The State of Health Care Quality

07

INDUSTRY TRENDS AND ANALYSIS

NCQA
Measuring quality
Improving health care

THE STATE OF HEALTH CARE QUALITY **2007**

NATIONAL COMMITTEE FOR QUALITY ASSURANCE
WASHINGTON, D.C.

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Printed in the U.S.A.

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TABLE OF CONTENTS

PRESIDENT'S MESSAGE

Dear Colleague:

NCQA's eleventh annual survey of the quality of health care in America reveals promising trends, highlights successes and shows where improvement is needed. Through the conscious, coordinated efforts of health plans, physicians, nurses, patients and others to improve clinical quality by consistently delivering care based upon medical evidence, performance improved for the eighth consecutive year. But in what is a warning sign for us all, the pace of those improvements has slowed.

Some of these advances have had a profoundly positive effect on our nation's health. Most notably, the use of beta-blockers, a lifesaving treatment recommended for almost all patients who suffer a heart attack, has become nearly universal after 11 years of measurement and reporting. This single improvement has prolonged and improved the lives of thousands of Americans, a reason to celebrate and to redouble our efforts to further improve cardiac care.

I am also heartened by the increase in HEDIS reporting by PPO plans. These plans, which just two years ago reported little to no quality data, are embracing the quality agenda. This year, 141 plans voluntarily submitted audited HEDIS data on 21 million of their members. This is up sharply from the 80 PPOs that reported HEDIS in 2005--tremendous progress in a short period of time. In July, NCQA published new health plan accreditation standards that require all PPOs to submit audited HEDIS data that, for the first time, will be released to the public in a plan-specific manner just a year from now. Fourteen PPOs, covering another 10 million Americans, have committed to the new standards, but more than 100 million Americans are in PPOs that have yet to make that pledge.

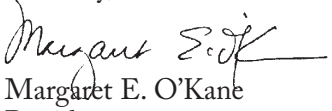
The stakes are too high to allow quality to be left to projections, assumptions or guesswork. Rising health care costs threaten much of the progress we've made. The continuing rise in the number of uninsured Americans is especially disturbing. In August, the U.S. Census Bureau reported that more than 47 million people live without health coverage. Yet we spend nearly twice as much on health care as other industrialized nations; our failure to spend this money more wisely is a black mark shared by us all.

We must redouble our efforts to understand the value yielded by the $2 trillion we invest in health care. This year, we have a new tool to help us do so: NCQA's first findings on a new suite of Relative Resource Use HEDIS measures are contained in this report. These new measures, used in conjunction with related quality data, allow us to compare how efficiently health plans deliver quality care. Our first-year results, which focus on diabetes, showcase the tremendous waste in our system: cost and quality are, at best, weakly correlated. An American living with diabetes is just as likely to get high-cost, low-quality care as she is to get low-cost, high-quality care. We cannot afford to continue wasting billions of dollars in this way. Data can point the way but only men and women of good faith can act and the time to do so is now.

Of course, the best care of all is the kind that keeps people healthy in the first place. Many employers have recognized the need to invest significant resources into promoting health and wellness in an effort to keep long-term health care costs low. As one employer told me recently, "With all we know about our health care system, my best investment is to keep my employees healthy." NCQA is working to develop evaluative approaches to health promotion programs.

Our progress to date is encouraging, but, to paraphrase the comic philosopher Pogo, we remain surrounded by insurmountable opportunities. I look forward to joining with you to marshal our collective commitment, vision and creativity to move us towards the kind of health care system we all deserve.

Sincerely,



Margaret E. O'Kane
President

INTRODUCTION

The *State of Health Care Quality* report is produced annually by NCQA to monitor and report on performance trends over time, track variations in patterns of care and provide recommendations for future quality improvement.

Every year, tens of thousands read this report, from consumers to benefits managers, policymakers, academics and consultants. As the purpose of this report is to drive improvement in the delivery of evidence-based medicine by drawing attention to the pressing quality issues we face as a nation, health care thought leaders and members of the media are also frequent readers.

The clinical quality, customer experience and resource use data upon which this report is based were voluntarily reported to NCQA by more than 500 health plans. All data, including data reported on the new Relative Resource Use measures reported for the first time this year, are rigorously audited. Consumer experience information is independently collected and verified.

All plans that submitted data are to be commended for their continuing commitment to accountability and quality improvement.

Copies of this report may be downloaded free of charge from NCQA's Web site, **www.ncqa.org.** Printed copies of the report are available for purchase from NCQA by calling (888) 275-7585.

We thank you for your interest and welcome your feedback; please let us know your thoughts by e-mailing us at **customersupport@ncqa.org**.

EXECUTIVE SUMMARY

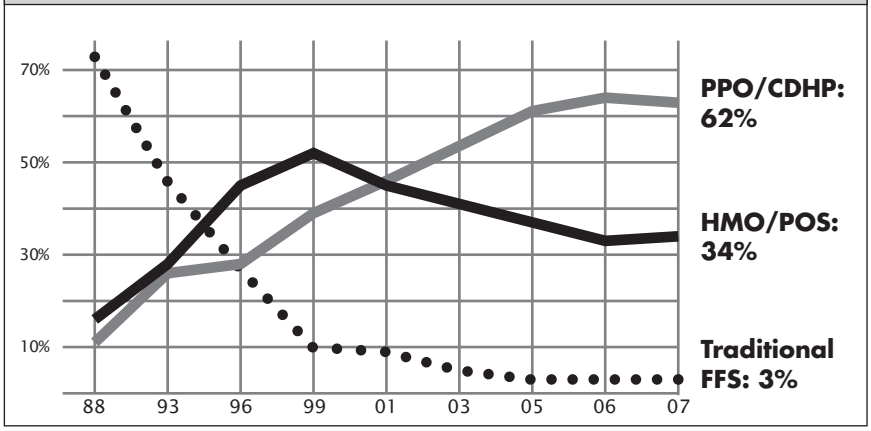
SURGE IN QUALITY REPORTING EXPANDS UNIVERSE OF ACCOUNTABILITY

Our eleventh survey of the state of health care quality in America finds a promising upward trend in the number of accountable health plans, a broad expansion in the number of Americans enrolled in plans that measure and report on their health care quality, and a new domain of health plan performance measurement. These gains, while important, must be considered in a context in which two million more Americans are uninsured today than were a year ago.

A sharp increase in the number of preferred provider organizations (PPOs) reporting on the quality of the care they deliver resulted in a record 82 million Americans being enrolled in accountable health plans. A total of 141 PPOs covering 21 million commercial and Medicare members submitted HEDIS data in 2006, many for the first time. This was a substantial increase from the 80 PPOs that submitted HEDIS data in 2005.

