21% of Expected Visits | – | – | 10.0 |
| Frequency of Prenatal Care Visits: 21–40% of Expected Visits | – | – | 6.5 |
| Frequency of Prenatal Care Visits: 41–60% of Expected Visits | – | – | 8.2 |
| Frequency of Prenatal Care Visits: 61–80% of Expected Visits | – | – | 14.4 |
| Frequency of Prenatal Care Visits: ≥81% of Expected Visits | – | – | 60.9 |
| Prenatal and Postpartum Care: Timeliness of Prenatal Care | 91.0 | – | 82.7 |
| Prenatal and Postpartum Care: Postpartum Visit Between 21 and 56 Days After Delivery | 80.6 | – | 64.1 |
| Plan All-Cause Readmissions: 18–64 Years— Lower rates signify better performance* | 0.81 | – | – |
| Plan All-Cause Readmissions: 65 Years And Older— Lower rates signify better performance* | – | 0.91 | – |

*This indicator is expressed as the ratio of the observed readmission rate to the expected (adjusted for case-mix) readmission rate. Ratios less than 1.0 indicate lower-than-expected readmission rates, whereas ratios greater than 1.0 indicate higher-than-expected readmission rates.

APPENDIX 6B: CAHPS MEMBER SATISFACTION MEASURES: 2011 NATIONAL HMO AVERAGES

| CAHPS MEMBER SATISFACTION MEASURES NATIONAL HMO AVERAGES—2011 | | | |
|--|------------|----------|----------|
| MEASURE | COMMERCIAL | MEDICARE | MEDICAID |
| Consumer and Patient Engagement and Experience | | | |
| Rating of Health Plan: Rating of 8, 9 or 10 | 66.1 | 88.5 | 73.5 |
| Rating of Health Plan: Rating of 9 or 10 | 42.1 | 63.9 | 55.6 |
| Rating of Health Care: Rating of 8, 9 or 10 | 77.6 | 86.5 | 69.9 |
| Rating of Health Care: Rating of 9 or 10 | 51.9 | 60.9 | 49.7 |
| Getting Needed Care: Usually or Always | 85.5 | 89.4 | 75.5 |
| Getting Needed Care: Always | 54.1 | 64.1 | 50.4 |
| Getting Care Quickly: Usually or Always | 86.2 | 87.8 | 80.3 |
| Getting Care Quickly: Always | 58.7 | 65.6 | 57.2 |
| How Well Doctors Communicate: Usually or Always | 94.0 | 94.2 | 87.8 |
| How Well Doctors Communicate: Always | 74.2 | 76.3 | 70.0 |
| Rating of Personal Doctor: Rating of 8, 9 or 10 | 83.9 | 92.9 | 77.1 |
| Rating of Personal Doctor: Rating of 9 or 10 | 66.0 | 74.6 | 61.8 |
| Rating of Specialist: Rating of 8, 9 or 10 | 83.2 | 91.3 | 77.7 |
| Rating of Specialist: Rating of 9 or 10 | 65.2 | 70.5 | 62.1 |
| Customer Service: Usually or Always | 86.1 | 88.3 | 80.4 |
| Customer Service: Always | 62.1 | 68.9 | 60.9 |
| Claims Processing: Usually or Always | 89.0 | – | – |
| Claims Processing: Always | 56.2 | – | – |

APPENDIX 7A: HEDIS EFFECTIVENESS OF CARE AND UTILIZATION MEASURES: 2011 NATIONAL PPO AVERAGES

| HEDIS EFFECTIVENESS OF CARE AND UTILIZATION MEASURES NATIONAL PPO AVERAGES—2011 | | |
|---|------------|----------|
| MEASURE | COMMERCIAL | MEDICARE |
| Overuse and Appropriateness | | |
| Imaging Studies for Low Back Pain | 73.7 | – |
| Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis | 21.5 | – |
| Screening, Prevention and Wellness | | |
| Adult BMI Assessment | 26.3 | 62.2 |
| Medical Assistance With Smoking and Tobacco Use Cessation: Advising Smokers and Tobacco Users to Quit | 72.4 | 79.3 |
| Medical Assistance With Smoking and Tobacco Use Cessation: Discussing Cessation Strategies | 40.1 | – |
| Medical Assistance With Smoking and Tobacco Use Cessation: Discussing Cessation Medications | 47.9 | – |
| Flu Shots for Adults | 51.4 | – |
| Flu Shots for Older Adults | – | 69.5 |
| Pneumonia Vaccine for Older Adults | – | 71.7 |
| Breast Cancer Screening | 66.7 | 65.8 |
| Cervical Cancer Screening | 74.4 | – |
| Colorectal Cancer Screening | 54.6 | 55.2 |
| Chlamydia Screening in Women: 16–20 Years | 39.6 | – |
| Chlamydia Screening in Women: 21–24 Years | 44.9 | – |
| Chlamydia Screening in Women: Total Rate | 42.4 | – |
| Chronic Condition Management | | |
| Aspirin Use and Discussion: Aspirin Use | 48.6 | – |
| Persistence of Beta-Blocker Treatment After a Heart Attack | 77.0 | 86.2 |
| Comprehensive Diabetes Care: Blood Pressure Control (<140/80 mm Hg) | 38.1 | 46.5 |
| Comprehensive Diabetes Care: Blood Pressure Control (<140/90 mm Hg) | 59.4 | 60.3 |
| Comprehensive Diabetes Care: Eye Exams | 48.4 | 63.8 |
| Comprehensive Diabetes Care: HbA1c Screening | 87.0 | 91.1 |
| Comprehensive Diabetes Care: Good Glycemic Control (HbA1c <7% for a Selected Population) | 36.4 | – |
| Comprehensive Diabetes Care: Good Glycemic Control (HbA1c <8%) | 55.2 | 63.2 |
| Comprehensive Diabetes Care: Poor Glycemic Control (HbA1c >9%)— Lower rates signify better performance | 33.5 | 28.8 |
| Comprehensive Diabetes Care: LDL Cholesterol Screening | 81.2 | 86.7 |
| Comprehensive Diabetes Care: LDL Cholesterol Control (<100 mg/dL) | 41.8 | 50.9 |
| Comprehensive Diabetes Care: Medical Attention for Nephropathy | 77.9 | 88.1 |
| Controlling High Blood Pressure | 58.4 | 60.6 |
| Cholesterol Management for Patients With Cardiovascular Conditions: LDL Cholesterol Screening | 83.5 | 88.3 |

HEDIS EFFECTIVENESS OF CARE AND UTILIZATION MEASURES NATIONAL PPO AVERAGES – 2011

| MEASURE | COMMERCIAL | MEDICARE |
|--|------------|----------|
| Cholesterol Management for Patients With Cardiovascular Conditions: LDL Control (<100 mg/dL) | 50.1 | 56.6 |
| Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis | 86.7 | 77.2 |
| Use of Appropriate Medications for People With Asthma: 5–11 Years | 96.6 | – |
| Use of Appropriate Medications for People With Asthma: 12–18 Years | 93.1 | – |
| Use of Appropriate Medications for People With Asthma: 19–50 Years | 88.3 | – |
| Use of Appropriate Medications for People With Asthma: 51–64 Years | 93.0 | – |
| Use of Appropriate Medications for People With Asthma: Overall Rate | 91.6 | – |
| Use of Spirometry Testing in the Assessment and Diagnosis of COPD | 40.5 | 35.6 |
| Pharmacotherapy Management of COPD: Bronchodilators | 76.8 | 75.9 |
| Pharmacotherapy Management of COPD: Systemic Corticosteroids | 69.5 | 68.8 |
| Annual Monitoring for Patients on Persistent Medications: ACE Inhibitors or ARBs | 78.8 | 91.4 |
| Annual Monitoring for Patients on Persistent Medications: Anticonvulsants | 56.9 | 68.5 |
| Annual Monitoring for Patients on Persistent Medications: Digoxin | 79.2 | 93.2 |
| Annual Monitoring for Patients on Persistent Medications: Diuretics | 78.4 | 91.8 |
| Annual Monitoring for Patients on Persistent Medications: Combined | 78.2 | 91.2 |
| Antidepressant Medication Management: Acute Phase | 64.9 | 70.8 |
| Antidepressant Medication Management: Continuation Phase | 48.8 | 58.4 |
| Follow-Up After Hospitalization for Mental Illness: Within 7 Days Post-Discharge | 54.0 | 38.7 |
| Follow-Up After Hospitalization for Mental Illness: Within 30 Days Post-Discharge | 72.7 | 60.6 |
| Alcohol and Other Drug Dependence Treatment: Initiation | 40.6 | 47.6 |
| Alcohol and Other Drug Dependence Treatment: Engagement | 16.0 | 3.8 |
| Measures Targeted Toward Children and Adolescents | | |
| Appropriate Testing for Children With Pharyngitis | 79.3 | – |
| Appropriate Treatment for Children With Upper Respiratory Infection | 82.0 | – |
| Childhood Immunization Status: DTaP/DT | 76.8 | – |
| Childhood Immunization Status: Hepatitis B | 74.7 | – |
| Childhood Immunization Status: HiB | 86.1 | – |
| Childhood Immunization Status: IPV | 83.4 | – |
| Childhood Immunization Status: MMR | 86.9 | – |
| Childhood Immunization Status: Pneumococcal Conjugate (PCV) | 77.7 | – |
| Childhood Immunization Status: VZV | 86.9 | – |
| Childhood Immunization Status: Hepatitis A | 32.3 | – |
| Childhood Immunization Status: Rotavirus | 67.2 | – |

HEDIS EFFECTIVENESS OF CARE AND UTILIZATION MEASURES NATIONAL PPO AVERAGES – 2011

| MEASURE | COMMERCIAL | MEDICARE |
|--|------------|----------|
| Childhood Immunization Status: Influenza | 57.3 | – |
| Childhood Immunization Status: Combination 2 (DTaP, IPV, MMR, HiB, Hepatitis B and VZV) | 64.8 | – |
| Childhood Immunization Status: Combination 3 (DTaP, IPV, MMR, HiB, Hepatitis B, VZV and PCV) | 63.1 | – |
| Childhood Immunization Status: Combination 10 (DTaP, IPV, MMR, HiB, Hepatitis A, Hepatitis B, VZV, PCV, Rotavirus and Influenza) | 17.0 | – |
| Immunizations for Adolescents: Meningococcal | 51.4 | – |
| Immunizations for Adolescents: Tdap/Td | 65.4 | – |
| Immunizations for Adolescents: Combination 1 (Meningococcal, Tdap/Td) | 48.2 | – |
| Follow-Up Care for Children Prescribed ADHD Medication: Initiation | 39.4 | – |
| Follow-Up Care for Children Prescribed ADHD Medication: Continuation | 44.9 | – |
| Lead Screening in Children | – | – |
| Weight Assessment and Counseling for Nutrition and Physical Activity in Children and Adolescents: BMI Percentile (3–17 Years) | 24.6 | – |
| Weight Assessment and Counseling for Nutrition and Physical Activity in Children and Adolescents: Counseling for Nutrition (3–17 Years) | 28.4 | – |
| Weight Assessment and Counseling for Nutrition and Physical Activity in Children and Adolescents: Counseling for Physical Activity (3–17 Years) | 25.7 | – |
| Well-Child Visits (Ages 0–15 Months): Six or More Well-Child Visits | 76.1 | – |
| Well-Child Visits (Ages 3–6 Years): One or More Well-Child Visits | 69.8 | – |
| Adolescent Well-Care Visits: At Least One Comprehensive Well-Care Visit | 40.6 | – |
| Children and Adolescents' Access to Primary Care Practitioners: Children 12–24 Months | 97.2 | – |
| Children and Adolescents' Access to Primary Care Practitioners: Children 25 Months–6 Years | 90.3 | – |
| Children and Adolescents' Access to Primary Care Practitioners: Children 7–11 Years | 90.1 | – |
| Children and Adolescents' Access to Primary Care Practitioners: Adolescents 12–19 Years | 87.3 | – |
| Measures Targeted Toward Older Adults | | |
| Fall Risk Management: Discussion | – | 30.7 |
| Fall Risk Management: Management | – | 54.6 |
| Potentially Harmful Drug-Disease Interactions in the Elderly: Chronic Renal Failure and NSAIDs or Cox-2 Selective NSAIDs— Lower rates signify better performance | – | 10.0 |
| Potentially Harmful Drug-Disease Interactions in the Elderly: Dementia and Tricyclic Antidepressants or Anticholinergic Agents— Lower rates signify better performance | – | 25.6 |
| Potentially Harmful Drug-Disease Interactions in the Elderly: Falls and Tricyclic Antidepressants, Antipsychotics and Sleep Agents— Lower rates signify better performance | – | 15.3 |

HEDIS EFFECTIVENESS OF CARE AND UTILIZATION MEASURES NATIONAL PPO AVERAGES—2011

| MEASURE | COMMERCIAL | MEDICARE |
|---|------------|----------|
| Potentially Harmful Drug-Disease Interactions in the Elderly: Overall Rate— Lower rates signify better performance | – | 20.6 |
| Use of High-Risk Medications in the Elderly: At Least One Medication— Lower rates signify better performance | – | 18.5 |
| Use of High-Risk Medications in the Elderly: At Least Two Medications— Lower rates signify better performance | – | 3.5 |
| Management of Urinary Incontinence: Discussion | – | 56.9 |
| Physical Activity in Older Adults: Discussion | – | 53.7 |
| Physical Activity in Older Adults: Advice | – | 47.6 |
| Osteoporosis Testing in Older Women | – | 75.0 |
| Osteoporosis Management in Women Who Had a Fracture | – | 19.3 |
| Glaucoma Screening in Older Adults | – | 66.6 |
| Other Access and Utilization | | |
| Prenatal and Postpartum Care: Timeliness of Prenatal Care | 81.9 | – |
| Prenatal and Postpartum Care: Postpartum Visit Between 21 and 56 Days After Delivery | 71.3 | – |
| Plan All-Cause Readmissions: 18–64 Years— Lower rates signify better performance* | 0.80 | – |
| Plan All-Cause Readmissions: 65 Years And Older— Lower rates signify better performance* | – | 0.88 |

*This indicator is expressed as the ratio of the observed readmission rate to the expected (adjusted for case-mix) readmission rate. Ratios less than 1.0 indicate lower-than-expected readmission rates, whereas ratios greater than 1.0 indicate higher-than-expected readmission rates.

APPENDIX 7B: CAHPS MEMBER SATISFACTION MEASURES: 2011 NATIONAL PPO AVERAGES

| CAHPS MEMBER SATISFACTION MEASURES NATIONAL PPO AVERAGES—2011 | | |
|--|------------|----------|
| MEASURE | COMMERCIAL | MEDICARE |
| Consumer and Patient Engagement and Experience | | |
| Rating of Health Plan: Rating of 8, 9 or 10 | 58.4 | 87.7 |
| Rating of Health Plan: Rating of 9 or 10 | 33.9 | 58.5 |
| Rating of Health Care: Rating of 8, 9 or 10 | 76.2 | 89.3 |
| Rating of Health Care: Rating of 9 or 10 | 49.0 | 62.6 |
| Getting Needed Care: Usually or Always | 86.2 | 92.6 |
| Getting Needed Care: Always | 53.8 | 66.6 |
| Getting Care Quickly: Usually or Always | 87.0 | 90.1 |
| Getting Care Quickly: Always | 58.0 | 67.5 |
| How Well Doctors Communicate: Usually or Always | 94.6 | 95.5 |
| How Well Doctors Communicate: Always | 73.8 | 77.3 |
| Rating of Personal Doctor: Rating of 8, 9 or 10 | 83.2 | 94.1 |
| Rating of Personal Doctor: Rating of 9 or 10 | 63.7 | 76.1 |
| Rating of Specialist: Rating of 8, 9 or 10 | 82.1 | 92.7 |
| Rating of Specialist: Rating of 9 or 10 | 62.7 | 73.6 |
| Customer Service: Usually or Always | 82.2 | 88.5 |
| Customer Service: Always | 54.8 | 68.3 |
| Claims Processing: Usually or Always | 87.8 | – |
| Claims Processing: Always | 50.5 | – |

APPENDIX 8A: ACCREDITED VS. NONACCREDITED PLANS: 2011 COMMERCIAL HMO AVERAGES

| HEDIS EFFECTIVENESS OF CARE AND UTILIZATION MEASURES ACCREDITED VS. NONACCREDITED PLANS: COMMERCIAL HMO AVERAGES – 2011 | | | |
|--|------------|---------------|------------|
| MEASURE | ACCREDITED | NONACCREDITED | DIFFERENCE |
| Overuse and Appropriateness | | | |
| Imaging Studies for Low Back Pain | 74.6 | 73.5 | 1.1 |
| Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis | 23.9 | 21.9 | 2.0 |
| Screening, Prevention and Wellness | | | |
| Adult BMI Assessment | 55.6 | 54.8 | 0.8 |
| Medical Assistance With Smoking and Tobacco Use Cessation: Advising Smokers and Tobacco Users to Quit | 78.5 | 74.6 | 3.9 |
| Medical Assistance With Smoking and Tobacco Use Cessation: Discussing Cessation Strategies | 48.2 | 45.0 | 3.2 |
| Medical Assistance With Smoking and Tobacco Use Cessation: Discussing Cessation Medications | 53.7 | 50.8 | 2.9 |
| Flu Shots for Adults | 53.0 | 54.7 | -1.7 |
| Breast Cancer Screening | 71.2 | 68.1 | 3.0 |
| Cervical Cancer Screening | 77.5 | 72.8 | 4.7 |
| Colorectal Cancer Screening | 63.4 | 58.7 | 4.7 |
| Chlamydia Screening in Women: 16–20 Years | 43.1 | 35.1 | 8.0 |
| Chlamydia Screening in Women: 21–24 Years | 50.2 | 41.1 | 9.1 |
| Chlamydia Screening in Women: Total Rate | 46.8 | 38.1 | 8.7 |
| Chronic Condition Management | | | |
| Aspirin Use and Discussion: Aspirin Use | 46.5 | 49.5 | -3.0 |
| Persistence of Beta-Blocker Treatment After a Heart Attack | 81.5 | 80.5 | 1.0 |
| Comprehensive Diabetes Care: Blood Pressure Control (<140/80 mm Hg) | 44.9 | 41.6 | 3.3 |
| Comprehensive Diabetes Care: Blood Pressure Control (<140/90 mm Hg) | 66.9 | 61.8 | 5.2 |
| Comprehensive Diabetes Care: Eye Exams | 58.1 | 52.2 | 5.9 |
| Comprehensive Diabetes Care: HbA1c Screening | 90.2 | 89.2 | 1.0 |
| Comprehensive Diabetes Care: Good Glycemic Control (HbA1c <7% for a Selected Population) | 43.3 | 37.7 | 5.6 |
| Comprehensive Diabetes Care: Good Glycemic Control (HbA1c <8%) | 62.4 | 57.1 | 5.3 |
| Comprehensive Diabetes Care: Poor Glycemic Control (HbA1c >9%)— Lower rates signify better performance | 27.2 | 32.3 | 5.1 |
| Comprehensive Diabetes Care: LDL Cholesterol Screening | 85.7 | 84.0 | 1.7 |
| Comprehensive Diabetes Care: LDL Cholesterol Control (<100 mg/dL) | 49.2 | 44.2 | 5.0 |
| Comprehensive Diabetes Care: Medical Attention for Nephropathy | 84.3 | 82.3 | 2.0 |
| Controlling High Blood Pressure | 66.7 | 60.6 | 6.1 |