The expansion of PPO HEDIS reporting bodes quite well for our health care system. More than 6 in 10 Americans who receive health coverage through their employer are enrolled in PPOs, up from less than 40 percent a decade ago *(Figure 1)*. While HMOs and point-of-service plans have a long history of collecting and reporting quality performance data, PPOs have only recently started to engage in such efforts.

FIGURE 1: ENROLLMENT TRENDS BY PRODUCT TYPE, 1988 - 2007



Source: Kaiser Family Foundation/HRET Employer Health Benefits Survey, 2007.
Note: Values may not sum to 100% due to rounding.

In 2005, NCQA called upon PPO plans to voluntarily report HEDIS data; a total of 80 plans, ranging from national carriers to independent insurers, did so. This year, 83 commercial and 58 Medicare PPOs--covering more than 21 million Americans--reported audited HEDIS results. Accordingly, NCQA is able to report on 22 HEDIS measures of clinical quality for PPO plans *(Figure 2, opposite)*, and eight measures of consumer experience *(Figure 3, opposite)*.

In July, NCQA published new health plan accreditation standards that require PPOs seeking accreditation to submit audited HEDIS data and be scored on their results; HEDIS will represent nearly 40 percent of a plan's accreditation score. So far, 14 PPOs, representing 10.2 million Americans, have committed to seeking accreditation under those standards.

Interest in PPO accountability continues to grow in the public sector as well. The Medicare program and the federal Office of Personnel Management now require PPO plans to engage in HEDIS reporting. States are now taking a closer look at PPO reporting. In August, California's insurance commissioner announced plans to produce a statewide PPO report card for consumers based on HEDIS data in 2009.

EXECUTIVE SUMMARY

FIGURE 2. HEDIS EFFECTIVENESS OF CARE MEASURES: NATIONAL AVERAGES COMMERCIAL PPO PLANS, 2005-2006*

MEASURE	2005	2006
Antidepressant Medication Management - Optimal Practitioner Contacts	N/A	19.3
Appropriate Treatment for Children with Upper Respiratory Infection	83.3	82.1
Avoidance of Antibiotic Treatment for Adults with Acute Bronchitis	N/A	29.7
Breast Cancer Screening	64.6	63.5
Chlamydia Screening - 16-20 Years	27.2	29.4
Cholesterol Management - LDL-C Control (<100 mg/dL)	N/A	14.9
Colorectal Cancer Screening - Reported Rate	N/A	41.8
Comprehensive Diabetes Care - LDL-C Control (<100 mg/dL)	N/A	12.7
Comprehensive Diabetes Care - Eye Exams	N/A	35.5
Comprehensive Diabetes Care - Poor HbA1c Control	N/A	20.8
Disease Modifying Therapy for Rheumatoid Arthritis	N/A	82.3
Flu Shots for Adults Ages 50-64	36.8	44.5
Follow up after Hospitalization for Mental Illness - 7 Days	N/A	48.3
Follow up after Hospitalization for Mental Illness - 30 Days	N/A	68.1
Follow-up for Children Prescribed ADHD Medication - Initiation	N/A	30.6
Imaging Studies for Low Back Pain	72.9	72.1
Prenatal and Postpartum Care - Postpartum Care	N/A	45.6
Prenatal and Postpartum Care - Timeliness of Prenatal Care	N/A	60.3
Use of Appropriate Medications for Patients with Asthma - 5-9 Years	N/A	97.1
Use of Approp. Medications for Patients with Asthma - 10-17 Years	N/A	94.4
Use of Approp. Medications for Patients with Asthma - 18-56 Years	N/A	91.4
Use of Approp. Medications for Patients with Asthma - Total	N/A	92.7

**Denotes the year in which medical services were delivered; 2006 data is typically reported in 2007.*

FIGURE 3. CAHPS MEASURES OF CONSUMER EXPERIENCE: NATIONAL AVERAGES COMMERCIAL PPO PLANS, 2005-2006

MEASURE	2005	2006
Claims Processing	90.1	87.0
Getting Care Quickly	81.2	87.1
Getting Needed Care	84.3	85.3
How Well Doctors Communicate	N/A	93.7
Rating of Health Care (8, 9, or 10)	N/A	75.1
Rating of Health Plan (8, 9, or 10)	63.5	59.5
Rating of Personal Doctor (8, 9, or 10)	78.6	83.0
Rating of Specialist (8, 9, or 10)	N/A	81.0

EXECUTIVE SUMMARY

PPO plans that chose to report their data performed comparably to their health plan counterparts. A comparison of HEDIS effectiveness of care rates reveals that on some dimensions of care, PPO plans lag only marginally behind accountable managed care plans. In some cases, such as treatment for asthma, PPOs performed at a higher level *(Figure 4)*.

FIGURE 4. HEDIS MEASURES OF CARE: HMO/POS VS. PPO SELECT RATES, COMMERCIAL, 2006

MEASURE	HMO/POS	PPO
Appropriate Treatment for Children with an Upper Respiratory Infection	82.8	82.1
Breast Cancer Screening	68.9	63.5
Disease Modifying Therapy for Rheumatoid Arthritis	84.8	82.3
Flu Shots for Adults (50-64)	45.6	44.5
Imaging Studies for Low Back Pain	73.9	72.1
Use of Appropriate Medications for Asthma (combined)	91.6	92.7

The more than 140 PPO plans that reported HEDIS data in 2006 *(see Figure 5)* are industry leaders who deserve tremendous credit for stepping up and stepping forward. In the coming years, NCQA expects this total to grow dramatically. This augurs well for better care for, and better quality of life for the millions of Americans enrolled in these plans--but more than 100 million Americans with health insurance remain in the dark about how well their health plan performs.

EXECUTIVE SUMMARY

FIGURE 5. COMMERCIAL PPO PLANS REPORTING HEDIS DATA IN 2006

REPORTING PLANS, 2006*	
Aetna Life Insurance Company - North East Region	CGLIC - CIGNA - New York
Aetna Life Insurance Company - West Region	CGLIC - CIGNA - North Carolina
Aetna Life Insurance Company MidAtlantic Region	CGLIC - CIGNA - Ohio
Aetna Life Insurance Company - North Central Region	CGLIC - CIGNA - Oklahoma
Aetna Life Insurance Company Southeast/Southwest Region - Southeast	CGLIC - CIGNA - Oregon
Aetna Life Insurance Company Southeast/Southwest Region - Southwest	CGLIC - CIGNA - Pennsylvania/Delaware
AmeriHealth HMO, Inc. - New Jersey	CGLIC - CIGNA - South Carolina
Anthem Health Plans Kentucky, Inc. dba Anthem Blue Cross and Blue Shield in Kentucky	CGLIC - CIGNA - South Dakota/North Dakota/Nebraska
Anthem Health Plans of Virginia, Inc. dba Anthem Blue Cross Blue Shield	CGLIC - CIGNA - Tennessee
Anthem Insurance Companies, Inc. dba Anthem Blue Cross and Blue Shield in Indiana	CGLIC - CIGNA - Texas
Blue Cross & Blue Shield of Rhode Island	CGLIC - CIGNA - Utah
Blue Cross and Blue Shield of Massachusetts, Inc.	CGLIC - CIGNA - Vermont
Blue Cross and Blue Shield of New Mexico	CGLIC - CIGNA - Virginia
Blue Cross and Blue Shield of North Carolina	CGLIC - CIGNA - Washington
Blue Cross and Blue Shield of Vermont	CGLIC - CIGNA - West Virginia
Blue Cross of California	CGLIC - CIGNA - Wisconsin
Capital District Physicians Health Plan, Inc.	Community Insurance Company dba Anthem Blue Cross and Blue Shield in Ohio
Cariten Insurance Company	Compcare Health Services Insurance Corporation dba Anthem Blue Cross and Blue Shield
CGLIC - CIGNA - Arizona	Geisinger Health Plan
CGLIC - CIGNA - California	Health Alliance Medical Plans
CGLIC - CIGNA - Colorado	Health Alliance Plan of Michigan
CGLIC - CIGNA - Connecticut	HealthPartners, Inc.
CGLIC - CIGNA - Florida	HIP Health Plan of New York
CGLIC - CIGNA - Georgia	HMO Missouri, Inc.
CGLIC - CIGNA - Illinois	Horizon Healthcare of New Jersey, Inc. dba Horizon HMO
CGLIC - CIGNA - Indiana	Humana Health Plan of Texas, Inc.
CGLIC - CIGNA - Iowa	Humana Health Plan, Inc. - Kentucky
CGLIC - CIGNA - Kansas	Humana Healthplan of Ohio, Inc.
CGLIC - CIGNA - Kentucky	Humana Insurance Company
CGLIC - CIGNA - Louisiana	Humana Medical Plan, Inc. - Florida
CGLIC - CIGNA - Maryland/District of Columbia	Medica
CGLIC - CIGNA - Massachusetts/Rhode Island	Medical Mutual of Ohio
CGLIC - CIGNA - Michigan	ODS Health Plan, Inc.
CGLIC - CIGNA - Minnesota	OSF Health Plans, Inc.
CGLIC - CIGNA - Mississippi/Alabama	PersonalCare Insurance of Illinois, Inc.
CGLIC - CIGNA - Missouri	Presbyterian Insurance Company
CGLIC - CIGNA - Montana/Wyoming/Idaho	QCC Insurance Company (Personal Choice)
CGLIC - CIGNA - Nevada	SummaCare, Inc.
CGLIC - CIGNA - New Hampshire/Maine	Tufts Associated Health Maintenance Organization, Inc.
CGLIC - CIGNA - New Jersey	
CGLIC - CIGNA - New Mexico	

**List comprises those PPO plans that allowed their names to be published.*

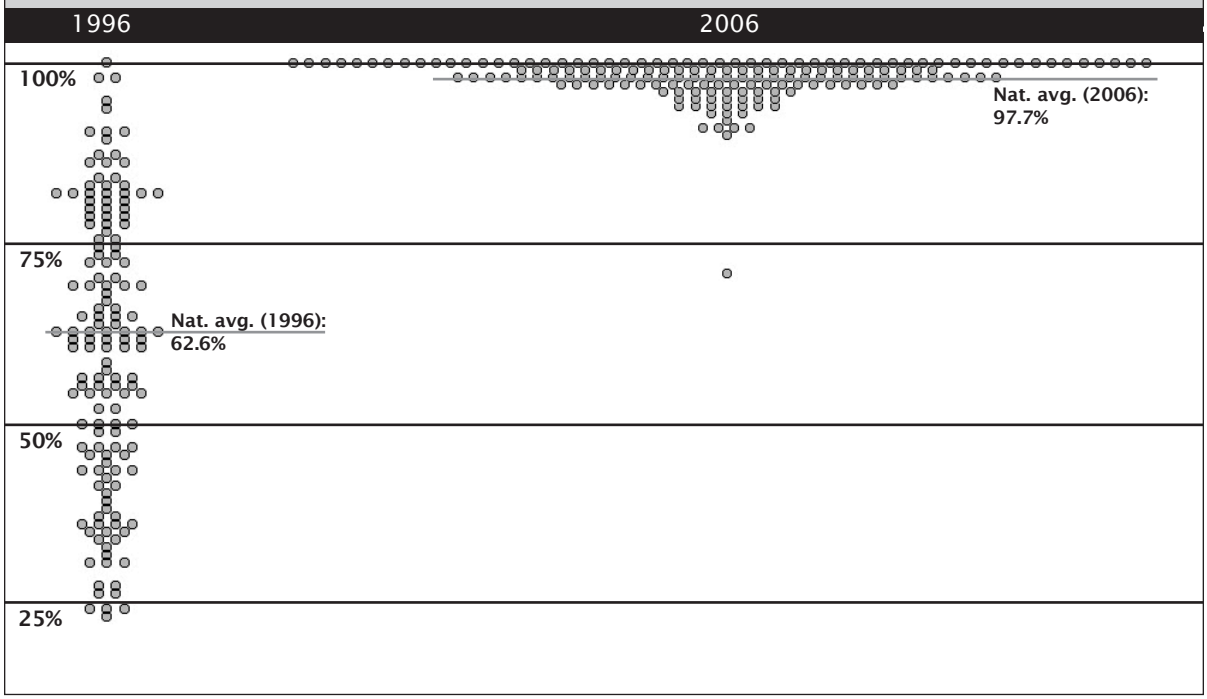
EXECUTIVE SUMMARY

BETA-BLOCKER TREATMENT: A QUALITY MEASUREMENT SUCCESS STORY

Among the most remarkable achievements brought about through the systematic measurement, reporting and improvement of quality is the rise in the percentage of heart attack patients who are receiving beta-blocker drugs to prevent second, often fatal, heart attacks. When NCQA began measuring this life-saving treatment in 1996, fewer than 2 in 3 patients were receiving the right care. But in 2006, more than 97 percent of heart attack patients received beta-blockers and nearly every plan that reported on its performance had beta-blocker treatment rates of 90 percent or higher *(Figure 6).*

This single improvement has saved between 4,400 and 5,600 lives over the last six years, and improved the health of tens of thousands of people. With beta-blocker treatment rates so high and variation from plan to plan so low, NCQA will replace this measure with a new and more challenging measure assessing whether patients stay on this inexpensive yet lifesaving therapy for at least six months after their heart attack.