HEDIS EFFECTIVENESS OF CARE AND UTILIZATION MEASURES ACCREDITED VS. NONACCREDITED PLANS: COMMERCIAL HMO AVERAGES – 2011

| MEASURE | ACCREDITED | NONACCREDITED | DIFFERENCE |
|---|------------|---------------|------------|
| Cholesterol Management for Patients With Cardiovascular Conditions: LDL Cholesterol Screening | 88.6 | 86.5 | 2.0 |
| Cholesterol Management for Patients With Cardiovascular Conditions: LDL Control (<100 mg/dL) | 61.3 | 54.6 | 6.7 |
| Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis | 87.8 | 87.0 | 0.8 |
| Use of Appropriate Medications for People With Asthma: 5–11 Years | 96.4 | 94.4 | 2.1 |
| Use of Appropriate Medications for People With Asthma: 12–18 Years | 92.8 | 92.1 | 0.7 |
| Use of Appropriate Medications for People With Asthma: 19–50 Years | 89.4 | 88.2 | 1.2 |
| Use of Appropriate Medications for People With Asthma: 51–64 Years | 93.0 | 94.1 | -1.1 |
| Use of Appropriate Medications for People With Asthma: Overall Rate | 92.3 | 90.7 | 1.6 |
| Use of Spirometry Testing in the Assessment and Diagnosis of COPD | 43.9 | 38.9 | 5.0 |
| Pharmacotherapy Management of COPD: Bronchodilators | 80.3 | 77.7 | 2.6 |
| Pharmacotherapy Management of COPD: Systemic Corticosteroids | 71.6 | 69.6 | 2.0 |
| Annual Monitoring for Patients on Persistent Medications: ACE Inhibitors or ARBs | 82.5 | 82.4 | 0.1 |
| Annual Monitoring for Patients on Persistent Medications: Anticonvulsants | 60.1 | 61.8 | -1.7 |
| Annual Monitoring for Patients on Persistent Medications: Digoxin | 85.0 | 87.2 | -2.2 |
| Annual Monitoring for Patients on Persistent Medications: Diuretics | 82.0 | 82.3 | -0.3 |
| Annual Monitoring for Patients on Persistent Medications: Combined | 81.9 | 82.0 | -0.1 |
| Antidepressant Medication Management: Acute Phase | 65.7 | 65.1 | 0.6 |
| Antidepressant Medication Management: Continuation Phase | 49.5 | 49.2 | 0.3 |
| Follow-Up After Hospitalization for Mental Illness: Within 7 Days Post-Discharge | 60.2 | 53.0 | 7.2 |
| Follow-Up After Hospitalization for Mental Illness: Within 30 Days Post-Discharge | 77.3 | 73.0 | 4.3 |
| Alcohol and Other Drug Dependence Treatment: Initiation | 40.2 | 39.8 | 0.4 |
| Alcohol and Other Drug Dependence Treatment: Engagement | 15.5 | 13.9 | 1.6 |
| Measures Targeted Toward Children and Adolescents | | | |
| Appropriate Testing for Children With Pharyngitis | 81.7 | 74.3 | 7.4 |
| Appropriate Treatment for Children With Upper Respiratory Infection | 85.3 | 78.7 | 6.5 |
| Childhood Immunization Status: DTaP/DT | 87.6 | 82.4 | 5.3 |
| Childhood Immunization Status: Hepatitis B | 89.5 | 82.0 | 7.5 |
| Childhood Immunization Status: HiB | 94.8 | 91.7 | 3.0 |
| Childhood Immunization Status: IPV | 93.2 | 89.6 | 3.6 |
| Childhood Immunization Status: MMR | 91.9 | 90.1 | 1.7 |
| Childhood Immunization Status: Pneumococcal Conjugate (PCV) | 88.1 | 83.0 | 5.1 |
| Childhood Immunization Status: VZV | 91.8 | 89.5 | 2.3 |

| HEDIS EFFECTIVENESS OF CARE AND UTILIZATION MEASURES | | | |
|---|-------------------|----------------------|-------------------|
| ACCREDITED VS. NONACCREDITED PLANS: COMMERCIAL HMO AVERAGES – 2011 | | | |
| MEASURE | ACCREDITED | NONACCREDITED | DIFFERENCE |
| Childhood Immunization Status: Hepatitis A | 38.7 | 40.1 | -1.5 |
| Childhood Immunization Status: Rotavirus | 75.7 | 72.7 | 3.0 |
| Childhood Immunization Status: Influenza | 61.9 | 58.4 | 3.4 |
| Childhood Immunization Status: Combination 2 (DTaP, IPV, MMR, HiB, Hepatitis B and VZV) | 79.5 | 72.1 | 7.5 |
| Childhood Immunization Status: Combination 3 (DTaP, IPV, MMR, HiB, Hepatitis B, VZV and PCV) | 77.4 | 69.2 | 8.3 |
| Childhood Immunization Status: Combination 10 (DTaP, IPV, MMR, HiB, Hepatitis A, Hepatitis B, VZV, PCV, Rotavirus and Influenza) | 23.4 | 21.3 | 2.0 |
| Immunizations for Adolescents: Meningococcal | 62.3 | 60.0 | 2.4 |
| Immunizations for Adolescents: Tdap/Td | 77.1 | 76.3 | 0.8 |
| Immunizations for Adolescents: Combination 1 (Meningococcal, Tdap/Td) | 59.8 | 57.6 | 2.2 |
| Follow-Up Care for Children Prescribed ADHD Medication: Initiation | 39.9 | 37.0 | 2.9 |
| Follow-Up Care for Children Prescribed ADHD Medication: Continuation | 44.3 | 43.5 | 0.8 |
| Weight Assessment and Counseling for Nutrition and Physical Activity in Children and Adolescents: BMI Percentile (3–17 Years) | 46.0 | 40.1 | 5.9 |
| Weight Assessment and Counseling for Nutrition and Physical Activity in Children and Adolescents: Counseling for Nutrition (3–17 Years) | 47.8 | 41.0 | 6.8 |
| Weight Assessment and Counseling for Nutrition and Physical Activity in Children and Adolescents: Counseling for Physical Activity (3–17 Years) | 44.1 | 38.8 | 5.3 |
| Well-Child Visits (Ages 0–15 Months): Six or More Well-Child Visits | 79.5 | 72.3 | 7.2 |
| Well-Child Visits (Ages 3–6 Years): One or More Well-Child Visits | 74.4 | 64.8 | 9.6 |
| Adolescent Well-Care Visits: At Least One Comprehensive Well-Care Visit | 45.0 | 36.5 | 8.4 |
| Children and Adolescents' Access to Primary Care Practitioners: Children 12–24 Months | 98.0 | 97.3 | 0.8 |
| Children and Adolescents' Access to Primary Care Practitioners: Children 25 Months–6 Years | 92.4 | 89.8 | 2.5 |
| Children and Adolescents' Access to Primary Care Practitioners: Children 7–11 Years | 92.4 | 89.7 | 2.8 |
| Children and Adolescents' Access to Primary Care Practitioners: Adolescents 12–19 Years | 89.8 | 87.4 | 2.4 |
| Other Access and Utilization | | | |
| Prenatal and Postpartum Care: Timeliness of Prenatal Care | 92.2 | 86.0 | 6.2 |
| Prenatal and Postpartum Care: Postpartum Visit Between 21 and 56 Days After Delivery | 81.8 | 75.4 | 6.5 |
| Plan All-Cause Readmissions: 18–64 Years — Lower rates signify better performance* | 0.81 | 0.81 | 0.00 |

*This indicator is expressed as the ratio of the observed readmission rate to the expected (adjusted for case-mix) readmission rate. Ratios less than 1.0 indicate lower-than-expected readmission rates, whereas ratios greater than 1.0 indicate higher-than-expected readmission rates.

APPENDIX 8B: ACCREDITED VS. NONACCREDITED PLANS: 2011 COMMERCIAL HMO AVERAGES

| CAHPS MEMBER SATISFACTION MEASURES | | | |
|--|------------|---------------|------------|
| ACCREDITED VS. NONACCREDITED PLANS: COMMERCIAL HMO AVERAGES—2011 | | | |
| MEASURE | ACCREDITED | NONACCREDITED | DIFFERENCE |
| Consumer and Patient Engagement and Experience | | | |
| Rating of Health Plan: Rating of 8, 9 or 10 | 66.2 | 65.6 | 0.7 |
| Rating of Health Plan: Rating of 9 or 10 | 42.0 | 42.5 | -0.5 |
| Rating of Health Care: Rating of 8, 9 or 10 | 77.5 | 78.1 | -0.6 |
| Rating of Health Care: Rating of 9 or 10 | 51.6 | 53.1 | -1.5 |
| Getting Needed Care: Usually or Always | 85.9 | 84.0 | 1.9 |
| Getting Needed Care: Always | 54.4 | 52.6 | 1.8 |
| Getting Care Quickly: Usually or Always | 86.3 | 85.7 | 0.6 |
| Getting Care Quickly: Always | 58.8 | 58.4 | 0.5 |
| How Well Doctors Communicate: Usually or Always | 93.9 | 94.5 | -0.5 |
| How Well Doctors Communicate: Always | 74.1 | 74.6 | -0.6 |
| Rating of Personal Doctor: Rating of 8, 9 or 10 | 83.6 | 84.9 | -1.2 |
| Rating of Personal Doctor: Rating of 9 or 10 | 65.6 | 67.6 | -2.0 |
| Rating of Specialist: Rating of 8, 9 or 10 | 83.3 | 82.9 | 0.4 |
| Rating of Specialist: Rating of 9 or 10 | 65.1 | 65.6 | -0.5 |
| Customer Service: Usually or Always | 86.0 | 86.7 | -0.7 |
| Customer Service: Always | 61.4 | 65.9 | -4.5 |
| Claims Processing: Usually or Always | 89.0 | 89.0 | 0.1 |
| Claims Processing: Always | 56.0 | 57.0 | -1.0 |

APPENDIX 9A: ACCREDITED VS. NONACCREDITED PLANS: 2011 COMMERCIAL PPO AVERAGES

| HEDIS EFFECTIVENESS OF CARE AND UTILIZATION MEASURES ACCREDITED VS. NONACCREDITED PLANS: COMMERCIAL PPO AVERAGES—2011 | | | |
|--|------------|---------------|------------|
| MEASURE | ACCREDITED | NONACCREDITED | DIFFERENCE |
| Overuse and Appropriateness | | | |
| Imaging Studies for Low Back Pain | 73.5 | 75.6 | -2.1 |
| Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis | 21.2 | 23.6 | -2.4 |
| Screening, Prevention and Wellness | | | |
| Adult BMI Assessment | 24.8 | 36.4 | -11.5 |
| Medical Assistance With Smoking and Tobacco Use Cessation: Advising Smokers and Tobacco Users to Quit | 72.3 | 74.2 | -1.9 |
| Medical Assistance With Smoking and Tobacco Use Cessation: Discussing Cessation Strategies | 39.9 | 42.3 | -2.4 |
| Medical Assistance With Smoking and Tobacco Use Cessation: Discussing Cessation Medications | 47.8 | 50.4 | -2.6 |
| Flu Shots for Adults | 52.2 | 45.6 | 6.5 |
| Breast Cancer Screening | 66.8 | 65.6 | 1.3 |
| Cervical Cancer Screening | 74.5 | 73.8 | 0.7 |
| Colorectal Cancer Screening | 55.2 | 50.5 | 4.7 |
| Chlamydia Screening in Women: 16–20 Years | 39.9 | 37.5 | 2.4 |
| Chlamydia Screening in Women: 21–24 Years | 45.2 | 42.8 | 2.4 |
| Chlamydia Screening in Women: Total Rate | 42.7 | 40.4 | 2.2 |
| Chronic Condition Management | | | |
| Aspirin Use and Discussion: Aspirin Use | 48.5 | 49.4 | -0.9 |
| Persistence of Beta-Blocker Treatment After a Heart Attack | 77.1 | 76.7 | 0.4 |
| Comprehensive Diabetes Care: Blood Pressure Control (<140/80 mm Hg) | 39.1 | 33.1 | 5.9 |
| Comprehensive Diabetes Care: Blood Pressure Control (<140/90 mm Hg) | 60.9 | 51.3 | 9.5 |
| Comprehensive Diabetes Care: Eye Exams | 48.4 | 48.6 | -0.1 |
| Comprehensive Diabetes Care: HbA1c Screening | 87.3 | 85.1 | 2.2 |
| Comprehensive Diabetes Care: Good Glycemic Control (HbA1c <7% for a Selected Population) | 37.0 | 34.1 | 2.9 |
| Comprehensive Diabetes Care: Good Glycemic Control (HbA1c <8%) | 56.1 | 50.6 | 5.4 |
| Comprehensive Diabetes Care: Poor Glycemic Control (HbA1c >9%)— Lower rates signify better performance | 32.0 | 42.3 | 10.3 |
| Comprehensive Diabetes Care: LDL Cholesterol Screening | 81.5 | 79.5 | 2.0 |
| Comprehensive Diabetes Care: LDL Cholesterol Control (<100 mg/dL) | 42.6 | 37.0 | 5.6 |
| Comprehensive Diabetes Care: Medical Attention for Nephropathy | 77.9 | 77.4 | 0.5 |
| Controlling High Blood Pressure | 59.3 | 52.4 | 6.9 |

HEDIS EFFECTIVENESS OF CARE AND UTILIZATION MEASURES ACCREDITED VS. NONACCREDITED PLANS: COMMERCIAL PPO AVERAGES – 2011

| MEASURE | ACCREDITED | NONACCREDITED | DIFFERENCE |
|---|------------|---------------|------------|
| Cholesterol Management for Patients With Cardiovascular Conditions: LDL Cholesterol Screening | 83.6 | 82.9 | 0.7 |
| Cholesterol Management for Patients With Cardiovascular Conditions: LDL Control (<100 mg/dL) | 50.8 | 46.0 | 4.9 |
| Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis | 86.8 | 86.2 | 0.5 |
| Use of Appropriate Medications for People With Asthma: 5–11 Years | 96.6 | 96.3 | 0.3 |
| Use of Appropriate Medications for People With Asthma: 12–18 Years | 93.2 | 92.4 | 0.8 |
| Use of Appropriate Medications for People With Asthma: 19–50 Years | 88.4 | 87.9 | 0.5 |
| Use of Appropriate Medications for People With Asthma: 51–64 Years | 93.1 | 91.8 | 1.4 |
| Use of Appropriate Medications for People With Asthma: Overall Rate | 91.7 | 90.5 | 1.3 |
| Use of Spirometry Testing in the Assessment and Diagnosis of COPD | 40.4 | 41.2 | -0.8 |
| Pharmacotherapy Management of COPD: Bronchodilators | 76.9 | 76.2 | 0.7 |
| Pharmacotherapy Management of COPD: Systemic Corticosteroids | 69.8 | 67.6 | 2.2 |
| Annual Monitoring for Patients on Persistent Medications: ACE Inhibitors or ARBs | 78.8 | 78.8 | 0.0 |
| Annual Monitoring for Patients on Persistent Medications: Anticonvulsants | 56.8 | 57.2 | -0.4 |
| Annual Monitoring for Patients on Persistent Medications: Digoxin | 78.9 | 81.5 | -2.6 |
| Annual Monitoring for Patients on Persistent Medications: Diuretics | 78.4 | 78.4 | 0.0 |
| Annual Monitoring for Patients on Persistent Medications: Combined | 78.2 | 78.2 | -0.1 |
| Antidepressant Medication Management: Acute Phase | 64.6 | 67.3 | -2.7 |
| Antidepressant Medication Management: Continuation Phase | 48.4 | 51.9 | -3.5 |
| Follow-Up After Hospitalization for Mental Illness: Within 7 Days Post-Discharge | 54.1 | 53.2 | 0.9 |
| Follow-Up After Hospitalization for Mental Illness: Within 30 Days Post-Discharge | 72.8 | 71.6 | 1.1 |
| Alcohol and Other Drug Dependence Treatment: Initiation | 40.6 | 40.3 | 0.3 |
| Alcohol and Other Drug Dependence Treatment: Engagement | 16.3 | 14.1 | 2.2 |
| Measures Targeted Toward Children and Adolescents | | | |
| Appropriate Testing for Children With Pharyngitis | 79.4 | 78.5 | 0.9 |
| Appropriate Treatment for Children With Upper Respiratory Infection | 81.8 | 83.9 | -2.2 |
| Childhood Immunization Status: DTaP/DT | 77.2 | 73.8 | 3.4 |
| Childhood Immunization Status: Hepatitis B | 74.9 | 73.1 | 1.8 |
| Childhood Immunization Status: HiB | 86.4 | 83.9 | 2.5 |
| Childhood Immunization Status: IPV | 83.7 | 81.1 | 2.6 |
| Childhood Immunization Status: MMR | 87.3 | 83.7 | 3.7 |
| Childhood Immunization Status: Pneumococcal Conjugate (PCV) | 78.4 | 73.7 | 4.6 |
| Childhood Immunization Status: VZV | 87.4 | 83.6 | 3.8 |
| Childhood Immunization Status: Hepatitis A | 33.0 | 28.2 | 4.8 |