FIGURE 6: BETA-BLOCKER TREATMENT AFTER A HEART ATTACK
INDIVIDUAL HEALTH PLAN PERFORMANCE, 1996 AND 2006



GAPS IN QUALITY PERSIST IN KEY AREAS OF CARE

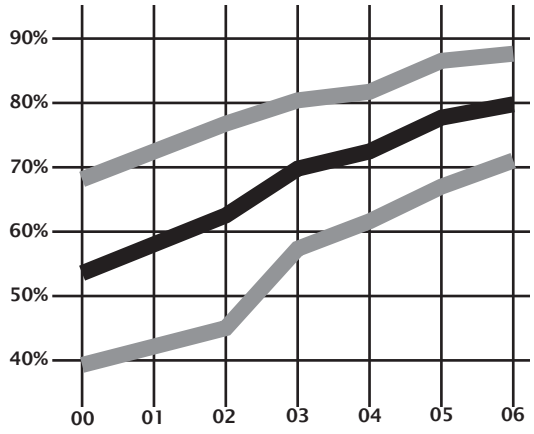
The quality of care delivered by health plans also improved in 2006--the eighth consecutive year of such overall gains--but the rate of improvement has generally slowed.

In 2006, commercial health plans posted improvements in 30 of 44 HEDIS measures of effectiveness of care. Medicaid plans showed gains on 34 of 43 such measures. However, among the growing number of private plans participating in Medicare, there was improvement in only 8 of 21 measures of care. This marks the second consecutive year that Medicare plans did not improve in a majority of areas measured, highlighting a need to refocus on quality improvement efforts in this key public program.

EXECUTIVE SUMMARY

FIGURE 7. CHILDHOOD IMMUNIZATION STATUS, COMBINATION 2

COMMERCIAL MEAN, 10TH AND 90TH %ILES, 2000 - 2006



Among the notable quality improvements in 2006: immunization rates among children and adolescents continued a nine-year upward trend. Nearly 80 percent of children in commercial health plans received all recommended immunizations, up from 77.7 percent in 2005 *(Figure 7)*. The percentage of children who were fully immunized in Medicaid managed care plans lagged slightly behind at 73.4 percent, but up from 70.4 percent in 2005.

Some of the most notable gains in quality occurred among those HEDIS measures of care that are relatively new to the measure set: adults over 50 were more likely to be screened for colon cancer as screening rates improved to 54.5 percent in 2006 from 52.3 percent in 2005. Rates of appropriate treatment for adults with acute bronchitis and rheumatoid arthritis also rose significantly in 2006 *(Figure 8)*.

FIGURE 8. HEDIS EFFECTIVENESS OF CARE MEASURES

SELECT TRENDS, 2004 - 2006

COMMERCIAL AVERAGES	2004	2005	2006
Appropriate Testing for Children with Pharyngitis	72.6	69.7	72.7
Avoidance of Antibiotic Treatment, Adults w/Acute Bronchitis	N/A	66.1	71.3
Colorectal Cancer Screening	49.0	52.3	54.5
Disease-Modifying Therapy for Rheumatoid Arthritis	N/A	80.9	84.8
Persistence of Beta-Blocker Treatment After a Heart Attack	67.4	70.3	72.5
MEDICAID AVERAGES	**2004**	**2005**	**2006**
Appropriate Testing for Children with Pharyngitis	54.4	52.0	56.0
Avoidance of Antibiotic Treatment, Adults w/Acute Bronchitis	N/A	69.4	72.0
Disease-Modifying Therapy for Rheumatoid Arthritis	N/A	67.5	67.6
Persistence of Beta-Blocker Treatment After a Heart Attack	69.9	69.8	68.1

Behind each of these measures are people getting the right care at the right time. For instance, the 2.2 percentage point increase in screening rates for colon cancer means that an additional 182,000 people--a sum equal to the population of Knoxville, Tennessee--received the recommended screening.

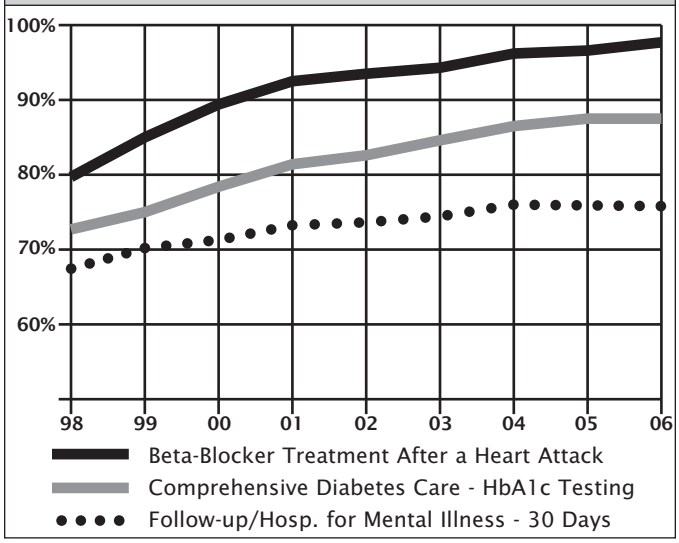
EXECUTIVE SUMMARY

While overall quality improved, fewer HEDIS measures showed significant increases than in 2005. And some areas have not shown significant improvement over a number of years: measures of mental illness treatment have shown frustratingly little improvement over several years, suggesting the need for benefit redesign and focused quality improvement strategies.

The slowing pace in improvement can be attributed, in part, to the high levels of performance on measures that have been in the market for many years; the higher the average rate the less room there is for further improvement. (*Figure 9).* Yet performance on several key measures appears stuck at an unacceptably low level. Plan leaders and policymakers need to focus greater attention on the reasons behind this apparent stagnation, including examination of public and private payment systems.

FIGURE 9. SELECT TRENDS IN HEDIS AVERAGES

COMMERCIAL PLANS, 1999 - 2006



Of course, some plans continue to perform at exceptional levels. An examination of the top 10 percent of health plans shows what our health care system is able to achieve. If the entire health care system could perform as well as the top achievers, NCQA estimates that as many as 75,000 lives could be saved each year and our national bill for hospital care would be reduced by as much as $3.7 billion *(Figure 10)*.

FIGURE 10. AVOIDABLE DEATHS AND MEDICAL COSTS DUE TO UNEXPLAINED VARIATIONS IN CARE: SELECT MEASURES AND CONDITIONS, U.S. POPULATION, 2006

MEASURE	AVOIDABLE DEATHS	AVOIDABLE HOSPITAL COSTS
Beta-Blocker Treatment After a Heart Attack	500 - 1,200	$6.1 million - $10.8 million
Breast Cancer Screening	200 - 700	$89 million
Cervical Cancer Screening	600 - 800	N/A
Cholesterol Management	4,400 - 9,400	$20.1 million - $60.9 million
Colorectal Cancer Screening	6,000 - 12,600	$284 million - $411 million
Controlling High Blood Pressure	9,200 - 22,800	$292 million - $708 million
Diabetes Care - HbA1c Control	7,100 - 15,900	$1.3 billion - $1.7 billion
Osteoporosis Management	N/A	$9.9 million - $10.4 million
Prenatal Care	1,000 - 1,600	N/A
Smoking Cessation	7,000 - 10,700	$673 million - $725 million
TOTAL	**35,000 - 75,000**	**$2.7 billion - $3.7 billion**

EXECUTIVE SUMMARY

This is not a pipe dream. In fact, improvement in the delivery of evidence-based care in just four areas of medicine has saved the lives of as many as 124,600 Americans, roughly the population of Hartford, Connecticut *(Figure 11)*.

FIGURE 11. LIVES SAVED DUE TO IMPROVEMENTS IN ACCOUNTABLE PLANS
COMMERCIAL AND MEDICARE, 2000 - 2006

MEASURE	LIVES SAVED
Beta-Blocker Treatment After a Heart Attack	4,400 - 5,600
Cholesterol Management for Patients w/Cardiovascular Cond.	10,100 - 17,000
Controlling High Blood Pressure	56,800 - 98,600
Poor HbA1c Control	2,000 - 3,400
TOTAL	**73,300 - 124,600**

POOR QUALITY CARE RESULTS IN LOST WORK DAYS, PRODUCTIVITY

The gap between top-performing plans and the performance of the system as a whole also carries a heavy toll for American workers and their employers. Poor quality care leads to as many as 45 million avoidable sick days, the equivalent of 180,000 full-time employees--or all of Salt Lake City--calling in sick every day for a full year. Low-quality care also carries a high price tag for employers to the tune of more than $7.4 billion in lost productivity *(Figure 12)*.

FIGURE 12. ESTIMATED SICK DAYS* AND LOST PRODUCTIVITY DUE TO UNEXPLAINED VARIATIONS IN CARE, U.S. WORKFORCE, 2006

CONDITION	AVOIDABLE SICK DAYS	LOST PRODUCTIVITY
Asthma	6.3 million	$1.0 billion
Depression	13.2 million	$2.2 billion
Diabetes	10.9 million	$1.7 billion
Heart Disease	5.9 million	$961 million
Hypertension	8.7 million	$1.4 billion
TOTAL	**45.0 million**	**$7.4 billion**

**Includes days attributable to 'presenteeism,' when sick employees report to work but illness compromises their productivity.*

ACCREDITATION, PUBLIC REPORTING REMAIN RELIABLE QUALITY INDICATORS

One key to quality improvement is plans' willingness to be accredited. Accredited health plans--those that undergo regular, comprehensive review against a comprehensive set of standards pertaining to quality improvement, access to care, utilization management and patients' rights and responsibilities--continue to deliver higher quality care than those that do not seek such review. For example, accredited plans provide needed prenatal care to 92.2 percent of the women they serve compared with only 83.5 percent of the women in unaccredited plans *(Figure 13, overleaf)*.

A second factor is health plans' willingness to allow their quality performance data to be publicly reported. Such plans routinely perform at a higher level than those that choose not to do so (*Figure 14, overleaf)*. In 2006, 58.9 percent of teenagers in publicly reporting plans had all needed immunizations, compared with 42.9 percent of those in plans that did not allow their data to be reported. A total of 276 commercial HMOs and point-of-service plans reported quality data to NCQA in 2006; 139 Medicaid plans did likewise, as did 211 Medicare Advantage plans. In all, these plans cover a collective 76.4 million Americans.

EXECUTIVE SUMMARY

FIGURE 13. HEDIS EFFECTIVENESS OF CARE MEASURES ACCREDITED VS. NON-ACCREDITED PLANS: SELECT COMMERCIAL AVERAGES, 2006

MEASURE	ACCREDITED	UNACCREDITED	DIFFERENCE
Adolescent Immunization Status - Combo 2	60.2	47.4	12.8
Beta-Blocker Treatment After a Heart Attack	98.2	94.4	3.8
Breast Cancer Screening	69.3	67.3	2.0
Cervical Cancer Screening	81.8	78.0	3.9
Childhood Immunization Status - Combo 2	80.8	76.3	4.6
Comprehensive Diabetes Care - Poor HbA1c Control*	29.1	31.4	(2.3)
Controlling High Blood Pressure	59.7	59.4	0.3
Follow-up After Hospitalization for Mental Illness - 30 Days	77.0	69.5	7.6
Prenatal and Postpartum Care - Timeliness of Prenatal Care	92.2	83.5	8.7

** Lower rates are better for this measure; the negative difference signifies higher performance among NCQA-Accredited plans for this measure.*

FIGURE 14. HEDIS EFFECTIVENESS OF CARE MEASURES PUBLIC VS. NON-PUBLICLY REPORTING PLANS: SELECT COMMERCIAL AVERAGES, 2006

MEASURE	PUBLIC	NON-PUBLIC	DIFFERENCE
Adolescent Immunization Status - Combo 2	58.9	42.9	16.0
Beta-Blocker Treatment After a Heart Attack	97.9	93.4	4.5
Breast Cancer Screening	69.1	66.9	2.2
Cervical Cancer Screening	81.4	77.6	3.8
Childhood Immunization Status - Combo 2	80.7	71.3	9.4
Comprehensive Diabetes Care - Poor HbA1c Control*	29.4	31.9	(2.5)
Controlling High Blood Pressure	59.8	57.1	2.8
Follow-up After Hospitalization for Mental Illness - 30 Days	76.5	66.2	10.3
Prenatal and Postpartum Care - Timeliness of Prenatal Care	91.8	79.6	11.9

** Lower rates are better for this measure; the negative difference signifies higher performance among publicly reporting plans for this measure.*

NEW MEASURES OF CARE ASSESS VALUE

Despite recent moderation, health care premiums are increasing at an unsustainable rate. If we fail to rationally assess the value we get in return for the $2 trillion we spend every year on health care and drive inefficiency from the system, the high cost of care will itself ration care for us by pricing those who can't afford health care out of the system.

In an effort to measure the efficiency of health plan spending, NCQA developed the first generation of Relative Resource Use HEDIS measures. These measures assess resource use across six major conditions in a standardized, risk-adjusted manner. When used in concert with related quality measures, they provide a rough estimate of value for a given condition: that is, how much health is being delivered in return for our health care dollar.

The data presented in this year's edition of the report focus on diabetes spending. Initial results suggest that there is no meaningful relationship between how much plans spend and the quality of care they deliver--in other words, getting *more* care isn't the same thing as getting *better* care.

For more information about the initial findings from these measures, see page 61.