| HEDIS EFFECTIVENESS OF CARE AND UTILIZATION MEASURES ACCREDITED VS. NONACCREDITED PLANS: COMMERCIAL PPO AVERAGES—2011 | | | |
|---|-------------------|----------------------|-------------------|
| MEASURE | ACCREDITED | NONACCREDITED | DIFFERENCE |
| Childhood Immunization Status: Rotavirus | 68.0 | 62.5 | 5.6 |
| Childhood Immunization Status: Influenza | 58.5 | 50.3 | 8.2 |
| Childhood Immunization Status: Combination 2 (DTaP, IPV, MMR, HiB, Hepatitis B and VZV) | 65.3 | 61.5 | 3.8 |
| Childhood Immunization Status: Combination 3 (DTaP, IPV, MMR, HiB, Hepatitis B, VZV and PCV) | 63.8 | 58.5 | 5.3 |
| Childhood Immunization Status: Combination 10 (DTaP, IPV, MMR, HiB, Hepatitis A, Hepatitis B, VZV, PCV, Rotavirus and Influenza) | 17.7 | 13.3 | 4.4 |
| Immunizations for Adolescents: Meningococcal | 51.8 | 48.8 | 3.0 |
| Immunizations for Adolescents: Tdap/Td | 65.4 | 64.9 | 0.6 |
| Immunizations for Adolescents: Combination 1 (Meningococcal, Tdap/Td) | 48.6 | 45.5 | 3.0 |
| Follow-Up Care for Children Prescribed ADHD Medication: Initiation | 39.7 | 37.1 | 2.6 |
| Follow-Up Care for Children Prescribed ADHD Medication: Continuation | 44.9 | 45.0 | -0.1 |
| Weight Assessment and Counseling for Nutrition and Physical Activity in Children and Adolescents: BMI Percentile (3–17 Years) | 23.7 | 29.9 | -6.2 |
| Weight Assessment and Counseling for Nutrition and Physical Activity in Children and Adolescents: Counseling for Nutrition (3–17 Years) | 27.4 | 33.8 | -6.3 |
| Weight Assessment and Counseling for Nutrition and Physical Activity in Children and Adolescents: Counseling for Physical Activity (3–17 Years) | 24.9 | 30.3 | -5.4 |
| Well-Child Visits (Ages 0–15 Months): Six or More Well-Child Visits | 77.1 | 68.9 | 8.2 |
| Well-Child Visits (Ages 3–6 Years): One or More Well-Child Visits | 70.1 | 67.4 | 2.7 |
| Adolescent Well-Care Visits: At Least One Comprehensive Well-Care Visit | 41.0 | 37.6 | 3.4 |
| Children and Adolescents' Access to Primary Care Practitioners: Children 12–24 Months | 97.3 | 96.3 | 1.0 |
| Children and Adolescents' Access to Primary Care Practitioners: Children 25 Months–6 Years | 90.6 | 88.1 | 2.4 |
| Children and Adolescents' Access to Primary Care Practitioners: Children 7–11 Years | 90.4 | 88.1 | 2.3 |
| Children and Adolescents' Access to Primary Care Practitioners: Adolescents 12–19 Years | 87.5 | 86.0 | 1.5 |
| Other Access and Utilization | | | |
| Prenatal and Postpartum Care: Timeliness of Prenatal Care | 82.5 | 77.7 | 4.8 |
| Prenatal and Postpartum Care: Postpartum Visit Between 21 and 56 Days After Delivery | 71.7 | 68.6 | 3.1 |
| Plan All-Cause Readmissions: 18–64 Years— Lower rates signify better performance* | 0.80 | 0.77 | -0.03 |

*This indicator is expressed as the ratio of the observed readmission rate to the expected (adjusted for case-mix) readmission rate. Ratios less than 1.0 indicate lower-than-expected readmission rates, whereas ratios greater than 1.0 indicate higher-than-expected readmission rates.

APPENDIX 9B: ACCREDITED VS. NONACCREDITED PLANS: 2011 COMMERCIAL PPO AVERAGES

| CAHPS MEMBER SATISFACTION MEASURES | | | |
|--|------------|---------------|------------|
| ACCREDITED VS. NONACCREDITED PLANS: COMMERCIAL PPO AVERAGES—2011 | | | |
| MEASURE | ACCREDITED | NONACCREDITED | DIFFERENCE |
| Consumer and Patient Engagement and Experience | | | |
| Rating of Health Plan: Rating of 8, 9 or 10 | 59.0 | 54.9 | 4.1 |
| Rating of Health Plan: Rating of 9 or 10 | 34.3 | 31.4 | 3.0 |
| Rating of Health Care: Rating of 8, 9 or 10 | 76.3 | 75.2 | 1.2 |
| Rating of Health Care: Rating of 9 or 10 | 48.9 | 49.4 | -0.4 |
| Getting Needed Care: Usually or Always | 86.2 | 86.5 | -0.3 |
| Getting Needed Care: Always | 53.8 | 53.3 | 0.5 |
| Getting Care Quickly: Usually or Always | 87.1 | 86.5 | 0.6 |
| Getting Care Quickly: Always | 58.0 | 58.6 | -0.6 |
| How Well Doctors Communicate: Usually or Always | 94.7 | 94.4 | 0.3 |
| How Well Doctors Communicate: Always | 73.9 | 73.0 | 1.0 |
| Rating of Personal Doctor: Rating of 8, 9 or 10 | 83.1 | 83.8 | -0.6 |
| Rating of Personal Doctor: Rating of 9 or 10 | 63.6 | 63.9 | -0.2 |
| Rating of Specialist: Rating of 8, 9 or 10 | 82.1 | 82.1 | 0.0 |
| Rating of Specialist: Rating of 9 or 10 | 62.6 | 63.7 | -1.1 |
| Customer Service: Usually or Always | 82.2 | 82.2 | 0.0 |
| Customer Service: Always | 54.7 | 56.2 | -1.5 |
| Claims Processing: Usually or Always | 87.8 | 88.0 | -0.2 |
| Claims Processing: Always | 50.4 | 51.9 | -1.5 |

APPENDIX 10A: ACCREDITED VS. NONACCREDITED PLANS: 2011 MEDICAID HMO AVERAGES

| HEDIS EFFECTIVENESS OF CARE AND UTILIZATION MEASURES ACCREDITED VS. NONACCREDITED PLANS: MEDICAID HMO AVERAGES—2011 | | | |
|--|------------|---------------|------------|
| MEASURE | ACCREDITED | NONACCREDITED | DIFFERENCE |
| Overuse and Appropriateness | | | |
| Imaging Studies for Low Back Pain | 74.9 | 76.9 | -2.0 |
| Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis | 22.2 | 27.2 | -5.0 |
| Screening, Prevention and Wellness | | | |
| Adult BMI Assessment | 57.4 | 45.3 | 12.1 |
| Medical Assistance With Smoking and Tobacco Use Cessation: Advising Smokers and Tobacco Users to Quit | 74.7 | 74.2 | 0.5 |
| Medical Assistance With Smoking and Tobacco Use Cessation: Discussing Cessation Strategies | 40.9 | 39.1 | 1.8 |
| Medical Assistance With Smoking and Tobacco Use Cessation: Discussing Cessation Medications | 45.2 | 42.4 | 2.7 |
| Breast Cancer Screening | 50.4 | 50.5 | -0.2 |
| Cervical Cancer Screening | 68.8 | 64.4 | 4.4 |
| Chlamydia Screening in Women: 16–20 Years | 55.1 | 54.7 | 0.3 |
| Chlamydia Screening in Women: 21–24 Years | 64.3 | 62.3 | 1.9 |
| Chlamydia Screening in Women: Total Rate | 58.4 | 57.5 | 1.0 |
| Chronic Condition Management | | | |
| Persistence of Beta-Blocker Treatment After a Heart Attack | 82.1 | 75.9 | 6.2 |
| Comprehensive Diabetes Care: Blood Pressure Control (<140/80 mm Hg) | 40.9 | 37.3 | 3.6 |
| Comprehensive Diabetes Care: Blood Pressure Control (<140/90 mm Hg) | 62.1 | 59.5 | 2.6 |
| Comprehensive Diabetes Care: Eye Exams | 54.1 | 52.5 | 1.5 |
| Comprehensive Diabetes Care: HbA1c Screening | 82.8 | 82.2 | 0.6 |
| Comprehensive Diabetes Care: Good Glycemic Control (HbA1c <7% for a Selected Population) | 36.1 | 34.4 | 1.7 |
| Comprehensive Diabetes Care: Good Glycemic Control (HbA1c <8%) | 49.0 | 47.1 | 1.9 |
| Comprehensive Diabetes Care: Poor Glycemic Control (HbA1c >9%)— Lower rates signify better performance | 42.0 | 44.2 | 2.3 |
| Comprehensive Diabetes Care: LDL Cholesterol Screening | 75.1 | 74.9 | 0.1 |
| Comprehensive Diabetes Care: LDL Cholesterol Control (<100 mg/dL) | 35.5 | 34.9 | 0.6 |
| Comprehensive Diabetes Care: Medical Attention for Nephropathy | 78.2 | 77.5 | 0.7 |
| Controlling High Blood Pressure | 58.2 | 54.5 | 3.7 |
| Cholesterol Management for Patients With Cardiovascular Conditions: LDL Cholesterol Screening | 82.0 | 81.9 | 0.1 |
| Cholesterol Management for Patients With Cardiovascular Conditions: LDL Control (<100 mg/dL) | 43.7 | 39.1 | 4.5 |
| Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis | 70.0 | 66.3 | 3.8 |

HEDIS EFFECTIVENESS OF CARE AND UTILIZATION MEASURES ACCREDITED VS. NONACCREDITED PLANS: MEDICAID HMO AVERAGES—2011

| MEASURE | ACCREDITED | NONACCREDITED | DIFFERENCE |
|---|------------|---------------|------------|
| Use of Appropriate Medications for People With Asthma: 5–11 Years | 90.9 | 90.0 | 1.0 |
| Use of Appropriate Medications for People With Asthma: 12–18 Years | 87.3 | 85.6 | 1.6 |
| Use of Appropriate Medications for People With Asthma: 19–50 Years | 73.7 | 76.1 | -2.4 |
| Use of Appropriate Medications for People With Asthma: 51–64 Years | 71.5 | 75.4 | -4.0 |
| Use of Appropriate Medications for People With Asthma: Overall Rate | 85.5 | 84.4 | 1.1 |
| Use of Spirometry Testing in the Assessment and Diagnosis of COPD | 31.9 | 32.2 | -0.2 |
| Pharmacotherapy Management of COPD: Bronchodilators | 81.4 | 78.4 | 3.1 |
| Pharmacotherapy Management of COPD: Systemic Corticosteroids | 64.6 | 63.0 | 1.7 |
| Annual Monitoring for Patients on Persistent Medications: ACE Inhibitors or ARBs | 86.2 | 85.4 | 0.8 |
| Annual Monitoring for Patients on Persistent Medications: Anticonvulsants | 65.4 | 64.8 | 0.5 |
| Annual Monitoring for Patients on Persistent Medications: Digoxin | 90.1 | 90.5 | -0.4 |
| Annual Monitoring for Patients on Persistent Medications: Diuretics | 85.8 | 84.9 | 0.9 |
| Annual Monitoring for Patients on Persistent Medications: Combined | 83.9 | 83.8 | 0.1 |
| Antidepressant Medication Management: Acute Phase | 50.9 | 51.3 | -0.4 |
| Antidepressant Medication Management: Continuation Phase | 34.5 | 34.4 | 0.1 |
| Follow-Up After Hospitalization for Mental Illness: Within 7 Days Post-Discharge | 48.0 | 44.8 | 3.2 |
| Follow-Up After Hospitalization for Mental Illness: Within 30 Days Post-Discharge | 66.8 | 62.9 | 3.9 |
| Alcohol and Other Drug Dependence Treatment: Initiation | 40.7 | 37.3 | 3.4 |
| Alcohol and Other Drug Dependence Treatment: Engagement | 11.5 | 12.4 | -0.9 |
| Measures Targeted Toward Children and Adolescents | | | |
| Appropriate Testing for Children With Pharyngitis | 68.0 | 64.7 | 3.3 |
| Appropriate Treatment for Children With Upper Respiratory Infection | 84.7 | 86.2 | -1.5 |
| Childhood Immunization Status: DTaP/DT | 79.9 | 79.7 | 0.2 |
| Childhood Immunization Status: Hepatitis B | 89.7 | 87.7 | 2.0 |
| Childhood Immunization Status: HiB | 91.2 | 90.7 | 0.5 |
| Childhood Immunization Status: IPV | 91.0 | 90.1 | 0.9 |
| Childhood Immunization Status: MMR | 90.9 | 90.8 | 0.1 |
| Childhood Immunization Status: Pneumococcal Conjugate (PCV) | 79.6 | 78.9 | 0.8 |
| Childhood Immunization Status: VZV | 90.6 | 90.3 | 0.4 |
| Childhood Immunization Status: Hepatitis A | 39.5 | 38.7 | 0.8 |
| Childhood Immunization Status: Rotavirus | 63.6 | 60.7 | 2.9 |
| Childhood Immunization Status: Influenza | 45.9 | 43.4 | 2.5 |
| Childhood Immunization Status: Combination 2 (DTaP, IPV, MMR, HiB, Hepatitis B and VZV) | 75.7 | 73.0 | 2.7 |

| HEDIS EFFECTIVENESS OF CARE AND UTILIZATION MEASURES | | | |
|---|-------------------|----------------------|-------------------|
| ACCREDITED VS. NONACCREDITED PLANS: MEDICAID HMO AVERAGES—2011 | | | |
| MEASURE | ACCREDITED | NONACCREDITED | DIFFERENCE |
| Childhood Immunization Status: Combination 3 (DTaP, IPV, MMR, HiB, Hepatitis B, VZV and PCV) | 71.8 | 69.3 | 2.5 |
| Childhood Immunization Status: Combination 10 (DTaP, IPV, MMR, HiB, Hepatitis A, Hepatitis B, VZV, PCV, Rotavirus and Influenza) | 18.2 | 16.1 | 2.2 |
| Immunizations for Adolescents: Meningococcal | 64.3 | 61.8 | 2.5 |
| Immunizations for Adolescents: Tdap/Td | 76.3 | 75.1 | 1.2 |
| Immunizations for Adolescents: Combination 1 (Meningococcal, Tdap/Td) | 61.7 | 59.0 | 2.7 |
| Follow-Up Care for Children Prescribed ADHD Medication: Initiation | 38.2 | 39.8 | -1.7 |
| Follow-Up Care for Children Prescribed ADHD Medication: Continuation | 45.5 | 46.5 | -1.0 |
| Lead Screening in Children | 67.5 | 68.2 | -0.7 |
| Weight Assessment and Counseling for Nutrition and Physical Activity in Children and Adolescents: BMI Percentile (3–17 Years) | 46.0 | 46.0 | -0.1 |
| Weight Assessment and Counseling for Nutrition and Physical Activity in Children and Adolescents: Counseling for Nutrition (3–17 Years) | 51.1 | 48.7 | 2.4 |
| Weight Assessment and Counseling for Nutrition and Physical Activity in Children and Adolescents: Counseling for Physical Activity (3–17 Years) | 41.1 | 40.0 | 1.2 |
| Well-Child Visits (Ages 0–15 Months): Six or More Well-Child Visits | 63.2 | 59.8 | 3.4 |
| Well-Child Visits (Ages 3–6 Years): One or More Well-Child Visits | 72.8 | 71.2 | 1.5 |
| Adolescent Well-Care Visits: At Least One Comprehensive Well-Care Visit | 50.8 | 48.6 | 2.2 |
| Children and Adolescents' Access to Primary Care Practitioners: Children 12–24 Months | 96.3 | 95.8 | 0.5 |
| Children and Adolescents' Access to Primary Care Practitioners: Children 25 Months–6 Years | 88.5 | 87.9 | 0.6 |
| Children and Adolescents' Access to Primary Care Practitioners: Children 7–11 Years | 90.1 | 88.9 | 1.2 |
| Children and Adolescents' Access to Primary Care Practitioners: Adolescents 12–19 Years | 88.3 | 87.3 | 1.0 |
| Other Access and Utilization | | | |
| Frequency of Prenatal Care Visits: <21% of Expected Visits | 8.6 | 12.2 | -3.6 |
| Frequency of Prenatal Care Visits: 21–40% of Expected Visits | 6.1 | 7.2 | -1.2 |
| Frequency of Prenatal Care Visits: 41–60% of Expected Visits | 7.7 | 9.0 | -1.4 |
| Frequency of Prenatal Care Visits: 61–80% of Expected Visits | 14.4 | 14.5 | -0.1 |
| Frequency of Prenatal Care Visits: ≥81% of Expected Visits | 63.4 | 57.0 | 6.4 |
| Prenatal and Postpartum Care: Timeliness of Prenatal Care | 85.6 | 79.6 | 6.0 |
| Prenatal and Postpartum Care: Postpartum Visit Between 21 and 56 Days After Delivery | 65.2 | 63.0 | 2.2 |

APPENDIX 10B: ACCREDITED VS. NONACCREDITED PLANS: 2011 MEDICAID HMO AVERAGES

| CAHPS MEMBER SATISFACTION MEASURES | | | |
|--|------------|---------------|------------|
| ACCREDITED VS. NONACCREDITED PLANS: MEDICAID HMO AVERAGES—2011 | | | |
| MEASURE | ACCREDITED | NONACCREDITED | DIFFERENCE |
| Consumer and Patient Engagement and Experience | | | |
| Rating of Health Plan: Rating of 8, 9 or 10 | 74.4 | 71.7 | 2.6 |
| Rating of Health Plan: Rating of 9 or 10 | 56.6 | 53.6 | 3.0 |
| Rating of Health Care: Rating of 8, 9 or 10 | 70.2 | 69.3 | 0.8 |
| Rating of Health Care: Rating of 9 or 10 | 50.1 | 49.0 | 1.1 |
| Getting Needed Care: Usually or Always | 76.6 | 73.5 | 3.1 |
| Getting Needed Care: Always | 51.3 | 48.6 | 2.7 |
| Getting Care Quickly: Usually or Always | 80.6 | 79.9 | 0.7 |
| Getting Care Quickly: Always | 57.2 | 57.2 | 0.0 |
| How Well Doctors Communicate: Usually or Always | 88.1 | 87.3 | 0.9 |
| How Well Doctors Communicate: Always | 70.2 | 69.7 | 0.5 |
| Rating of Personal Doctor: Rating of 8, 9 or 10 | 77.2 | 76.9 | 0.3 |
| Rating of Personal Doctor: Rating of 9 or 10 | 62.0 | 61.4 | 0.6 |
| Rating of Specialist: Rating of 8, 9 or 10 | 78.1 | 76.8 | 1.3 |
| Rating of Specialist: Rating of 9 or 10 | 62.3 | 61.7 | 0.6 |
| Customer Service: Usually or Always | 81.1 | 79.5 | 1.5 |
| Customer Service: Always | 61.8 | 59.6 | 2.3 |

APPENDIX 11A: ACCREDITED VS. NONACCREDITED PLANS: 2011 MEDICARE HMO AVERAGES

| HEDIS EFFECTIVENESS OF CARE AND UTILIZATION MEASURES ACCREDITED VS. NONACCREDITED PLANS: MEDICARE HMO AVERAGES – 2011 | | | |
|--|------------|---------------|------------|
| MEASURE | ACCREDITED | NONACCREDITED | DIFFERENCE |
| Screening, Prevention and Wellness | | | |
| Adult BMI Assessment | 69.4 | 67.3 | 2.0 |
| Medical Assistance With Smoking and Tobacco Use Cessation: Advising Smokers and Tobacco Users to Quit | 81.7 | 81.3 | 0.4 |
| Flu Shots for Older Adults | 72.1 | 66.6 | 5.5 |
| Pneumonia Vaccine for Older Adults | 74.2 | 66.2 | 8.0 |
| Breast Cancer Screening | 70.9 | 67.6 | 3.3 |
| Colorectal Cancer Screening | 65.0 | 56.7 | 8.2 |
| Chronic Condition Management | | | |
| Persistence of Beta-Blocker Treatment After a Heart Attack | 87.9 | 86.6 | 1.3 |
| Comprehensive Diabetes Care: Blood Pressure Control (<140/80 mm Hg) | 49.8 | 47.2 | 2.7 |
| Comprehensive Diabetes Care: Blood Pressure Control (<140/90 mm Hg) | 64.4 | 62.2 | 2.2 |
| Comprehensive Diabetes Care: Eye Exams | 70.0 | 63.3 | 6.7 |
| Comprehensive Diabetes Care: HbA1c Screening | 92.1 | 90.2 | 1.9 |
| Comprehensive Diabetes Care: Good Glycemic Control (HbA1c <8%) | 70.4 | 61.8 | 8.6 |
| Comprehensive Diabetes Care: Poor Glycemic Control (HbA1c >9%)— Lower rates signify better performance | 20.8 | 30.3 | 9.4 |
| Comprehensive Diabetes Care: LDL Cholesterol Screening | 89.8 | 87.2 | 2.6 |
| Comprehensive Diabetes Care: LDL Cholesterol Control (<100 mg/dL) | 57.3 | 49.2 | 8.1 |
| Comprehensive Diabetes Care: Medical Attention for Nephropathy | 90.6 | 89.4 | 1.2 |
| Controlling High Blood Pressure | 67.3 | 61.8 | 5.5 |
| Cholesterol Management for Patients With Cardiovascular Conditions: LDL Cholesterol Screening | 90.1 | 88.0 | 2.2 |
| Cholesterol Management for Patients With Cardiovascular Conditions: LDL Control (<100 mg/dL) | 62.3 | 52.6 | 9.8 |
| Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis | 76.5 | 69.6 | 6.9 |
| Use of Spirometry Testing in the Assessment and Diagnosis of COPD | 39.0 | 34.3 | 4.7 |
| Pharmacotherapy Management of COPD: Bronchodilators | 78.4 | 78.4 | 0.0 |
| Pharmacotherapy Management of COPD: Systemic Corticosteroids | 69.6 | 64.7 | 5.0 |
| Annual Monitoring for Patients on Persistent Medications: ACE Inhibitors or ARBs | 91.7 | 91.1 | 0.6 |
| Annual Monitoring for Patients on Persistent Medications: Anticonvulsants | 67.3 | 67.4 | -0.1 |
| Annual Monitoring for Patients on Persistent Medications: Digoxin | 93.7 | 93.2 | 0.5 |
| Annual Monitoring for Patients on Persistent Medications: Diuretics | 92.0 | 91.4 | 0.6 |
| Annual Monitoring for Patients on Persistent Medications: Combined | 91.4 | 90.5 | 1.0 |

| HEDIS EFFECTIVENESS OF CARE AND UTILIZATION MEASURES ACCREDITED VS. NONACCREDITED PLANS: MEDICARE HMO AVERAGES—2011 | | | |
|--|-------------------|----------------------|-------------------|
| MEASURE | ACCREDITED | NONACCREDITED | DIFFERENCE |
| Antidepressant Medication Management: Acute Phase | 68.4 | 64.6 | 3.9 |
| Antidepressant Medication Management: Continuation Phase | 55.6 | 51.4 | 4.2 |
| Follow-Up After Hospitalization for Mental Illness: Within 7 Days Post-Discharge | 45.4 | 32.5 | 12.9 |
| Follow-Up After Hospitalization for Mental Illness: Within 30 Days Post-Discharge | 63.9 | 50.1 | 13.8 |
| Alcohol and Other Drug Dependence Treatment: Initiation | 42.5 | 39.9 | 2.6 |
| Alcohol and Other Drug Dependence Treatment: Engagement | 4.1 | 3.4 | 0.7 |
| Measures Targeted Toward Older Adults | | | |
| Fall Risk Management: Discussion | 28.9 | 35.3 | -6.5 |
| Fall Risk Management: Management | 57.6 | 62.0 | -4.4 |
| Potentially Harmful Drug-Disease Interactions in the Elderly: Chronic Renal Failure and NSAIDs or Cox-2 Selective NSAIDs— Lower rates signify better performance | 8.9 | 14.5 | 5.6 |
| Potentially Harmful Drug-Disease Interactions in the Elderly: Dementia and Tricyclic Antidepressants or Anticholinergic Agents— Lower rates signify better performance | 22.7 | 29.9 | 7.2 |
| Potentially Harmful Drug-Disease Interactions in the Elderly: Falls and Tricyclic Antidepressants, Antipsychotics and Sleep Agents— Lower rates signify better performance | 14.0 | 16.8 | 2.8 |
| Potentially Harmful Drug-Disease Interactions in the Elderly: Overall Rate— Lower rates signify better performance | 18.2 | 24.0 | 5.8 |
| Use of High-Risk Medications in the Elderly: At Least One Medication— Lower rates signify better performance | 15.5 | 20.5 | 4.9 |
| Use of High-Risk Medications in the Elderly: At Least Two Medications— Lower rates signify better performance | 2.5 | 4.3 | 1.8 |
| Management of Urinary Incontinence: Discussion | 56.6 | 57.9 | -1.3 |
| Physical Activity in Older Adults: Discussion | 54.1 | 52.3 | 1.8 |
| Physical Activity in Older Adults: Advice | 48.4 | 48.9 | -0.5 |
| Osteoporosis Testing in Older Women | 75.5 | 68.0 | 7.5 |
| Osteoporosis Management in Women Who Had a Fracture | 23.8 | 21.9 | 1.9 |
| Glaucoma Screening in Older Adults | 68.2 | 64.2 | 4.0 |
| Other Access and Utilization | | | |
| Plan All-Cause Readmissions: 65 Years And Older— Lower rates signify better performance* | 0.89 | 0.93 | 0.04 |

*This indicator is expressed as the ratio of the observed readmission rate to the expected (adjusted for case-mix) readmission rate. Ratios less than 1.0 indicate lower-than-expected readmission rates, whereas ratios greater than 1.0 indicate higher-than-expected readmission rates.

APPENDIX 11B: ACCREDITED VS. NONACCREDITED PLANS: 2011 MEDICARE HMO AVERAGES

| CAHPS MEMBER SATISFACTION MEASURES | | | |
|---|-------------------|----------------------|-------------------|
| ACCREDITED VS. NONACCREDITED PLANS: MEDICARE HMO AVERAGES—2011 | | | |
| MEASURE | ACCREDITED | NONACCREDITED | DIFFERENCE |
| Consumer and Patient Engagement and Experience | | | |
| Rating of Health Plan: Rating of 8, 9 or 10 | 89.4 | 87.9 | 1.5 |
| Rating of Health Plan: Rating of 9 or 10 | 63.4 | 64.2 | -0.9 |
| Rating of Health Care: Rating of 8, 9 or 10 | 89.3 | 84.7 | 4.5 |
| Rating of Health Care: Rating of 9 or 10 | 63.4 | 59.2 | 4.3 |
| Getting Needed Care: Usually or Always | 91.8 | 87.8 | 4.0 |
| Getting Needed Care: Always | 66.5 | 62.5 | 4.0 |
| Getting Care Quickly: Usually or Always | 89.9 | 86.4 | 3.4 |
| Getting Care Quickly: Always | 67.6 | 64.3 | 3.4 |
| How Well Doctors Communicate: Usually or Always | 95.4 | 93.3 | 2.1 |
| How Well Doctors Communicate: Always | 77.4 | 75.5 | 1.9 |
| Rating of Personal Doctor: Rating of 8, 9 or 10 | 94.1 | 92.1 | 2.0 |
| Rating of Personal Doctor: Rating of 9 or 10 | 76.5 | 73.3 | 3.1 |
| Rating of Specialist: Rating of 8, 9 or 10 | 92.6 | 90.5 | 2.2 |
| Rating of Specialist: Rating of 9 or 10 | 73.3 | 68.6 | 4.7 |
| Customer Service: Usually or Always | 89.6 | 87.6 | 2.0 |
| Customer Service: Always | 69.9 | 68.3 | 1.5 |

APPENDIX 12A: ACCREDITED VS. NONACCREDITED PLANS: 2011 MEDICARE PPO AVERAGES

| HEDIS EFFECTIVENESS OF CARE AND UTILIZATION MEASURES | | | |
|---|-------------------|----------------------|-------------------|
| ACCREDITED VS. NONACCREDITED PLANS: MEDICARE PPO AVERAGES – 2011 | | | |
| MEASURE | ACCREDITED | NONACCREDITED | DIFFERENCE |
| Screening, Prevention and Wellness | | | |
| Adult BMI Assessment | 59.9 | 63.3 | -3.4 |
| Medical Assistance With Smoking and Tobacco Use Cessation: Advising Smokers and Tobacco Users to Quit | 78.6 | 79.6 | -0.9 |
| Flu Shots for Older Adults | 72.3 | 68.1 | 4.2 |
| Pneumonia Vaccine for Older Adults | 73.3 | 70.9 | 2.4 |
| Breast Cancer Screening | 67.6 | 64.9 | 2.7 |
| Colorectal Cancer Screening | 59.5 | 53.2 | 6.3 |
| Chronic Condition Management | | | |
| Persistence of Beta-Blocker Treatment After a Heart Attack | 87.4 | 85.6 | 1.8 |
| Comprehensive Diabetes Care: Blood Pressure Control (<140/80 mm Hg) | 46.3 | 46.5 | -0.2 |
| Comprehensive Diabetes Care: Blood Pressure Control (<140/90 mm Hg) | 60.5 | 60.2 | 0.3 |
| Comprehensive Diabetes Care: Eye Exams | 65.6 | 63.1 | 2.5 |
| Comprehensive Diabetes Care: HbA1c Screening | 91.6 | 90.9 | 0.7 |
| Comprehensive Diabetes Care: Good Glycemic Control (HbA1c <8%) | 67.3 | 61.3 | 6.0 |
| Comprehensive Diabetes Care: Poor Glycemic Control (HbA1c >9%)— Lower rates signify better performance | 24.6 | 30.7 | 6.2 |
| Comprehensive Diabetes Care: LDL Cholesterol Screening | 87.7 | 86.2 | 1.4 |
| Comprehensive Diabetes Care: LDL Cholesterol Control (<100 mg/dL) | 54.4 | 49.3 | 5.1 |
| Comprehensive Diabetes Care: Medical Attention for Nephropathy | 88.3 | 87.9 | 0.4 |
| Controlling High Blood Pressure | 63.4 | 59.3 | 4.0 |
| Cholesterol Management for Patients With Cardiovascular Conditions: LDL Cholesterol Screening | 88.0 | 88.4 | -0.4 |
| Cholesterol Management for Patients With Cardiovascular Conditions: LDL Control (<100 mg/dL) | 59.9 | 55.0 | 4.9 |
| Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis | 78.6 | 76.5 | 2.1 |
| Use of Spirometry Testing in the Assessment and Diagnosis of COPD | 35.0 | 36.0 | -1.0 |
| Pharmacotherapy Management of COPD: Bronchodilators | 77.8 | 74.8 | 3.1 |
| Pharmacotherapy Management of COPD: Systemic Corticosteroids | 69.6 | 68.2 | 1.4 |
| Annual Monitoring for Patients on Persistent Medications: ACE Inhibitors or ARBs | 91.1 | 91.5 | -0.4 |
| Annual Monitoring for Patients on Persistent Medications: Anticonvulsants | 65.4 | 70.0 | -4.6 |
| Annual Monitoring for Patients on Persistent Medications: Digoxin | 93.2 | 93.2 | 0.0 |
| Annual Monitoring for Patients on Persistent Medications: Diuretics | 91.4 | 91.9 | -0.5 |
| Annual Monitoring for Patients on Persistent Medications: Combined | 90.8 | 91.3 | -0.5 |

HEDIS EFFECTIVENESS OF CARE AND UTILIZATION MEASURES ACCREDITED VS. NONACCREDITED PLANS: MEDICARE PPO AVERAGES—2011

| MEASURE | ACCREDITED | NONACCREDITED | DIFFERENCE |
|--|------------|---------------|------------|
| Antidepressant Medication Management: Acute Phase | 70.2 | 71.1 | -0.9 |
| Antidepressant Medication Management: Continuation Phase | 58.1 | 58.5 | -0.5 |
| Follow-Up After Hospitalization for Mental Illness: Within 7 Days Post-Discharge | 42.9 | 36.0 | 6.8 |
| Follow-Up After Hospitalization for Mental Illness: Within 30 Days Post-Discharge | 64.1 | 58.4 | 5.6 |
| Alcohol and Other Drug Dependence Treatment: Initiation | 47.5 | 47.6 | -0.1 |
| Alcohol and Other Drug Dependence Treatment: Engagement | 4.2 | 3.6 | 0.6 |
| Measures Targeted Toward Older Adults | | | |
| Fall Risk Management: Discussion | 29.4 | 31.3 | -1.9 |
| Fall Risk Management: Management | 54.2 | 54.8 | -0.6 |
| Potentially Harmful Drug-Disease Interactions in the Elderly: Chronic Renal Failure and NSAIDs or Cox-2 Selective NSAIDs— Lower rates signify better performance | 9.2 | 10.6 | 1.4 |
| Potentially Harmful Drug-Disease Interactions in the Elderly: Dementia and Tricyclic Antidepressants or Anticholinergic Agents— Lower rates signify better performance | 25.3 | 25.8 | 0.6 |
| Potentially Harmful Drug-Disease Interactions in the Elderly: Falls and Tricyclic Antidepressants, Antipsychotics and Sleep Agents— Lower rates signify better performance | 14.3 | 15.8 | 1.5 |
| Potentially Harmful Drug-Disease Interactions in the Elderly: Overall Rate— Lower rates signify better performance | 20.1 | 20.8 | 0.7 |
| Use of High-Risk Medications in the Elderly: At Least One Medication— Lower rates signify better performance | 17.4 | 18.9 | 1.5 |
| Use of High-Risk Medications in the Elderly: At Least Two Medications— Lower rates signify better performance | 3.2 | 3.7 | 0.5 |
| Management of Urinary Incontinence: Discussion | 57.2 | 56.7 | 0.5 |
| Physical Activity in Older Adults: Discussion | 56.2 | 52.6 | 3.6 |
| Physical Activity in Older Adults: Advice | 49.4 | 46.9 | 2.5 |
| Osteoporosis Testing in Older Women | 77.4 | 74.0 | 3.4 |
| Osteoporosis Management in Women Who Had a Fracture | 20.7 | 18.5 | 2.2 |
| Glaucoma Screening in Older Adults | 66.4 | 66.7 | -0.3 |
| Other Access and Utilization | | | |
| Plan All-Cause Readmissions: 65 Years And Older— Lower rates signify better performance* | 0.88 | 0.88 | 0.00 |

*This indicator is expressed as the ratio of the observed readmission rate to the expected (adjusted for case-mix) readmission rate. Ratios less than 1.0 indicate lower-than-expected readmission rates, whereas ratios greater than 1.0 indicate higher-than-expected readmission rates.