EXECUTIVE SUMMARY

RECOMMENDATIONS: CHARTING A COURSE TO RELIABLE, EFFICIENT HEALTH CARE

Based on this year's results, NCQA urges consideration of the following recommendations:

Demand universal reporting on quality. Choice is a fundamental principle of American health care. Each year employers select which health plans they will offer their employees. Half of all privately-insured Americans have a choice of plans. To make wise choices, employers and employees need clear, comparable information that helps them decide what is best for themselves and their families. Despite recent progress, more than 100 million working Americans are members of health plans that have not yet joined the transparency trend. Public and private purchasers, policymakers and consumers must ramp up their demand for quality information at all levels of health care.

Reform payment systems to drive quality improvement. In health care, as in almost everything, you get what you pay for. But current payment systems reward volume, not value. Experiments with reforms that pay for performance have proven very successful and need to be expanded in both the public and private sectors. For these programs to work, they must be anchored in meaningful measurement, involve those who will be measured in its design, and create incentives for providers and patients alike.

Put the health back in health care. Our health care system is centered on treating illness and injury. But our efforts to ensure that the sick are properly cared for have left a blind spot around promoting health. By promoting health and wellness now, we can help keep a lid on future health care spending. A growing number of employers have begun to offer health promotion benefits to their employees. NCQA is developing ways to evaluate the effectiveness of these efforts so that we don't waste these precious resources on approaches that fail to preserve and protect the health of our people.

HEDIS MEASURES OF CARE

ABOUT HEDIS

The Healthcare Effectiveness Data and Information Set (HEDIS) is a tool used by more than 90 percent of America's managed health care plans--and a growing number of PPO plans--to measure performance on important dimensions of care and service. By providing objective clinical performance data measured against a detailed set of measure criteria, HEDIS provides purchasers and consumers the means to make informed comparisons among health plans on the basis of performance.

Employers, consultants and consumers use HEDIS data, along with accreditation information, to help them select the best health plan for their needs. HEDIS data are also the centerpiece of most health plan "report cards" that appear in national magazines and local newspapers.

HEDIS measures address a broad range of important health issues, including:

- Use of Appropriate Medications for People with Asthma
- Cholesterol Management for Patients with Cardiovascular Conditions
- Controlling High Blood Pressure
- Antidepressant Medication Management
- Breast, Cervical and Colorectal Cancers
- Comprehensive Diabetes Care

Included in HEDIS is the CAHPS 4.0H survey, which measures members' experiences with their care in areas such as claims processing, rating of their own health plan, and getting needed care quickly.

To ensure the validity of HEDIS results, all data are rigorously audited by certified auditors, using a process designed by NCQA.

More details about national averages and performance trends are available in the Appendices.

TERMS

National Variation: Undesirable variation in care is a critical area for improvement. This report quantifies "national variation"--the difference between the top 10 percent and bottom 10 percent of health plans--for each measure to provide a more complete picture of the gaps in quality.

Top States: This report identifies the top-performing state on each measure of care. Some states appear frequently on these lists; differences in economic or demographic factors aside, it is difficult to understand why care would appear to be dramatically better in a handful of states. Only states where five or more plans reported data were considered for inclusion; such information for Medicare managed care plans was not available at press time.

NEW IN THIS YEAR'S REPORT

This report includes HEDIS measures of Relative Resource Use for diabetes care, a detailed analysis of patterns in health plan spending for diabetes care and the quality of care that results. See page 61.

A NOTE ON MEDICARE SURVEY DATA

The Medicare CAHPS survey of consumer experience for Medicare Advantage plans experienced delays in being fielded this year; accordingly, Medicare CAHPS data, and HEDIS measures collected through the survey (such as Flu Shots for Adults and Medical Assistance with Smoking Cessation) are not available at press time. NCQA will issue an updated version of this report--including Medicare CAHPS data and details on top-performing states--later in the year.

ADOLESCENT IMMUNIZATION STATUS

Medicaid immunization rates soar in 2006; immunizations save lives and money.

Immunizations play a key role in protecting the health of adolescents. Unfortunately, some adolescents are affected by vaccine-preventable diseases such as measles, mumps, rubella, hepatitis B and varicella (chicken pox). Immunizations effectively and inexpensively reduce the incidence of these dangerous, costly diseases.

ABOUT ADOLESCENT IMMUNIZATION

- Immunizations for hepatitis B, varicella, and measles, mumps, rubella (MMR) are recommended for adolescents by the Centers for Disease Control and Prevention.[1]
- Immunizations are one of the most cost-effective health intervention strategies available, saving society more than $5 for each dollar spent on immunizations.[2]

MEASURE DEFINITION

The Adolescent Immunization Status measure estimates the percentage of enrolled adolescents turning 13 years old who had a second MMR, three hepatitis B and one chicken pox (VZV) vaccinations by their 13th birthday. The measure calculates a rate for each vaccine and one combination rate.

THE CASE FOR IMPROVEMENT

- Discontinuation of the measles vaccine in the U.S. would lead to three to four million measles cases annually, and would result in 1,800 deaths, 1,000 cases of encephalitis and 80,000 cases of pneumonia.[2]
- The MMR vaccine saves over $16.00 in direct medical costs for every $1 spent.[3]
- Since the chicken pox vaccine program was introduced in the U.S., related hospitalizations have declined 88 percent.[4]
- Total direct medical expenditures for chicken pox hospitalizations and ambulatory visits have decreased from $85 million in 1994 and 1995 to $22 million in 2002-- a 74 percent drop.[4]
- Since hepatitis B vaccination became routine among children and adolescents, new infections declined from an average of 260,000 per year in the 1980s to about 51,000 in 2004.[5]

RESULTS AND ANALYSIS

COMMERCIAL		
Chicken Pox Vaccination: Nationwide variability: 48.0 pts Top state: **Massachusetts, 90.8**	**63.1**	up 2.9 pts
Hepatitis B Vaccination: Nationwide variability: 39.3 pts Top state: **Massachusetts, 92.6**	**74.6**	up 2.8 pts
Measles/Mumps/Rubella: Nationwide variability: 31.1 pts Top state: **Massachusetts, 92.0**	**78.8**	up 0.3 pts
Combination 2 Rate: Nationwide variability: 49.4 pts Top state: **Massachusetts, 86.9**	**57.7**	up 4.0 pts
MEDICAID		
Chicken Pox Vaccination: Nationwide variability: 51.8 pts Top state: **Michigan, 74.4**	**57.4**	up 9.1pts
Hepatitis B Vaccination: Nationwide variability: 40.6 pts Top state: **Michigan, 82.2**	**71.1**	up 7.5 pts
Measles/Mumps/Rubella: Nationwide variability: 33.4 pts Top state: **Minnesota, 85.7**	**75.4**	up 4.7 pts
Combination 2 Rate: Nationwide variability: 53.1 pts Top state: **Michigan, 68.4**	**51.2**	up 8.8 pts

ADOLESCENT IMMUNIZATION STATUS

COMBINATION 2: TRENDS, 1998 - 2006

YEAR	COMMERCIAL	MEDICAID
2006	**57.7**	**51.2**
2005	53.7	42.4
2004	46.9	38.1
2003	41.6	33.9
2002	31.2	24.8
2001	24.8	18.6
2000	18.4	13.2
1999	13.9	N/A
1998	10.5	N/A

ANNUAL MONITORING FOR PATIENTS ON PERSISTENT MEDICATIONS

Monitoring key to avoiding overdoses, other adverse drug events.