APPENDIX 12B: ACCREDITED VS. NONACCREDITED PLANS: 2011 MEDICARE PPO AVERAGES

| CAHPS MEMBER SATISFACTION MEASURES | | | |
|--|------------|---------------|------------|
| ACCREDITED VS. NONACCREDITED PLANS: MEDICARE PPO AVERAGES—2011 | | | |
| MEASURE | ACCREDITED | NONACCREDITED | DIFFERENCE |
| Consumer and Patient Engagement and Experience | | | |
| Rating of Health Plan: Rating of 8, 9 or 10 | 87.2 | 88.0 | -0.9 |
| Rating of Health Plan: Rating of 9 or 10 | 56.4 | 59.4 | -3.0 |
| Rating of Health Care: Rating of 8, 9 or 10 | 89.8 | 89.1 | 0.7 |
| Rating of Health Care: Rating of 9 or 10 | 62.7 | 62.5 | 0.2 |
| Getting Needed Care: Usually or Always | 93.1 | 92.3 | 0.8 |
| Getting Needed Care: Always | 67.1 | 66.4 | 0.7 |
| Getting Care Quickly: Usually or Always | 90.2 | 90.0 | 0.3 |
| Getting Care Quickly: Always | 67.1 | 67.7 | -0.6 |
| How Well Doctors Communicate: Usually or Always | 95.7 | 95.4 | 0.3 |
| How Well Doctors Communicate: Always | 77.1 | 77.4 | -0.3 |
| Rating of Personal Doctor: Rating of 8, 9 or 10 | 94.3 | 94.0 | 0.3 |
| Rating of Personal Doctor: Rating of 9 or 10 | 75.7 | 76.3 | -0.6 |
| Rating of Specialist: Rating of 8, 9 or 10 | 92.6 | 92.8 | -0.1 |
| Rating of Specialist: Rating of 9 or 10 | 72.8 | 74.0 | -1.1 |
| Customer Service: Usually or Always | 88.4 | 88.6 | -0.2 |
| Customer Service: Always | 67.2 | 68.6 | -1.4 |

APPENDIX 13A: PUBLICLY REPORTING VS. NONPUBLICLY REPORTING PLANS: 2011 COMMERCIAL HMOS

| HEDIS EFFECTIVENESS OF CARE AND UTILIZATION MEASURES PUBLICLY REPORTING VS. NONPUBLICLY REPORTING PLANS: COMMERCIAL HMO AVERAGES—2011 | | | |
|---|--------|-----------|------------|
| MEASURE | PUBLIC | NONPUBLIC | DIFFERENCE |
| Overuse and Appropriateness | | | |
| Imaging Studies for Low Back Pain | 74.6 | 70.5 | 4.1 |
| Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis | 23.9 | 19.5 | 4.4 |
| Screening, Prevention and Wellness | | | |
| Adult BMI Assessment | 55.9 | 48.6 | 7.3 |
| Medical Assistance With Smoking and Tobacco Use Cessation: Advising Smokers and Tobacco Users to Quit | 77.6 | 77.5 | 0.1 |
| Medical Assistance With Smoking and Tobacco Use Cessation: Discussing Cessation Strategies | 47.4 | 49.8 | -2.4 |
| Medical Assistance With Smoking and Tobacco Use Cessation: Discussing Cessation Medications | 52.9 | 54.9 | -2.0 |
| Flu Shots for Adults | 53.2 | 55.3 | -2.2 |
| Breast Cancer Screening | 70.7 | 68.4 | 2.4 |
| Cervical Cancer Screening | 76.9 | 72.3 | 4.6 |
| Colorectal Cancer Screening | 62.8 | 57.9 | 4.9 |
| Chlamydia Screening in Women: 16–20 Years | 42.2 | 34.8 | 7.4 |
| Chlamydia Screening in Women: 21–24 Years | 49.2 | 39.9 | 9.3 |
| Chlamydia Screening in Women: Total Rate | 45.7 | 37.4 | 8.3 |
| Chronic Condition Management | | | |
| Aspirin Use and Discussion: Aspirin Use | 46.7 | 53.4 | -6.7 |
| Persistence of Beta-Blocker Treatment After a Heart Attack | 81.5 | 78.1 | 3.4 |
| Comprehensive Diabetes Care: Blood Pressure Control (<140/80 mm Hg) | 44.7 | 38.9 | 5.8 |
| Comprehensive Diabetes Care: Blood Pressure Control (<140/90 mm Hg) | 66.7 | 56.8 | 9.8 |
| Comprehensive Diabetes Care: Eye Exams | 57.8 | 47.4 | 10.5 |
| Comprehensive Diabetes Care: HbA1c Screening | 90.1 | 88.3 | 1.8 |
| Comprehensive Diabetes Care: Good Glycemic Control (HbA1c <7% for a Selected Population) | 43.0 | 32.2 | 10.8 |
| Comprehensive Diabetes Care: Good Glycemic Control (HbA1c <8%) | 62.0 | 53.4 | 8.6 |
| Comprehensive Diabetes Care: Poor Glycemic Control (HbA1c >9%)— Lower rates signify better performance | 27.5 | 36.6 | 9.1 |
| Comprehensive Diabetes Care: LDL Cholesterol Screening | 85.5 | 83.4 | 2.1 |
| Comprehensive Diabetes Care: LDL Cholesterol Control (<100 mg/dL) | 48.6 | 42.6 | 6.0 |
| Comprehensive Diabetes Care: Medical Attention for Nephropathy | 84.1 | 81.3 | 2.7 |
| Controlling High Blood Pressure | 65.9 | 59.2 | 6.7 |

**HEDIS EFFECTIVENESS OF CARE AND UTILIZATION MEASURES
PUBLICLY REPORTING VS. NONPUBLICLY REPORTING
PLANS: COMMERCIAL HMO AVERAGES—2011**

| MEASURE | PUBLIC | NONPUBLIC | DIFFERENCE |
|---|--------|-----------|------------|
| Cholesterol Management for Patients With Cardiovascular Conditions: LDL Cholesterol Screening | 88.3 | 86.2 | 2.1 |
| Cholesterol Management for Patients With Cardiovascular Conditions: LDL Control (<100 mg/dL) | 60.8 | 50.4 | 10.4 |
| Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis | 87.8 | 85.4 | 2.4 |
| Use of Appropriate Medications for People With Asthma: 5–11 Years | 96.0 | 96.4 | -0.4 |
| Use of Appropriate Medications for People With Asthma: 12–18 Years | 92.8 | 90.8 | 2.0 |
| Use of Appropriate Medications for People With Asthma: 19–50 Years | 89.2 | 88.6 | 0.6 |
| Use of Appropriate Medications for People With Asthma: 51–64 Years | 93.1 | 94.1 | -1.0 |
| Use of Appropriate Medications for People With Asthma: Overall Rate | 91.9 | 91.9 | 0.1 |
| Use of Spirometry Testing in the Assessment and Diagnosis of COPD | 43.2 | 39.6 | 3.6 |
| Pharmacotherapy Management of COPD: Bronchodilators | 79.9 | 79.6 | 0.3 |
| Pharmacotherapy Management of COPD: Systemic Corticosteroids | 71.4 | 69.8 | 1.6 |
| Annual Monitoring for Patients on Persistent Medications: ACE Inhibitors or ARBs | 82.4 | 83.5 | -1.1 |
| Annual Monitoring for Patients on Persistent Medications: Anticonvulsants | 60.2 | 63.1 | -2.9 |
| Annual Monitoring for Patients on Persistent Medications: Digoxin | 85.1 | 89.7 | -4.7 |
| Annual Monitoring for Patients on Persistent Medications: Diuretics | 82.0 | 83.4 | -1.4 |
| Annual Monitoring for Patients on Persistent Medications: Combined | 81.8 | 83.2 | -1.4 |
| Antidepressant Medication Management: Acute Phase | 65.7 | 64.5 | 1.2 |
| Antidepressant Medication Management: Continuation Phase | 49.7 | 47.0 | 2.7 |
| Follow-Up After Hospitalization for Mental Illness: Within 7 Days Post-Discharge | 59.4 | 51.7 | 7.7 |
| Follow-Up After Hospitalization for Mental Illness: Within 30 Days Post-Discharge | 77.1 | 68.2 | 8.9 |
| Alcohol and Other Drug Dependence Treatment: Initiation | 40.3 | 38.8 | 1.5 |
| Alcohol and Other Drug Dependence Treatment: Engagement | 15.5 | 11.5 | 3.9 |
| Measures Targeted Toward Children and Adolescents | | | |
| Appropriate Testing for Children With Pharyngitis | 80.5 | 76.5 | 4.0 |
| Appropriate Treatment for Children With Upper Respiratory Infection | 84.6 | 76.7 | 8.0 |
| Childhood Immunization Status: DTaP/DT | 87.1 | 80.4 | 6.7 |
| Childhood Immunization Status: Hepatitis B | 89.1 | 75.0 | 14.1 |
| Childhood Immunization Status: HiB | 94.5 | 90.3 | 4.2 |
| Childhood Immunization Status: IPV | 92.9 | 88.0 | 4.9 |
| Childhood Immunization Status: MMR | 91.5 | 91.4 | 0.1 |
| Childhood Immunization Status: Pneumococcal Conjugate (PCV) | 87.5 | 81.4 | 6.1 |

**HEDIS EFFECTIVENESS OF CARE AND UTILIZATION MEASURES
PUBLICLY REPORTING VS. NONPUBLICLY REPORTING
PLANS: COMMERCIAL HMO AVERAGES—2011**

| MEASURE | PUBLIC | NONPUBLIC | DIFFERENCE |
|---|--------|-----------|------------|
| Childhood Immunization Status: VZV | 91.3 | 90.5 | 0.8 |
| Childhood Immunization Status: Hepatitis A | 38.5 | 43.5 | -5.0 |
| Childhood Immunization Status: Rotavirus | 75.2 | 73.3 | 1.9 |
| Childhood Immunization Status: Influenza | 61.3 | 58.8 | 2.5 |
| Childhood Immunization Status: Combination 2 (DTaP, IPV, MMR, HiB, Hepatitis B and VZV) | 79.2 | 65.4 | 13.7 |
| Childhood Immunization Status: Combination 3 (DTaP, IPV, MMR, HiB, Hepatitis B, VZV and PCV) | 77.0 | 62.3 | 14.7 |
| Childhood Immunization Status: Combination 10 (DTaP, IPV, MMR, HiB, Hepatitis A, Hepatitis B, VZV, PCV, Rotavirus and Influenza) | 23.1 | 20.8 | 2.3 |
| Immunizations for Adolescents: Meningococcal | 61.9 | 62.5 | -0.7 |
| Immunizations for Adolescents: Tdap/Td | 77.0 | 76.9 | 0.0 |
| Immunizations for Adolescents: Combination 1 (Meningococcal, Tdap/Td) | 59.3 | 60.7 | -1.3 |
| Follow-Up Care for Children Prescribed ADHD Medication: Initiation | 39.8 | 32.9 | 6.9 |
| Follow-Up Care for Children Prescribed ADHD Medication: Continuation | 44.3 | 42.3 | 2.0 |
| Weight Assessment and Counseling for Nutrition and Physical Activity in Children and Adolescents: BMI Percentile (3–17 Years) | 45.2 | 39.4 | 5.7 |
| Weight Assessment and Counseling for Nutrition and Physical Activity in Children and Adolescents: Counseling for Nutrition (3–17 Years) | 46.9 | 39.8 | 7.1 |
| Weight Assessment and Counseling for Nutrition and Physical Activity in Children and Adolescents: Counseling for Physical Activity (3–17 Years) | 43.4 | 37.6 | 5.8 |
| Well-Child Visits (Ages 0–15 Months): Six or More Well-Child Visits | 78.5 | 73.4 | 5.0 |
| Well-Child Visits (Ages 3–6 Years): One or More Well-Child Visits | 73.3 | 64.2 | 9.1 |
| Adolescent Well-Care Visits: At Least One Comprehensive Well-Care Visit | 43.9 | 36.3 | 7.6 |
| Children and Adolescents' Access to Primary Care Practitioners: Children 12–24 Months | 97.9 | 97.2 | 0.7 |
| Children and Adolescents' Access to Primary Care Practitioners: Children 25 Months–6 Years | 92.1 | 88.9 | 3.2 |
| Children and Adolescents' Access to Primary Care Practitioners: Children 7–11 Years | 92.1 | 89.9 | 2.2 |
| Children and Adolescents' Access to Primary Care Practitioners: Adolescents 12–19 Years | 89.4 | 87.9 | 1.5 |
| Other Access and Utilization | | | |
| Prenatal and Postpartum Care: Timeliness of Prenatal Care | 91.7 | 82.4 | 9.4 |
| Prenatal and Postpartum Care: Postpartum Visit Between 21 and 56 Days After Delivery | 81.4 | 71.0 | 10.5 |
| Plan All-Cause Readmissions: 18–64 Years— Lower rates signify better performance* | 0.81 | 0.84 | 0.03 |

*This indicator is expressed as the ratio of the observed readmission rate to the expected (adjusted for case-mix) readmission rate. Ratios less than 1.0 indicate lower-than-expected readmission rates, whereas ratios greater than 1.0 indicate higher-than-expected readmission rates.

APPENDIX 13B: PUBLICLY REPORTING VS. NONPUBLICLY REPORTING PLANS: 2011 COMMERCIAL HMOS

| CAHPS MEMBER SATISFACTION MEASURES PUBLICLY REPORTING VS. NONPUBLICLY REPORTING PLANS: COMMERCIAL HMO AVERAGES—2011 | | | |
|---|--------|-----------|------------|
| MEASURE | PUBLIC | NONPUBLIC | DIFFERENCE |
| Consumer and Patient Engagement and Experience | | | |
| Rating of Health Plan: Rating of 8, 9 or 10 | 66.1 | 66.4 | -0.3 |
| Rating of Health Plan: Rating of 9 or 10 | 42.0 | 43.7 | -1.8 |
| Rating of Health Care: Rating of 8, 9 or 10 | 77.6 | 77.4 | 0.2 |
| Rating of Health Care: Rating of 9 or 10 | 51.8 | 53.0 | -1.2 |
| Getting Needed Care: Usually or Always | 85.8 | 82.8 | 3.0 |
| Getting Needed Care: Always | 54.2 | 52.6 | 1.7 |
| Getting Care Quickly: Usually or Always | 86.2 | 85.6 | 0.6 |
| Getting Care Quickly: Always | 58.8 | 58.2 | 0.6 |
| How Well Doctors Communicate: Usually or Always | 94.0 | 94.0 | 0.1 |
| How Well Doctors Communicate: Always | 74.2 | 73.8 | 0.5 |
| Rating of Personal Doctor: Rating of 8, 9 or 10 | 83.9 | 83.8 | 0.1 |
| Rating of Personal Doctor: Rating of 9 or 10 | 66.0 | 66.0 | 0.0 |
| Rating of Specialist: Rating of 8, 9 or 10 | 83.3 | 82.4 | 0.9 |
| Rating of Specialist: Rating of 9 or 10 | 65.2 | 65.1 | 0.1 |
| Customer Service: Usually or Always | 86.0 | 86.7 | -0.6 |
| Customer Service: Always | 61.8 | 66.4 | -4.6 |
| Claims Processing: Usually or Always | 89.0 | 89.8 | -0.9 |
| Claims Processing: Always | 55.9 | 60.4 | -4.5 |

APPENDIX 14A: PUBLICLY REPORTING VS. NONPUBLICLY REPORTING PLANS: 2011 COMMERCIAL PPOS

| HEDIS EFFECTIVENESS OF CARE AND UTILIZATION MEASURES PUBLICLY REPORTING VS. NONPUBLICLY REPORTING PLANS: COMMERCIAL PPO AVERAGES—2011 | | | |
|---|--------|-----------|------------|
| MEASURE | PUBLIC | NONPUBLIC | DIFFERENCE |
| Overuse and Appropriateness | | | |
| Imaging Studies for Low Back Pain | 73.6 | 76.4 | -2.8 |
| Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis | 21.4 | 22.8 | -1.3 |
| Screening, Prevention and Wellness | | | |
| Adult BMI Assessment | 26.0 | 33.3 | -7.3 |
| Medical Assistance With Smoking and Tobacco Use Cessation: Advising Smokers and Tobacco Users to Quit | 72.4 | 72.4 | 0.0 |
| Medical Assistance With Smoking and Tobacco Use Cessation: Discussing Cessation Strategies | 40.1 | – | – |
| Medical Assistance With Smoking and Tobacco Use Cessation: Discussing Cessation Medications | 47.9 | – | – |
| Flu Shots for Adults | 51.6 | 47.0 | 4.6 |
| Breast Cancer Screening | 66.7 | 65.9 | 0.8 |
| Cervical Cancer Screening | 74.5 | 73.6 | 0.9 |
| Colorectal Cancer Screening | 54.7 | 52.7 | 2.0 |
| Chlamydia Screening in Women: 16–20 Years | 39.7 | 37.0 | 2.7 |
| Chlamydia Screening in Women: 21–24 Years | 45.1 | 41.5 | 3.5 |
| Chlamydia Screening in Women: Total Rate | 42.5 | 39.4 | 3.1 |
| Chronic Condition Management | | | |
| Aspirin Use and Discussion: Aspirin Use | 48.6 | 44.6 | 4.0 |
| Persistence of Beta-Blocker Treatment After a Heart Attack | 76.9 | 80.2 | -3.3 |
| Comprehensive Diabetes Care: Blood Pressure Control (<140/80 mm Hg) | 38.5 | 32.7 | 5.8 |
| Comprehensive Diabetes Care: Blood Pressure Control (<140/90 mm Hg) | 60.0 | 49.4 | 10.7 |
| Comprehensive Diabetes Care: Eye Exams | 48.3 | 51.3 | -3.0 |
| Comprehensive Diabetes Care: HbA1c Screening | 87.0 | 87.2 | -0.3 |
| Comprehensive Diabetes Care: Good Glycemic Control (HbA1c <7% for a Selected Population) | 36.5 | 35.7 | 0.8 |
| Comprehensive Diabetes Care: Good Glycemic Control (HbA1c <8%) | 55.8 | 46.5 | 9.2 |
| Comprehensive Diabetes Care: Poor Glycemic Control (HbA1c >9%)— Lower rates signify better performance | 32.6 | 49.2 | 16.6 |
| Comprehensive Diabetes Care: LDL Cholesterol Screening | 81.3 | 80.6 | 0.7 |
| Comprehensive Diabetes Care: LDL Cholesterol Control (<100 mg/dL) | 42.2 | 34.4 | 7.8 |
| Comprehensive Diabetes Care: Medical Attention for Nephropathy | 77.9 | 78.3 | -0.4 |
| Controlling High Blood Pressure | 58.8 | 50.8 | 8.0 |

**HEDIS EFFECTIVENESS OF CARE AND UTILIZATION MEASURES
PUBLICLY REPORTING VS. NONPUBLICLY REPORTING
PLANS: COMMERCIAL PPO AVERAGES—2011**

| MEASURE | PUBLIC | NONPUBLIC | DIFFERENCE |
|---|--------|-----------|------------|
| Cholesterol Management for Patients With Cardiovascular Conditions: LDL Cholesterol Screening | 83.4 | 85.6 | -2.2 |
| Cholesterol Management for Patients With Cardiovascular Conditions: LDL Control (<100 mg/dL) | 50.3 | 47.7 | 2.6 |
| Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis | 86.7 | 86.3 | 0.5 |
| Use of Appropriate Medications for People With Asthma: 5–11 Years | 96.6 | 95.6 | 1.0 |
| Use of Appropriate Medications for People With Asthma: 12–18 Years | 93.1 | 91.9 | 1.2 |
| Use of Appropriate Medications for People With Asthma: 19–50 Years | 88.4 | 86.5 | 1.9 |
| Use of Appropriate Medications for People With Asthma: 51–64 Years | 93.0 | 92.4 | 0.6 |
| Use of Appropriate Medications for People With Asthma: Overall Rate | 91.7 | 89.6 | 2.1 |
| Use of Spirometry Testing in the Assessment and Diagnosis of COPD | 40.4 | 41.5 | -1.0 |
| Pharmacotherapy Management of COPD: Bronchodilators | 76.8 | 76.8 | 0.0 |
| Pharmacotherapy Management of COPD: Systemic Corticosteroids | 69.6 | 68.6 | 1.0 |
| Annual Monitoring for Patients on Persistent Medications: ACE Inhibitors or ARBs | 78.7 | 80.6 | -1.9 |
| Annual Monitoring for Patients on Persistent Medications: Anticonvulsants | 56.7 | 60.6 | -3.9 |
| Annual Monitoring for Patients on Persistent Medications: Digoxin | 78.9 | 87.2 | -8.3 |
| Annual Monitoring for Patients on Persistent Medications: Diuretics | 78.3 | 80.6 | -2.3 |
| Annual Monitoring for Patients on Persistent Medications: Combined | 78.1 | 80.2 | -2.1 |
| Antidepressant Medication Management: Acute Phase | 64.9 | 66.8 | -2.0 |
| Antidepressant Medication Management: Continuation Phase | 48.8 | 49.8 | -1.0 |
| Follow-Up After Hospitalization for Mental Illness: Within 7 Days Post-Discharge | 54.1 | 52.1 | 2.0 |
| Follow-Up After Hospitalization for Mental Illness: Within 30 Days Post-Discharge | 72.8 | 69.4 | 3.4 |
| Alcohol and Other Drug Dependence Treatment: Initiation | 40.6 | 40.7 | -0.1 |
| Alcohol and Other Drug Dependence Treatment: Engagement | 16.1 | 13.9 | 2.3 |
| Measures Targeted Toward Children and Adolescents | | | |
| Appropriate Testing for Children With Pharyngitis | 79.3 | 78.3 | 1.0 |
| Appropriate Treatment for Children With Upper Respiratory Infection | 82.0 | 82.6 | -0.5 |
| Childhood Immunization Status: DTaP/DT | 77.1 | 68.9 | 8.2 |
| Childhood Immunization Status: Hepatitis B | 74.5 | 80.3 | -5.8 |
| Childhood Immunization Status: HiB | 86.3 | 79.5 | 6.8 |
| Childhood Immunization Status: IPV | 83.6 | 77.6 | 6.1 |
| Childhood Immunization Status: MMR | 87.0 | 83.4 | 3.7 |
| Childhood Immunization Status: Pneumococcal Conjugate (PCV) | 78.1 | 69.0 | 9.2 |

**HEDIS EFFECTIVENESS OF CARE AND UTILIZATION MEASURES
PUBLICLY REPORTING VS. NONPUBLICLY REPORTING
PLANS: COMMERCIAL PPO AVERAGES—2011**

| MEASURE | PUBLIC | NONPUBLIC | DIFFERENCE |
|---|--------|-----------|------------|
| Childhood Immunization Status: VZV | 87.1 | 82.5 | 4.6 |
| Childhood Immunization Status: Hepatitis A | 32.6 | 27.3 | 5.2 |
| Childhood Immunization Status: Rotavirus | 67.6 | 59.6 | 8.0 |
| Childhood Immunization Status: Influenza | 57.7 | 48.9 | 8.8 |
| Childhood Immunization Status: Combination 2 (DTaP, IPV, MMR, HiB, Hepatitis B and VZV) | 64.7 | 66.6 | -1.9 |
| Childhood Immunization Status: Combination 3 (DTaP, IPV, MMR, HiB, Hepatitis B, VZV and PCV) | 63.0 | 63.2 | -0.2 |
| Childhood Immunization Status: Combination 10 (DTaP, IPV, MMR, HiB, Hepatitis A, Hepatitis B, VZV, PCV, Rotavirus and Influenza) | 17.2 | 13.7 | 3.5 |
| Immunizations for Adolescents: Meningococcal | 51.6 | 46.4 | 5.2 |
| Immunizations for Adolescents: Tdap/Td | 65.5 | 61.6 | 4.0 |
| Immunizations for Adolescents: Combination 1 (Meningococcal, Tdap/Td) | 48.4 | 42.7 | 5.8 |
| Follow-Up Care for Children Prescribed ADHD Medication: Initiation | 39.3 | 42.6 | -3.3 |
| Follow-Up Care for Children Prescribed ADHD Medication: Continuation | 44.6 | 55.6 | -11.0 |
| Weight Assessment and Counseling for Nutrition and Physical Activity in Children and Adolescents: BMI Percentile (3–17 Years) | 24.3 | 31.2 | -6.9 |
| Weight Assessment and Counseling for Nutrition and Physical Activity in Children and Adolescents: Counseling for Nutrition (3–17 Years) | 28.1 | 35.3 | -7.2 |
| Weight Assessment and Counseling for Nutrition and Physical Activity in Children and Adolescents: Counseling for Physical Activity (3–17 Years) | 25.3 | 34.3 | -9.1 |
| Well-Child Visits (Ages 0–15 Months): Six or More Well-Child Visits | 76.2 | 72.2 | 4.1 |
| Well-Child Visits (Ages 3–6 Years): One or More Well-Child Visits | 69.9 | 66.8 | 3.1 |
| Adolescent Well-Care Visits: At Least One Comprehensive Well-Care Visit | 40.6 | 40.4 | 0.1 |
| Children and Adolescents' Access to Primary Care Practitioners: Children 12–24 Months | 97.2 | 96.5 | 0.7 |
| Children and Adolescents' Access to Primary Care Practitioners: Children 25 Months–6 Years | 90.4 | 87.4 | 3.0 |
| Children and Adolescents' Access to Primary Care Practitioners: Children 7–11 Years | 90.2 | 87.5 | 2.8 |
| Children and Adolescents' Access to Primary Care Practitioners: Adolescents 12–19 Years | 87.3 | 87.1 | 0.2 |
| Other Access and Utilization | | | |
| Prenatal and Postpartum Care: Timeliness of Prenatal Care | 82.1 | 78.0 | 4.0 |
| Prenatal and Postpartum Care: Postpartum Visit Between 21 and 56 Days After Delivery | 71.3 | 72.3 | -1.0 |
| Plan All-Cause Readmissions: 18–64 Years— Lower rates signify better performance* | 0.80 | 0.77 | -0.03 |

*This indicator is expressed as the ratio of the observed readmission rate to the expected (adjusted for case-mix) readmission rate. Ratios less than 1.0 indicate lower-than-expected readmission rates, whereas ratios greater than 1.0 indicate higher-than-expected readmission rates.

APPENDIX 14B: PUBLICLY REPORTING VS. NONPUBLICLY REPORTING PLANS: 2011 COMMERCIAL PPOS

| CAHPS MEMBER SATISFACTION MEASURES PUBLICLY REPORTING VS. NONPUBLICLY REPORTING PLANS: COMMERCIAL PPO AVERAGES—2011 | | | |
|---|--------|-----------|------------|
| MEASURE | PUBLIC | NONPUBLIC | DIFFERENCE |
| Consumer and Patient Engagement and Experience | | | |
| Rating of Health Plan: Rating of 8, 9 or 10 | 58.7 | 54.2 | 4.5 |
| Rating of Health Plan: Rating of 9 or 10 | 34.1 | 31.5 | 2.5 |
| Rating of Health Care: Rating of 8, 9 or 10 | 76.2 | 75.9 | 0.2 |
| Rating of Health Care: Rating of 9 or 10 | 49.0 | 49.9 | -0.9 |
| Getting Needed Care: Usually or Always | 86.2 | 87.3 | -1.1 |
| Getting Needed Care: Always | 53.8 | 53.1 | 0.7 |
| Getting Care Quickly: Usually or Always | 87.0 | 86.8 | 0.2 |
| Getting Care Quickly: Always | 58.0 | 58.6 | -0.6 |
| How Well Doctors Communicate: Usually or Always | 94.6 | 94.7 | -0.1 |
| How Well Doctors Communicate: Always | 73.8 | 73.4 | 0.4 |
| Rating of Personal Doctor: Rating of 8, 9 or 10 | 83.2 | 84.5 | -1.4 |
| Rating of Personal Doctor: Rating of 9 or 10 | 63.6 | 64.4 | -0.8 |
| Rating of Specialist: Rating of 8, 9 or 10 | 82.1 | 82.4 | -0.3 |
| Rating of Specialist: Rating of 9 or 10 | 62.6 | 64.5 | -1.9 |
| Customer Service: Usually or Always | 82.1 | 85.8 | -3.8 |
| Customer Service: Always | 54.7 | 57.4 | -2.7 |
| Claims Processing: Usually or Always | 87.8 | 88.8 | -1.0 |
| Claims Processing: Always | 50.5 | 52.2 | -1.7 |

APPENDIX 15A: PUBLICLY REPORTING VS. NONPUBLICLY REPORTING PLANS: 2011 MEDICAID HMOS

| HEDIS EFFECTIVENESS OF CARE AND UTILIZATION MEASURES PUBLICLY REPORTING VS. NONPUBLICLY REPORTING PLANS: MEDICAID HMO AVERAGES—2011 | | | |
|---|--------|-----------|------------|
| MEASURE | PUBLIC | NONPUBLIC | DIFFERENCE |
| Overuse and Appropriateness | | | |
| Imaging Studies for Low Back Pain | 75.6 | 76.3 | -0.7 |
| Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis | 23.8 | 25.7 | -1.9 |
| Screening, Prevention and Wellness | | | |
| Adult BMI Assessment | 56.8 | 37.1 | 19.7 |
| Medical Assistance With Smoking and Tobacco Use Cessation: Advising Smokers and Tobacco Users to Quit | 74.5 | 74.7 | -0.2 |
| Medical Assistance With Smoking and Tobacco Use Cessation: Discussing Cessation Strategies | 40.7 | 38.8 | 1.9 |
| Medical Assistance With Smoking and Tobacco Use Cessation: Discussing Cessation Medications | 44.6 | 43.1 | 1.5 |
| Breast Cancer Screening | 50.6 | 50.1 | 0.5 |
| Cervical Cancer Screening | 68.0 | 63.2 | 4.8 |
| Chlamydia Screening in Women: 16–20 Years | 54.4 | 56.3 | -1.9 |
| Chlamydia Screening in Women: 21–24 Years | 63.4 | 63.5 | 0.0 |
| Chlamydia Screening in Women: Total Rate | 57.8 | 58.6 | -0.7 |
| Chronic Condition Management | | | |
| Persistence of Beta-Blocker Treatment After a Heart Attack | 81.0 | 78.2 | 2.8 |
| Comprehensive Diabetes Care: Blood Pressure Control (<140/80 mm Hg) | 40.6 | 34.9 | 5.8 |
| Comprehensive Diabetes Care: Blood Pressure Control (<140/90 mm Hg) | 62.0 | 57.2 | 4.8 |
| Comprehensive Diabetes Care: Eye Exams | 53.7 | 52.2 | 1.5 |
| Comprehensive Diabetes Care: HbA1c Screening | 83.0 | 81.5 | 1.5 |
| Comprehensive Diabetes Care: Good Glycemic Control (HbA1c <7% for a Selected Population) | 36.0 | 32.8 | 3.2 |
| Comprehensive Diabetes Care: Good Glycemic Control (HbA1c <8%) | 49.0 | 45.1 | 3.9 |
| Comprehensive Diabetes Care: Poor Glycemic Control (HbA1c >9%)— Lower rates signify better performance | 42.0 | 46.2 | 4.2 |
| Comprehensive Diabetes Care: LDL Cholesterol Screening | 74.9 | 75.3 | -0.4 |
| Comprehensive Diabetes Care: LDL Cholesterol Control (<100 mg/dL) | 35.6 | 34.0 | 1.6 |
| Comprehensive Diabetes Care: Medical Attention for Nephropathy | 77.6 | 78.5 | -0.8 |
| Controlling High Blood Pressure | 58.1 | 52.4 | 5.8 |
| Cholesterol Management for Patients With Cardiovascular Conditions: LDL Cholesterol Screening | 81.8 | 82.7 | -1.0 |
| Cholesterol Management for Patients With Cardiovascular Conditions: LDL Control (<100 mg/dL) | 43.6 | 36.4 | 7.2 |
| Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis | 69.1 | 67.8 | 1.3 |

**HEDIS EFFECTIVENESS OF CARE AND UTILIZATION MEASURES
PUBLICLY REPORTING VS. NONPUBLICLY REPORTING
PLANS: MEDICAID HMO AVERAGES—2011**

| MEASURE | PUBLIC | NONPUBLIC | DIFFERENCE |
|---|--------|-----------|------------|
| Use of Appropriate Medications for People With Asthma: 5–11 Years | 90.5 | 90.4 | 0.1 |
| Use of Appropriate Medications for People With Asthma: 12–18 Years | 86.7 | 86.3 | 0.5 |
| Use of Appropriate Medications for People With Asthma: 19–50 Years | 74.4 | 75.6 | -1.3 |
| Use of Appropriate Medications for People With Asthma: 51–64 Years | 71.7 | 76.9 | -5.2 |
| Use of Appropriate Medications for People With Asthma: Overall Rate | 85.0 | 84.9 | 0.1 |
| Use of Spirometry Testing in the Assessment and Diagnosis of COPD | 32.0 | 31.9 | 0.1 |
| Pharmacotherapy Management of COPD: Bronchodilators | 80.5 | 80.3 | 0.1 |
| Pharmacotherapy Management of COPD: Systemic Corticosteroids | 63.7 | 65.7 | -2.0 |
| Annual Monitoring for Patients on Persistent Medications: ACE Inhibitors or ARBs | 85.6 | 86.6 | -1.0 |
| Annual Monitoring for Patients on Persistent Medications: Anticonvulsants | 65.8 | 63.0 | 2.8 |
| Annual Monitoring for Patients on Persistent Medications: Digoxin | 90.1 | 91.2 | -1.2 |
| Annual Monitoring for Patients on Persistent Medications: Diuretics | 85.3 | 85.8 | -0.6 |
| Annual Monitoring for Patients on Persistent Medications: Combined | 83.6 | 84.5 | -0.9 |
| Antidepressant Medication Management: Acute Phase | 50.8 | 51.8 | -0.9 |
| Antidepressant Medication Management: Continuation Phase | 34.1 | 35.3 | -1.2 |
| Follow-Up After Hospitalization for Mental Illness: Within 7 Days Post-Discharge | 47.9 | 42.7 | 5.1 |
| Follow-Up After Hospitalization for Mental Illness: Within 30 Days Post-Discharge | 66.8 | 59.9 | 6.9 |
| Alcohol and Other Drug Dependence Treatment: Initiation | 39.7 | 37.6 | 2.1 |
| Alcohol and Other Drug Dependence Treatment: Engagement | 12.5 | 10.1 | 2.5 |
| Measures Targeted Toward Children and Adolescents | | | |
| Appropriate Testing for Children With Pharyngitis | 67.2 | 65.2 | 2.0 |
| Appropriate Treatment for Children With Upper Respiratory Infection | 85.4 | 85.2 | 0.2 |
| Childhood Immunization Status: DTaP/DT | 80.0 | 79.4 | 0.6 |
| Childhood Immunization Status: Hepatitis B | 89.3 | 87.1 | 2.3 |
| Childhood Immunization Status: HiB | 91.2 | 90.2 | 1.0 |
| Childhood Immunization Status: IPV | 91.0 | 89.1 | 1.9 |
| Childhood Immunization Status: MMR | 90.9 | 90.9 | 0.0 |
| Childhood Immunization Status: Pneumococcal Conjugate (PCV) | 79.8 | 77.5 | 2.3 |
| Childhood Immunization Status: VZV | 90.5 | 90.5 | 0.0 |
| Childhood Immunization Status: Hepatitis A | 38.6 | 41.0 | -2.4 |
| Childhood Immunization Status: Rotavirus | 62.8 | 60.6 | 2.2 |
| Childhood Immunization Status: Influenza | 45.2 | 43.6 | 1.6 |
| Childhood Immunization Status: Combination 2 (DTaP, IPV, MMR, HiB, Hepatitis B and VZV) | 75.0 | 72.9 | 2.1 |

**HEDIS EFFECTIVENESS OF CARE AND UTILIZATION MEASURES
PUBLICLY REPORTING VS. NONPUBLICLY REPORTING
PLANS: MEDICAID HMO AVERAGES—2011**

| MEASURE | PUBLIC | NONPUBLIC | DIFFERENCE |
|---|--------|-----------|------------|
| Childhood Immunization Status: Combination 3 (DTaP, IPV, MMR, HiB, Hepatitis B, VZV and PCV) | 71.5 | 67.9 | 3.6 |
| Childhood Immunization Status: Combination 10 (DTaP, IPV, MMR, HiB, Hepatitis A, Hepatitis B, VZV, PCV, Rotavirus and Influenza) | 17.4 | 16.8 | 0.7 |
| Immunizations for Adolescents: Meningococcal | 63.5 | 62.2 | 1.2 |
| Immunizations for Adolescents: Tdap/Td | 75.9 | 75.3 | 0.6 |
| Immunizations for Adolescents: Combination 1 (Meningococcal, Tdap/Td) | 60.9 | 59.3 | 1.6 |
| Follow-Up Care for Children Prescribed ADHD Medication: Initiation | 39.7 | 36.4 | 3.3 |
| Follow-Up Care for Children Prescribed ADHD Medication: Continuation | 47.6 | 40.0 | 7.7 |
| Lead Screening in Children | 67.9 | 67.7 | 0.2 |
| Weight Assessment and Counseling for Nutrition and Physical Activity in Children and Adolescents: BMI Percentile (3–17 Years) | 48.5 | 37.2 | 11.3 |
| Weight Assessment and Counseling for Nutrition and Physical Activity in Children and Adolescents: Counseling for Nutrition (3–17 Years) | 51.9 | 43.7 | 8.2 |
| Weight Assessment and Counseling for Nutrition and Physical Activity in Children and Adolescents: Counseling for Physical Activity (3–17 Years) | 42.1 | 35.3 | 6.9 |
| Well-Child Visits (Ages 0–15 Months): Six or More Well-Child Visits | 62.8 | 58.4 | 4.3 |
| Well-Child Visits (Ages 3–6 Years): One or More Well-Child Visits | 72.3 | 71.1 | 1.2 |
| Adolescent Well-Care Visits: At Least One Comprehensive Well-Care Visit | 49.9 | 49.2 | 0.7 |
| Children and Adolescents' Access to Primary Care Practitioners: Children 12–24 Months | 96.1 | 95.9 | 0.2 |
| Children and Adolescents' Access to Primary Care Practitioners: Children 25 Months–6 Years | 88.3 | 87.9 | 0.4 |
| Children and Adolescents' Access to Primary Care Practitioners: Children 7–11 Years | 89.7 | 88.9 | 0.9 |
| Children and Adolescents' Access to Primary Care Practitioners: Adolescents 12–19 Years | 88.2 | 86.9 | 1.3 |
| Other Access and Utilization | | | |
| Frequency of Prenatal Care Visits: <21% of Expected Visits | 8.9 | 13.7 | -4.8 |
| Frequency of Prenatal Care Visits: 21–40% of Expected Visits | 6.5 | 6.7 | -0.3 |
| Frequency of Prenatal Care Visits: 41–60% of Expected Visits | 7.9 | 9.1 | -1.1 |
| Frequency of Prenatal Care Visits: 61–80% of Expected Visits | 14.3 | 14.8 | -0.4 |
| Frequency of Prenatal Care Visits: ≥81% of Expected Visits | 62.5 | 55.7 | 6.8 |
| Prenatal and Postpartum Care: Timeliness of Prenatal Care | 84.7 | 77.8 | 6.9 |
| Prenatal and Postpartum Care: Postpartum Visit Between 21 and 56 Days After Delivery | 65.2 | 61.4 | 3.9 |