Adverse drug events cause an estimated 1 in 400 Americans to visit an emergency room yearly; of those, 1 in 6 require hospitalization.[1] Drugs that commonly require monitoring in outpatient settings account for over half of all unintentional drug overdoses resulting in an emergency room visit.[1] Patients with long-term use of certain medications are at higher risk for experiencing harmful side effects and drug-related toxicities. With monitoring, clinicians can adjust the patient's dosage to prevent adverse drug events.

ABOUT PERSISTENT MEDICATION MONITORING

- In one study, 25 to 50 percent of patients that received long-term therapy with drugs carrying a high risk of toxicity received no drug monitoring.[2]
- 87 percent of all hospitalizations from unintentional drug overdoses among those 65 and older are due to drugs that commonly require outpatient monitoring.[1]

MEASURE DEFINITION

This measure assesses the percentage of members 18 years and older on persistent medications who received annual monitoring for the following drugs of interest:

- ACE inhibitors/ARBs
- Digoxin
- Diuretics
- Anticonvulsants

A combined rate is also reported.

THE CASE FOR IMPROVEMENT

- The cost of annual monitoring is more than offset by savings in the treatment of avoidable drug reactions; over $85 billion is spent per year to treat drug-related problems caused by misuse in the ambulatory setting.[3]
- Hospitalizations due to adverse drug events result in almost two extra days spent in the hospital, an increased cost of $2,260 and almost twice the risk of death.[4]

RESULTS AND ANALYSIS

COMMERCIAL		
Combined Rate:	**74.3**	new measure
Nationwide variability: 15.4 pts		
Top state: **District of Columbia, 84.1**		
MEDICARE		
Combined Rate:	**76.4**	new measure
Nationwide variability: 22.8 pts		
MEDICAID		
Combined Rate:	**77.7**	new measure
Nationwide variability: 12.6 pts		
Top state: **Tennessee, 82.3**		

MONITORING FOR PATIENTS ON PERSISTENT MEDICATIONS

TRENDS, 2006

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2006	**74.3**	**76.4**	**77.7**

THIS IS A FIRST-YEAR MEASURE.

ANTIDEPRESSANT MEDICATION MANAGEMENT

Medication management rates largely unchanged since 2001.

About 1 in 7 Americans will suffer from major depressive disorder in their lifetime.[1] Depressive disorders are marked by a substantial, sustained disruption in a person's mood, behavior, physical health and thoughts. There are three main depressive disorders: major depression, dysthymia (a less severe, chronic form of depression) and bipolar disorder. In a given year, almost 21 million American adults suffer from a depressive disorder or depression.[2]

ABOUT ANTIDEPRESSANT MANAGEMENT

- 40 to 50 percent of primary care patients diagnosed with depression discontinue treatment within the first three months.[3]
- Another 50 percent discontinue antidepressant medications during the maintenance phase of treatment.[4]
- Premature discontinuation of treatment is associated with higher rates of depression relapse and major depressive episodes.[5]

MEASURE DEFINITION

This measure assesses three facets of successful pharmacological management of depression in patients 18 years and older.

Optimal Practitioner Contacts for Medication Management: The percentage of eligible members with a new diagnosis of depression treated with an antidepressant medication and received at least three follow-up office visits in the 12-week acute treatment phase.

Effective Acute Phase Treatment: The percentage of eligible members who remained on antidepressant medication during the entire 12-week acute phase.

Effective Continuation Phase Treatment: The percentage of eligible members who remained on antidepressant medication for at least six months.

RESULTS AND ANALYSIS

COMMERCIAL		
Practitioner Contacts: Nationwide variability: 19.6 pts Top state: **Connecticut, 31.7**	**20.0**	down 0.6 pts
Acute Treatment: Nationwide variability: 16.2 pts Top state: **New Jersey, 66.0**	**61.1**	down 0.3 pts
Continuation Treatment: Nationwide variability: 16.0 pts Top state: **Colorado, 51.3**	**45.1**	up 0.1 pts
MEDICARE		
Practitioner Contacts: Nationwide variability: 13.5 pts	**11.4**	down 0.4 pts
Acute Treatment: Nationwide variability: 26.7 pts	**58.2**	up 3.3 pts
Continuation Treatment: Nationwide variability: 28.2 pts	**41.0**	unchanged
MEDICAID		
Practitioner Contacts: Nationwide variability: 19.6 pts Top state: **New York, 21.7**	**21.3**	up 0.6 pts
Acute Treatment: Nationwide variability: 23.8 pts Top state: **Minnesota, 47.5**	**42.9**	down 3.1 pts
Continuation Treatment: Nationwide variability: 19.6 pts Top state: **Minnesota, 30.0**	**27.5**	down 2.8 pts

ANTIDEPRESSANT MEDICATION MANAGEMENT

THE CASE FOR IMPROVEMENT

- Major depressive disorder is the leading cause of disability in the United States and in market economies worldwide.[6]
- The overall health bills of employees who report depression are 70 percent higher than those of employees who do not.[7]
- Total medical costs are reduced in patients remaining on antidepressants for at least 90 days.[8]
- One study showed patients who discontinue antidepressant treatment within six months accumulate $432 in higher medical costs per year than adherent patients.[6]
- Chronically ill patients with co-morbid depression are high medical care utilizers, and are associated with lower survival rates, lower treatment compliance and a lower quality of life.[9]
- Depressed adults are less physically healthy, less socially active and less satisfied with their lives than adults who are not depressed.[10]
- Normally, depression symptoms such as weight loss, disturbed sleep, lack of energy, aches and pains, and deficiencies in memory and concentration may result in a missed diagnosis, particularly if the patient does not report psychological symptoms, such as anxiety, suicidal ideation or prior suicide attempts.[11]
- Workers with inadequately treated depression cost employers over $30 billion per year in lost productive time compared to the expected cost in workers without depression.[12]
- Depression affects people of all ages, but often first occurs in a person's late twenties.[13] Elderly people also suffer from high rates of depression.[14]
- Suicide rates increase with age and are very high among those 65 years and older. Most elderly suicide victims are seen by their primary care provider a few weeks prior to their suicide attempt and diagnosed with their first episode of mild to moderate depression.[13]