APPENDIX 15B: PUBLICLY REPORTING VS. NONPUBLICLY REPORTING PLANS: 2011 MEDICAID HMOS

| CAHPS MEMBER SATISFACTION MEASURES PUBLICLY REPORTING VS. NONPUBLICLY REPORTING PLANS: MEDICAID HMO AVERAGES—2011 | | | |
|---|--------|-----------|------------|
| MEASURE | PUBLIC | NONPUBLIC | DIFFERENCE |
| Consumer and Patient Engagement and Experience | | | |
| Rating of Health Plan: Rating of 8, 9 or 10 | 74.0 | 71.7 | 2.2 |
| Rating of Health Plan: Rating of 9 or 10 | 56.1 | 53.9 | 2.2 |
| Rating of Health Care: Rating of 8, 9 or 10 | 69.9 | 69.9 | 0.0 |
| Rating of Health Care: Rating of 9 or 10 | 49.6 | 50.1 | -0.5 |
| Getting Needed Care: Usually or Always | 76.3 | 72.3 | 4.0 |
| Getting Needed Care: Always | 51.1 | 47.5 | 3.6 |
| Getting Care Quickly: Usually or Always | 80.5 | 79.8 | 0.7 |
| Getting Care Quickly: Always | 57.2 | 57.5 | -0.4 |
| How Well Doctors Communicate: Usually or Always | 88.1 | 86.9 | 1.2 |
| How Well Doctors Communicate: Always | 70.3 | 69.2 | 1.1 |
| Rating of Personal Doctor: Rating of 8, 9 or 10 | 77.0 | 77.2 | -0.2 |
| Rating of Personal Doctor: Rating of 9 or 10 | 61.9 | 61.4 | 0.6 |
| Rating of Specialist: Rating of 8, 9 or 10 | 78.1 | 75.9 | 2.3 |
| Rating of Specialist: Rating of 9 or 10 | 62.5 | 60.5 | 1.9 |
| Customer Service: Usually or Always | 81.1 | 78.6 | 2.6 |
| Customer Service: Always | 62.0 | 58.1 | 3.8 |

APPENDIX 16A: PUBLICLY REPORTING VS. NONPUBLICLY REPORTING PLANS: 2011 MEDICARE HMOS

| HEDIS EFFECTIVENESS OF CARE AND UTILIZATION MEASURES PUBLICLY REPORTING VS. NONPUBLICLY REPORTING PLANS: MEDICARE HMO AVERAGES—2011 | | | |
|---|--------|-----------|------------|
| MEASURE | PUBLIC | NONPUBLIC | DIFFERENCE |
| Screening, Prevention and Wellness | | | |
| Adult BMI Assessment | 68.6 | 66.2 | 2.4 |
| Medical Assistance With Smoking and Tobacco Use Cessation: Advising Smokers and Tobacco Users to Quit | 81.3 | 82.4 | -1.1 |
| Flu Shots for Older Adults | 69.4 | 65.9 | 3.5 |
| Pneumonia Vaccine for Older Adults | 70.5 | 63.7 | 6.8 |
| Breast Cancer Screening | 69.7 | 64.4 | 5.3 |
| Colorectal Cancer Screening | 61.3 | 53.4 | 7.9 |
| Chronic Condition Management | | | |
| Persistence of Beta-Blocker Treatment After a Heart Attack | 87.5 | 85.5 | 2.0 |
| Comprehensive Diabetes Care: Blood Pressure Control (<140/80 mm Hg) | 49.0 | 44.6 | 4.3 |
| Comprehensive Diabetes Care: Blood Pressure Control (<140/90 mm Hg) | 63.7 | 59.6 | 4.1 |
| Comprehensive Diabetes Care: Eye Exams | 66.3 | 64.7 | 1.5 |
| Comprehensive Diabetes Care: HbA1c Screening | 91.5 | 88.5 | 3.0 |
| Comprehensive Diabetes Care: Good Glycemic Control (HbA1c <8%) | 66.6 | 58.1 | 8.5 |
| Comprehensive Diabetes Care: Poor Glycemic Control (HbA1c >9%)— Lower rates signify better performance | 25.0 | 34.0 | 9.1 |
| Comprehensive Diabetes Care: LDL Cholesterol Screening | 88.9 | 85.0 | 4.0 |
| Comprehensive Diabetes Care: LDL Cholesterol Control (<100 mg/dL) | 53.7 | 46.1 | 7.6 |
| Comprehensive Diabetes Care: Medical Attention for Nephropathy | 90.1 | 88.6 | 1.6 |
| Controlling High Blood Pressure | 64.5 | 61.6 | 2.8 |
| Cholesterol Management for Patients With Cardiovascular Conditions: LDL Cholesterol Screening | 89.5 | 85.6 | 3.9 |
| Cholesterol Management for Patients With Cardiovascular Conditions: LDL Control (<100 mg/dL) | 57.9 | 49.3 | 8.6 |
| Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis | 73.0 | 70.3 | 2.7 |
| Use of Spirometry Testing in the Assessment and Diagnosis of COPD | 36.9 | 32.6 | 4.3 |
| Pharmacotherapy Management of COPD: Bronchodilators | 77.9 | 81.2 | -3.2 |
| Pharmacotherapy Management of COPD: Systemic Corticosteroids | 66.9 | 66.0 | 0.9 |
| Annual Monitoring for Patients on Persistent Medications: ACE Inhibitors or ARBs | 91.7 | 89.7 | 1.9 |
| Annual Monitoring for Patients on Persistent Medications: Anticonvulsants | 67.2 | 68.5 | -1.3 |
| Annual Monitoring for Patients on Persistent Medications: Digoxin | 93.5 | 93.3 | 0.2 |
| Annual Monitoring for Patients on Persistent Medications: Diuretics | 92.0 | 90.0 | 2.0 |

**HEDIS EFFECTIVENESS OF CARE AND UTILIZATION MEASURES
PUBLICLY REPORTING VS. NONPUBLICLY REPORTING
PLANS: MEDICARE HMO AVERAGES—2011**

| MEASURE | PUBLIC | NONPUBLIC | DIFFERENCE |
|--|--------|-----------|------------|
| Annual Monitoring for Patients on Persistent Medications: Combined | 91.2 | 88.9 | 2.3 |
| Antidepressant Medication Management: Acute Phase | 66.8 | 63.3 | 3.5 |
| Antidepressant Medication Management: Continuation Phase | 53.5 | 51.9 | 1.6 |
| Follow-Up After Hospitalization for Mental Illness: Within 7 Days Post-Discharge | 39.5 | 30.6 | 8.9 |
| Follow-Up After Hospitalization for Mental Illness: Within 30 Days Post-Discharge | 57.4 | 49.3 | 8.1 |
| Alcohol and Other Drug Dependence Treatment: Initiation | 40.7 | 42.5 | -1.8 |
| Alcohol and Other Drug Dependence Treatment: Engagement | 3.7 | 3.9 | -0.2 |
| Measures Targeted Toward Older Adults | | | |
| Fall Risk Management: Discussion | 31.7 | 38.5 | -6.8 |
| Fall Risk Management: Management | 59.4 | 65.0 | -5.6 |
| Potentially Harmful Drug-Disease Interactions in the Elderly: Chronic Renal Failure and NSAIDs or Cox-2 Selective NSAIDs— Lower rates signify better performance | 11.3 | 14.5 | 3.1 |
| Potentially Harmful Drug-Disease Interactions in the Elderly: Dementia and Tricyclic Antidepressants or Anticholinergic Agents— Lower rates signify better performance | 26.5 | 29.4 | 2.8 |
| Potentially Harmful Drug-Disease Interactions in the Elderly: Falls and Tricyclic Antidepressants, Antipsychotics and Sleep Agents— Lower rates signify better performance | 15.2 | 18.0 | 2.8 |
| Potentially Harmful Drug-Disease Interactions in the Elderly: Overall Rate— Lower rates signify better performance | 21.2 | 24.2 | 3.0 |
| Use of High-Risk Medications in the Elderly: At Least One Medication— Lower rates signify better performance | 18.1 | 20.5 | 2.4 |
| Use of High-Risk Medications in the Elderly: At Least Two Medications— Lower rates signify better performance | 3.4 | 4.3 | 0.9 |
| Management of Urinary Incontinence: Discussion | 56.8 | 61.1 | -4.3 |
| Physical Activity in Older Adults: Discussion | 53.2 | 52.2 | 0.9 |
| Physical Activity in Older Adults: Advice | 48.7 | 48.6 | 0.1 |
| Osteoporosis Testing in Older Women | 72.2 | 64.3 | 7.9 |
| Osteoporosis Management in Women Who Had a Fracture | 22.9 | 21.7 | 1.2 |
| Glaucoma Screening in Older Adults | 66.1 | 64.3 | 1.8 |
| Other Access and Utilization | | | |
| Plan All-Cause Readmissions: 65 Years And Older— Lower rates signify better performance* | 0.89 | 1.01 | 0.12 |

*This indicator is expressed as the ratio of the observed readmission rate to the expected (adjusted for case-mix) readmission rate. Ratios less than 1.0 indicate lower-than-expected readmission rates, whereas ratios greater than 1.0 indicate higher-than-expected readmission rates.

APPENDIX 16B: PUBLICLY REPORTING VS. NONPUBLICLY REPORTING PLANS: 2011 MEDICARE HMOs

| CAHPS MEMBER SATISFACTION MEASURES PUBLICLY REPORTING VS. NONPUBLICLY REPORTING PLANS: MEDICARE HMO AVERAGES—2011 | | | |
|---|--------|-----------|------------|
| MEASURE | PUBLIC | NONPUBLIC | DIFFERENCE |
| Consumer and Patient Engagement and Experience | | | |
| Rating of Health Plan: Rating of 8, 9 or 10 | 88.8 | 87.3 | 1.5 |
| Rating of Health Plan: Rating of 9 or 10 | 63.8 | 64.2 | -0.4 |
| Rating of Health Care: Rating of 8, 9 or 10 | 87.4 | 82.3 | 5.1 |
| Rating of Health Care: Rating of 9 or 10 | 61.8 | 56.2 | 5.6 |
| Getting Needed Care: Usually or Always | 90.0 | 86.0 | 4.0 |
| Getting Needed Care: Always | 64.8 | 60.4 | 4.4 |
| Getting Care Quickly: Usually or Always | 88.3 | 85.2 | 3.1 |
| Getting Care Quickly: Always | 66.1 | 63.1 | 3.0 |
| How Well Doctors Communicate: Usually or Always | 94.5 | 92.4 | 2.1 |
| How Well Doctors Communicate: Always | 76.6 | 74.5 | 2.2 |
| Rating of Personal Doctor: Rating of 8, 9 or 10 | 93.3 | 91.3 | 2.0 |
| Rating of Personal Doctor: Rating of 9 or 10 | 75.1 | 71.9 | 3.2 |
| Rating of Specialist: Rating of 8, 9 or 10 | 91.7 | 89.3 | 2.4 |
| Rating of Specialist: Rating of 9 or 10 | 71.1 | 67.5 | 3.5 |
| Customer Service: Usually or Always | 88.6 | 86.5 | 2.1 |
| Customer Service: Always | 69.1 | 67.7 | 1.5 |

APPENDIX 17A: PUBLICLY REPORTING VS. NONPUBLICLY REPORTING PLANS: 2011 MEDICARE PPOS

| HEDIS EFFECTIVENESS OF CARE AND UTILIZATION MEASURES PUBLICLY REPORTING VS. NONPUBLICLY REPORTING PLANS: MEDICARE PPO AVERAGES—2011 | | | |
|---|--------|-----------|------------|
| MEASURE | PUBLIC | NONPUBLIC | DIFFERENCE |
| Screening, Prevention and Wellness | | | |
| Adult BMI Assessment | 61.9 | 66.1 | -4.2 |
| Medical Assistance With Smoking and Tobacco Use Cessation: Advising Smokers and Tobacco Users to Quit | 79.0 | 81.8 | -2.8 |
| Flu Shots for Older Adults | 69.8 | 65.9 | 3.9 |
| Pneumonia Vaccine for Older Adults | 72.2 | 66.4 | 5.8 |
| Breast Cancer Screening | 65.7 | 66.5 | -0.8 |
| Colorectal Cancer Screening | 55.6 | 50.5 | 5.1 |
| Chronic Condition Management | | | |
| Persistence of Beta-Blocker Treatment After a Heart Attack | 86.7 | 83.1 | 3.6 |
| Comprehensive Diabetes Care: Blood Pressure Control (<140/80 mm Hg) | 47.2 | 38.5 | 8.7 |
| Comprehensive Diabetes Care: Blood Pressure Control (<140/90 mm Hg) | 61.3 | 49.7 | 11.6 |
| Comprehensive Diabetes Care: Eye Exams | 64.4 | 58.2 | 6.2 |
| Comprehensive Diabetes Care: HbA1c Screening | 91.2 | 89.9 | 1.4 |
| Comprehensive Diabetes Care: Good Glycemic Control (HbA1c <8%) | 63.9 | 55.8 | 8.0 |
| Comprehensive Diabetes Care: Poor Glycemic Control (HbA1c >9%)— Lower rates signify better performance | 28.0 | 37.5 | 9.5 |
| Comprehensive Diabetes Care: LDL Cholesterol Screening | 86.7 | 86.1 | 0.7 |
| Comprehensive Diabetes Care: LDL Cholesterol Control (<100 mg/dL) | 51.5 | 44.7 | 6.8 |
| Comprehensive Diabetes Care: Medical Attention for Nephropathy | 88.0 | 88.5 | -0.5 |
| Controlling High Blood Pressure | 61.4 | 53.2 | 8.2 |
| Cholesterol Management for Patients With Cardiovascular Conditions: LDL Cholesterol Screening | 88.4 | 87.0 | 1.4 |
| Cholesterol Management for Patients With Cardiovascular Conditions: LDL Control (<100 mg/dL) | 57.2 | 50.3 | 6.9 |
| Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis | 77.4 | 75.2 | 2.3 |
| Use of Spirometry Testing in the Assessment and Diagnosis of COPD | 35.4 | 36.6 | -1.2 |
| Pharmacotherapy Management of COPD: Bronchodilators | 76.2 | 73.4 | 2.8 |
| Pharmacotherapy Management of COPD: Systemic Corticosteroids | 69.3 | 63.6 | 5.7 |
| Annual Monitoring for Patients on Persistent Medications: ACE Inhibitors or ARBs | 91.5 | 90.3 | 1.1 |
| Annual Monitoring for Patients on Persistent Medications: Anticonvulsants | 68.6 | 67.3 | 1.2 |
| Annual Monitoring for Patients on Persistent Medications: Digoxin | 93.3 | 92.1 | 1.2 |
| Annual Monitoring for Patients on Persistent Medications: Diuretics | 91.9 | 90.7 | 1.1 |

**HEDIS EFFECTIVENESS OF CARE AND UTILIZATION MEASURES
PUBLICLY REPORTING VS. NONPUBLICLY REPORTING
PLANS: MEDICARE PPO AVERAGES—2011**

| MEASURE | PUBLIC | NONPUBLIC | DIFFERENCE |
|--|--------|-----------|------------|
| Annual Monitoring for Patients on Persistent Medications: Combined | 91.2 | 90.1 | 1.1 |
| Antidepressant Medication Management: Acute Phase | 71.4 | 65.3 | 6.1 |
| Antidepressant Medication Management: Continuation Phase | 59.0 | 53.2 | 5.8 |
| Follow-Up After Hospitalization for Mental Illness: Within 7 Days Post-Discharge | 39.6 | 31.9 | 7.7 |
| Follow-Up After Hospitalization for Mental Illness: Within 30 Days Post-Discharge | 61.2 | 56.0 | 5.3 |
| Alcohol and Other Drug Dependence Treatment: Initiation | 47.5 | 47.8 | -0.2 |
| Alcohol and Other Drug Dependence Treatment: Engagement | 3.9 | 2.8 | 1.1 |
| Measures Targeted Toward Older Adults | | | |
| Fall Risk Management: Discussion | 30.6 | 32.1 | -1.5 |
| Fall Risk Management: Management | 54.4 | 57.2 | -2.8 |
| Potentially Harmful Drug-Disease Interactions in the Elderly: Chronic Renal Failure and NSAIDs or Cox-2 Selective NSAIDs— Lower rates signify better performance | 9.0 | 17.1 | 8.1 |
| Potentially Harmful Drug-Disease Interactions in the Elderly: Dementia and Tricyclic Antidepressants or Anticholinergic Agents— Lower rates signify better performance | 25.2 | 31.4 | 6.3 |
| Potentially Harmful Drug-Disease Interactions in the Elderly: Falls and Tricyclic Antidepressants, Antipsychotics and Sleep Agents— Lower rates signify better performance | 15.2 | 16.6 | 1.4 |
| Potentially Harmful Drug-Disease Interactions in the Elderly: Overall Rate— Lower rates signify better performance | 20.1 | 25.6 | 5.5 |
| Use of High-Risk Medications in the Elderly: At Least One Medication— Lower rates signify better performance | 18.3 | 20.1 | 1.8 |
| Use of High-Risk Medications in the Elderly: At Least Two Medications— Lower rates signify better performance | 3.4 | 4.6 | 1.2 |
| Management of Urinary Incontinence: Discussion | 56.9 | 56.5 | 0.4 |
| Physical Activity in Older Adults: Discussion | 53.8 | 52.5 | 1.3 |
| Physical Activity in Older Adults: Advice | 47.5 | 48.4 | -0.8 |
| Osteoporosis Testing in Older Women | 75.4 | 71.2 | 4.2 |
| Osteoporosis Management in Women Who Had a Fracture | 19.3 | 19.0 | 0.3 |
| Glaucoma Screening in Older Adults | 66.6 | 66.0 | 0.6 |
| Other Access and Utilization | | | |
| Plan All-Cause Readmissions: 65 Years And Older— Lower rates signify better performance* | 0.86 | 1.05 | 0.19 |

*This indicator is expressed as the ratio of the observed readmission rate to the expected (adjusted for case-mix) readmission rate. Ratios less than 1.0 indicate lower-than-expected readmission rates, whereas ratios greater than 1.0 indicate higher-than-expected readmission rates.

APPENDIX 17B: PUBLICLY REPORTING VS. NONPUBLICLY REPORTING PLANS: 2011 MEDICARE PPOS

| CAHPS MEMBER SATISFACTION MEASURES PUBLICLY REPORTING VS. NONPUBLICLY REPORTING PLANS: MEDICARE PPO AVERAGES—2011 | | | |
|---|--------|-----------|------------|
| MEASURE | PUBLIC | NONPUBLIC | DIFFERENCE |
| Consumer and Patient Engagement and Experience | | | |
| Rating of Health Plan: Rating of 8, 9 or 10 | 87.7 | 88.6 | -0.9 |
| Rating of Health Plan: Rating of 9 or 10 | 58.2 | 61.4 | -3.3 |
| Rating of Health Care: Rating of 8, 9 or 10 | 89.5 | 87.8 | 1.7 |
| Rating of Health Care: Rating of 9 or 10 | 62.7 | 61.5 | 1.2 |
| Getting Needed Care: Usually or Always | 92.7 | 91.7 | 0.9 |
| Getting Needed Care: Always | 66.4 | 68.5 | -2.1 |
| Getting Care Quickly: Usually or Always | 90.1 | 89.4 | 0.8 |
| Getting Care Quickly: Always | 67.3 | 69.1 | -1.8 |
| How Well Doctors Communicate: Usually or Always | 95.6 | 95.0 | 0.6 |
| How Well Doctors Communicate: Always | 77.2 | 79.0 | -1.8 |
| Rating of Personal Doctor: Rating of 8, 9 or 10 | 94.1 | 94.1 | 0.0 |
| Rating of Personal Doctor: Rating of 9 or 10 | 76.0 | 76.9 | -0.9 |
| Rating of Specialist: Rating of 8, 9 or 10 | 92.7 | 93.3 | -0.6 |
| Rating of Specialist: Rating of 9 or 10 | 73.5 | 74.9 | -1.5 |
| Customer Service: Usually or Always | 88.4 | 91.0 | -2.7 |
| Customer Service: Always | 67.9 | 73.4 | -5.5 |

APPENDIX 18A: HMOS VS. PPOS, COMMERCIAL PLANS

| HEDIS EFFECTIVENESS OF CARE AND UTILIZATION MEASURES | | | |
|---|------------|------------|-------------------|
| HMOS VS. PPOS: COMMERCIAL AVERAGES—2011 | | | |
| MEASURE | HMO | PPO | DIFFERENCE |
| Overuse and Appropriateness | | | |
| Imaging Studies for Low Back Pain | 74.4 | 73.7 | 0.6 |
| Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis | 23.5 | 21.5 | 2.1 |
| Screening, Prevention and Wellness | | | |
| Medical Assistance With Smoking and Tobacco Use Cessation: Advising Smokers and Tobacco Users to Quit | 77.6 | 72.4 | 5.2 |
| Medical Assistance With Smoking and Tobacco Use Cessation: Discussing Cessation Strategies | 47.6 | 40.1 | 7.5 |
| Medical Assistance With Smoking and Tobacco Use Cessation: Discussing Cessation Medications | 53.1 | 47.9 | 5.2 |
| Flu Shots for Adults | 53.3 | 51.4 | 1.9 |
| Breast Cancer Screening | 70.5 | 66.7 | 3.9 |
| Cervical Cancer Screening | 76.5 | 74.4 | 2.1 |
| Chlamydia Screening in Women: 16–20 Years | 41.5 | 39.6 | 1.9 |
| Chlamydia Screening in Women: 21–24 Years | 48.4 | 44.9 | 3.5 |
| Chlamydia Screening in Women: Total Rate | 45.0 | 42.4 | 2.6 |
| Chronic Condition Management | | | |
| Aspirin Use and Discussion: Aspirin Use | 46.9 | 48.6 | -1.6 |
| Persistence of Beta-Blocker Treatment After a Heart Attack | 81.3 | 77.0 | 4.3 |
| Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis | 87.6 | 86.7 | 1.0 |
| Use of Appropriate Medications for People With Asthma: 5–11 Years | 96.0 | 96.6 | -0.5 |
| Use of Appropriate Medications for People With Asthma: 12–18 Years | 92.7 | 93.1 | -0.4 |
| Use of Appropriate Medications for People With Asthma: 19–50 Years | 89.1 | 88.3 | 0.8 |
| Use of Appropriate Medications for People With Asthma: 51–64 Years | 93.2 | 93.0 | 0.2 |
| Use of Appropriate Medications for People With Asthma: Overall Rate | 91.9 | 91.6 | 0.4 |
| Use of Spirometry Testing in the Assessment and Diagnosis of COPD | 42.9 | 40.5 | 2.5 |
| Pharmacotherapy Management of COPD: Bronchodilators | 79.9 | 76.8 | 3.1 |
| Pharmacotherapy Management of COPD: Systemic Corticosteroids | 71.3 | 69.5 | 1.8 |
| Annual Monitoring for Patients on Persistent Medications: ACE Inhibitors or ARBs | 82.5 | 78.8 | 3.7 |
| Annual Monitoring for Patients on Persistent Medications: Anticonvulsants | 60.5 | 56.9 | 3.6 |
| Annual Monitoring for Patients on Persistent Medications: Digoxin | 85.4 | 79.2 | 6.2 |
| Annual Monitoring for Patients on Persistent Medications: Diuretics | 82.1 | 78.4 | 3.7 |
| Annual Monitoring for Patients on Persistent Medications: Combined | 81.9 | 78.2 | 3.7 |
| Antidepressant Medication Management: Acute Phase | 65.6 | 64.9 | 0.6 |
| Antidepressant Medication Management: Continuation Phase | 49.4 | 48.8 | 0.6 |

HEDIS EFFECTIVENESS OF CARE AND UTILIZATION MEASURES

HMOS VS. PPOS: COMMERCIAL AVERAGES—2011

| MEASURE | HMO | PPO | DIFFERENCE |
|--|------|------|------------|
| Follow-Up After Hospitalization for Mental Illness: Within 7 Days Post-Discharge | 58.9 | 54.0 | 4.9 |
| Follow-Up After Hospitalization for Mental Illness: Within 30 Days Post-Discharge | 76.5 | 72.7 | 3.8 |
| Alcohol and Other Drug Dependence Treatment: Initiation | 40.2 | 40.6 | -0.4 |
| Alcohol and Other Drug Dependence Treatment: Engagement | 15.2 | 16.0 | -0.8 |
| Measures Targeted Toward Children and Adolescents | | | |
| Appropriate Testing for Children With Pharyngitis | 80.2 | 79.3 | 0.9 |
| Appropriate Treatment for Children With Upper Respiratory Infection | 83.9 | 82.0 | 1.9 |
| Follow-Up Care for Children Prescribed ADHD Medication: Initiation | 39.4 | 39.4 | 0.0 |
| Follow-Up Care for Children Prescribed ADHD Medication: Continuation | 44.2 | 44.9 | -0.7 |
| Well-Child Visits (Ages 0–15 Months): Six or More Well-Child Visits | 78.0 | 76.1 | 2.0 |
| Well-Child Visits (Ages 3–6 Years): One or More Well-Child Visits | 72.5 | 69.8 | 2.7 |
| Adolescent Well-Care Visits: At Least One Comprehensive Well-Care Visit | 43.2 | 40.6 | 2.7 |
| Children and Adolescents' Access to Primary Care Practitioners: Children 12–24 Months | 97.9 | 97.2 | 0.7 |
| Children and Adolescents' Access to Primary Care Practitioners: Children 25 Months–6 Years | 91.9 | 90.3 | 1.6 |
| Children and Adolescents' Access to Primary Care Practitioners: Children 7–11 Years | 91.9 | 90.1 | 1.8 |
| Children and Adolescents' Access to Primary Care Practitioners: Adolescents 12–19 Years | 89.3 | 87.3 | 2.0 |
| Other Access and Utilization | | | |
| Plan All-Cause Readmissions: 18–64 Years— Lower rates signify better performance* | 0.81 | 0.80 | -0.01 |

*This indicator is expressed as the ratio of the observed readmission rate to the expected (adjusted for case-mix) readmission rate. Ratios less than 1.0 indicate lower-than-expected readmission rates, whereas ratios greater than 1.0 indicate higher-than-expected readmission rates.

APPENDIX 18B: HMOS VS. PPOS, COMMERCIAL PLANS

| CAHPS MEMBER SATISFACTION MEASURES | | | |
|---|------|------|------------|
| HMOS VS. PPOS: COMMERCIAL AVERAGES—2011 | | | |
| MEASURE | HMO | PPO | DIFFERENCE |
| Consumer and Patient Engagement and Experience | | | |
| Rating of Health Plan: Rating of 8, 9 or 10 | 66.1 | 58.4 | 7.6 |
| Rating of Health Plan: Rating of 9 or 10 | 42.1 | 33.9 | 8.2 |
| Rating of Health Care: Rating of 8, 9 or 10 | 77.6 | 76.2 | 1.5 |
| Rating of Health Care: Rating of 9 or 10 | 51.9 | 49.0 | 2.9 |
| Getting Needed Care: Usually or Always | 85.5 | 86.2 | -0.7 |
| Getting Needed Care: Always | 54.1 | 53.8 | 0.3 |
| Getting Care Quickly: Usually or Always | 86.2 | 87.0 | -0.8 |
| Getting Care Quickly: Always | 58.7 | 58.0 | 0.7 |
| How Well Doctors Communicate: Usually or Always | 94.0 | 94.6 | -0.6 |
| How Well Doctors Communicate: Always | 74.2 | 73.8 | 0.4 |
| Rating of Personal Doctor: Rating of 8, 9 or 10 | 83.9 | 83.2 | 0.7 |
| Rating of Personal Doctor: Rating of 9 or 10 | 66.0 | 63.7 | 2.3 |
| Rating of Specialist: Rating of 8, 9 or 10 | 83.2 | 82.1 | 1.1 |
| Rating of Specialist: Rating of 9 or 10 | 65.2 | 62.7 | 2.5 |
| Customer Service: Usually or Always | 86.1 | 82.2 | 3.9 |
| Customer Service: Always | 62.1 | 54.8 | 7.3 |
| Claims Processing: Usually or Always | 89.0 | 87.8 | 1.2 |
| Claims Processing: Always | 56.2 | 50.5 | 5.7 |

APPENDIX 19A: HMOS VS. PPOS, MEDICARE PLANS

| HEDIS EFFECTIVENESS OF CARE AND UTILIZATION MEASURES | | | |
|---|------------|------------|-------------------|
| HMOS VS. PPOS: MEDICARE AVERAGES—2011 | | | |
| MEASURE | HMO | PPO | DIFFERENCE |
| Screening, Prevention and Wellness | | | |
| Medical Assistance With Smoking and Tobacco Use Cessation: Advising Smokers and Tobacco Users to Quit | 81.5 | 79.3 | 2.2 |
| Flu Shots for Older Adults | 68.8 | 69.5 | -0.7 |
| Pneumonia Vaccine for Older Adults | 69.4 | 71.7 | -2.2 |
| Breast Cancer Screening | 68.9 | 65.8 | 3.1 |
| Chronic Condition Management | | | |
| Persistence of Beta-Blocker Treatment After a Heart Attack | 87.3 | 86.2 | 1.0 |
| Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis | 72.7 | 77.2 | -4.6 |
| Use of Spirometry Testing in the Assessment and Diagnosis of COPD | 36.3 | 35.6 | 0.8 |
| Pharmacotherapy Management of COPD: Bronchodilators | 78.4 | 75.9 | 2.5 |
| Pharmacotherapy Management of COPD: Systemic Corticosteroids | 66.8 | 68.8 | -2.0 |
| Annual Monitoring for Patients on Persistent Medications: ACE Inhibitors or ARBs | 91.3 | 91.4 | 0.0 |
| Annual Monitoring for Patients on Persistent Medications: Anticonvulsants | 67.4 | 68.5 | -1.1 |
| Annual Monitoring for Patients on Persistent Medications: Digoxin | 93.4 | 93.2 | 0.2 |
| Annual Monitoring for Patients on Persistent Medications: Diuretics | 91.6 | 91.8 | -0.1 |
| Annual Monitoring for Patients on Persistent Medications: Combined | 90.9 | 91.2 | -0.3 |
| Antidepressant Medication Management: Acute Phase | 66.3 | 70.8 | -4.4 |
| Antidepressant Medication Management: Continuation Phase | 53.3 | 58.4 | -5.1 |
| Follow-Up After Hospitalization for Mental Illness: Within 7 Days Post-Discharge | 38.0 | 38.7 | -0.6 |
| Follow-Up After Hospitalization for Mental Illness: Within 30 Days Post-Discharge | 56.1 | 60.6 | -4.5 |
| Alcohol and Other Drug Dependence Treatment: Initiation | 41.0 | 47.6 | -6.6 |
| Alcohol and Other Drug Dependence Treatment: Engagement | 3.7 | 3.8 | -0.1 |
| Measures Targeted Toward Older Adults | | | |
| Fall Risk Management: Discussion | 32.8 | 30.7 | 2.0 |
| Fall Risk Management: Management | 60.2 | 54.6 | 5.6 |
| Potentially Harmful Drug-Disease Interactions in the Elderly: Chronic Renal Failure and NSAIDs or Cox-2 Selective NSAIDs—Lower rates signify better performance | 11.7 | 10.0 | -1.7 |
| Potentially Harmful Drug-Disease Interactions in the Elderly: Dementia and Tricyclic Antidepressants or Anticholinergic Agents—Lower rates signify better performance | 27.0 | 25.6 | -1.3 |
| Potentially Harmful Drug-Disease Interactions in the Elderly: Falls and Tricyclic Antidepressants, Antipsychotics and Sleep Agents—Lower rates signify better performance | 15.6 | 15.3 | -0.3 |

HEDIS EFFECTIVENESS OF CARE AND UTILIZATION MEASURES

HMOS VS. PPOS: MEDICARE AVERAGES—2011

| MEASURE | HMO | PPO | DIFFERENCE |
|---|------|------|------------|
| Potentially Harmful Drug-Disease Interactions in the Elderly: Overall Rate— Lower rates signify better performance | 21.7 | 20.6 | -1.1 |
| Use of High-Risk Medications in the Elderly: At Least One Medication— Lower rates signify better performance | 18.5 | 18.5 | 0.0 |
| Use of High-Risk Medications in the Elderly: At Least Two Medications— Lower rates signify better performance | 3.6 | 3.5 | -0.1 |
| Management of Urinary Incontinence: Discussion | 57.3 | 56.9 | 0.4 |
| Physical Activity in Older Adults: Discussion | 53.0 | 53.7 | -0.7 |
| Physical Activity in Older Adults: Advice | 48.7 | 47.6 | 1.0 |
| Osteoporosis Testing in Older Women | 71.0 | 75.0 | -4.0 |
| Osteoporosis Management in Women Who Had a Fracture | 22.8 | 19.3 | 3.5 |
| Glaucoma Screening in Older Adults | 65.8 | 66.6 | -0.8 |
| Other Access and Utilization | | | |
| Plan All-Cause Readmissions: 65 Years And Older— Lower rates signify better performance* | 0.91 | 0.88 | -0.03 |

*This indicator is expressed as the ratio of the observed readmission rate to the expected (adjusted for case-mix) readmission rate. Ratios less than 1.0 indicate lower-than-expected readmission rates, whereas ratios greater than 1.0 indicate higher-than-expected readmission rates.

APPENDIX 19B: HMOS VS. PPOS, MEDICARE PLANS

| CAHPS MEMBER SATISFACTION MEASURES HMOS VS. PPOS: MEDICARE AVERAGES—2011 | | | |
|---|------|------|------------|
| MEASURE | HMO | PPO | DIFFERENCE |
| Consumer and Patient Engagement and Experience | | | |
| Rating of Health Plan: Rating of 8, 9 or 10 | 88.5 | 87.7 | 0.8 |
| Rating of Health Plan: Rating of 9 or 10 | 63.9 | 58.5 | 5.4 |
| Rating of Health Care: Rating of 8, 9 or 10 | 86.5 | 89.3 | -2.8 |
| Rating of Health Care: Rating of 9 or 10 | 60.9 | 62.6 | -1.7 |
| Getting Needed Care: Usually or Always | 89.4 | 92.6 | -3.2 |
| Getting Needed Care: Always | 64.1 | 66.6 | -2.5 |
| Getting Care Quickly: Usually or Always | 87.8 | 90.1 | -2.3 |
| Getting Care Quickly: Always | 65.6 | 67.5 | -1.9 |
| How Well Doctors Communicate: Usually or Always | 94.2 | 95.5 | -1.3 |
| How Well Doctors Communicate: Always | 76.3 | 77.3 | -1.0 |
| Rating of Personal Doctor: Rating of 8, 9 or 10 | 92.9 | 94.1 | -1.2 |
| Rating of Personal Doctor: Rating of 9 or 10 | 74.6 | 76.1 | -1.5 |
| Rating of Specialist: Rating of 8, 9 or 10 | 91.3 | 92.7 | -1.4 |
| Rating of Specialist: Rating of 9 or 10 | 70.5 | 73.6 | -3.1 |
| Customer Service: Usually or Always | 88.3 | 88.5 | -0.2 |
| Customer Service: Always | 68.9 | 68.3 | 0.6 |

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ACKNOWLEDGMENTS

Health Plans

The 2012 *State of Health Care Quality Report* would not be possible without the public reporting of performance results by the 728 HMO and POS plans and 329 PPO this report analyzes. Those plans collectively cover more than 125 million Americans, and are to be commended for their commitment to quality improvement.

Staff

NCQA employees who helped create this report include:

Analysis

Bennett Datu, PhD, MPH
Robert Saunders, PhD, MPP
Sarah Scholle, DrPH, MPH
Peichang Shi, MAS, MS

Data Collection Operations

Garcene Duckett
Felicia Fridie
Robin Gant
Carla Pacheco
Michele Taylor

Information Systems

Bob Chisholm
Jonathan Cook
Paul Jackovich
Judy Jiao
Bhuvaneshwari Maruthac
Aarthi Murugan
Raghav Seshadri
Subra Shanmugam
Helen Zhang

Performance Measurement

Mary Barton, MD, MPP
Sepheen C. Byron, MHS
Jennifer Chemi
Mohua Choudhury
Katherine Kross
Erin Giovannetti, PhD
Jeremy Gottlich
Candice Groseclose
Benjamin Hamlin, MPH
Rita Lewis, MPH
Divya Pamnani, MHSA
Jamie Puhek
Bob Rehm, MBA
Stephanie Rodriguez
Lindsey Roth, MPP
Jill Steinkogler, MHSA
Sean Whalen, MPH

Product Delivery

Judy Lacourciere
Kathleen C. Mudd, MBA, RN

Publications

Carolyn Moeller, MHS

Public Policy & Communications

Ashley Carter
Paul Cotton
Shireesha Jevaji
Andy Reynolds, MBA
Apoorva Stull, MA
Sarah Thomas, MS

Quality Solutions Group

Phyllis Torda, MAS



1100 13th Street, NW
Suite 1000
Washington, DC 20005
www.ncqa.org
Phone 202.955.3500
Fax 202.955.3599