OPTIMAL PRACTITIONER CONTACTS
TRENDS, 1998 - 2006

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2006	**20.0**	**11.4**	**21.3**
2005	20.6	11.8	20.7
2004	20.0	11.9	19.4
2003	20.3	10.5	18.0
2002	19.2	10.8	18.2
2001	19.8	11.9	19.0
2000	N/A	N/A	N/A
1999	21.4	N/A	N/A
1998	22.7	N/A	N/A

EFFECTIVE ACUTE PHASE TREATMENT
TRENDS, 1998 - 2006

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2006	**61.1**	**58.2**	**42.9**
2005	61.4	54.9	46.0
2004	60.9	56.3	46.4
2003	60.7	53.3	46.2
2002	59.8	52.1	47.4
2001	56.9	51.3	45.5
2000	N/A	N/A	N/A
1999	58.8	N/A	N/A
1998	54.3	N/A	N/A

EFFECTIVE CONTINUATION PHASE TREATMENT
TRENDS, 1998 - 2006

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2006	**45.1**	**41.0**	**27.5**
2005	45.0	41.0	30.3
2004	44.3	42.1	30.5
2003	44.1	39.2	29.3
2002	42.8	37.7	32.3
2001	40.1	36.8	30.0
2000	N/A	N/A	N/A
1999	42.1	N/A	N/A
1998	38.0	N/A	N/A

APPROPRIATE TESTING FOR CHILDREN WITH PHARYNGITIS

Inappropriate use, which contributes to antibiotic resistance, drops in 2006.

Pharyngitis, or sore throat, is a common diagnosis in children. Each year, 1 in 10 children who see a medical care provider will be evaluated for pharyngitis.[1] The majority of pharyngitis cases are caused by viral illnesses. While antibiotics are needed to treat *bacterial* pharyngitis, they are not useful for treating *viral* pharyngitis. Before antibiotics are prescribed, a simple diagnostic test needs to be run to validate a bacterial origin. Unfortunately, a diagnostic test is not always completed before antibiotics are prescribed.

ABOUT TESTING FOR PHARYNGITIS

- Only 15 to 36 percent of sore throat cases in children are caused by the bacterium group A streptococcus (GAS), more commonly referred to as strep throat.[2]
- Antibiotic use has been directly linked to the prevalence of antibiotic resistance in the community. Judicious use of antibiotics is important to reduce levels of such resistance.[3]
- A national study estimated that 7.3 million children ages 3 to 17 visit primary care and emergency settings with a sore throat on an annual basis.[2]
- One study found that in 36 percent of cases where a patient received antibiotics and underwent a test for strep throat, the test came back negative.[4]

MEASURE DEFINITION

This measure estimates the percentage of children 2 to 18 years of age who were diagnosed with pharyngitis, received an antibiotic and a GAS test for the episode.

RESULTS AND ANALYSIS

COMMERCIAL		
Testing Rate:	**72.7**	up 3.0 pts
Nationwide variability: 29.1 pts		
Top state: **Georgia, 86.8**		
MEDICAID		
Testing Rate:	**56.0**	up 4.0 pts
Nationwide variability: 50.6 pts		
Top state: **Virginia, 68.5**		

APPROPRIATE TESTING FOR CHILDREN WITH PHARYNGITIS

TRENDS, 2003 - 2006

YEAR	COMMERCIAL	MEDICAID
2006	**72.7**	**56.0**
2005	69.7	52.0
2004	72.6	54.4
2003	70.7	53.8

THE CASE FOR IMPROVEMENT

- In 2004, more than 4 in 10 physicians surveyed reported that they would start antibiotic treatment for children with pharyngitis before knowing the results of a strep test--and continue treatment despite a negative result.[5]
- Cost-effectiveness studies show that giving a strep test before prescribing antibiotics costs less and saves more lives than does prescribing antibiotics to all children with a sore throat.[6,7]
- Studies estimate that 2 percent of children have a mild adverse reaction to antibiotics for strep throat, while over 6 children out of 1,000 have a severe reaction, and 1 out of 100,000 children die.[7]

APPROPRIATE TREATMENT FOR CHILDREN WITH AN UPPER RESPIRATORY INFECTION

1 in 5 office visits for the common cold result in an inappropriate prescription.

This year, Americans will suffer an estimated 1 billion upper respiratory infections (URIs) known more commonly as colds.[1] Colds are most prevalent among children due to their frequent relative lack of exposure to prior colds and to their contact with other children. Consequently, children have, on average, six to ten colds a year. Existing clinical guidelines do not support the use of antibiotics as the cause of the common cold is often viral. However, research indicates antibiotics are frequently prescribed in children with URIs.[2]

ABOUT TREATMENT FOR UPPER RESPIRATORY INFECTIONS

- Studies have found about 1 in 5 office visits for the common cold to result in an antibiotic prescription for children under 15.[3]
- Inappropriate treatment of the common cold with antibiotics increases drug resistance, decreasing the effectiveness of currently available pharmaceuticals against bacteria and increasing an individual's risk of becoming infected with a drug-resistant bacteria.[4]

MEASURE DEFINITION

This measure estimates the percentage of children three months to 18 years of age who were diagnosed with an URI and did *not* receive an antibiotic prescription within 3 days of the visit. Higher rates indicate more appropriate use of antibiotics.

THE CASE FOR IMPROVEMENT

- Appropriate treatment decreases the number of people at risk for complications arising from the side effects of antibiotics, ranging from fevers and rashes to prolonged hospital stays and even death.
- Appropriate antibiotic use lessens the spread of antibiotic resistance, prolonging the effectiveness of current antibiotic drugs and decreasing the risk of infection by a drug-resistant pathogen.
- Annually, an estimated $27 million is spent for inappropriate treatment on over seven million patients.[4]
- Appropriate antibiotic use decreases the need to develop new (and often expensive) antibiotic drugs to replace those that have become ineffective due to resistance. It also decreases the odds of developing infections for which no effective antibiotics exist.

RESULTS AND ANALYSIS

COMMERCIAL

Testing Rate: **82.8** down 0.1 pt
Nationwide variability: 17.3 pts
Top state: **Washington, 90.8**

MEDICAID

Testing Rate: **83.4** up 0.9 pts
Nationwide variability: 19.5 pts
Top state: **New York, 86.6**

APPROPRIATE TREATMENT FOR CHILDREN WITH AN UPPER RESPIRATORY INFECTION
TRENDS, 2003 - 2006

YEAR	COMMERCIAL	MEDICAID
2006	**82.8**	**83.4**
2005	82.9	82.5
2004	82.7	79.9
2003	80.8	80.1

AVOIDANCE OF ANTIBIOTIC TREATMENT IN ADULTS WITH ACUTE BRONCHITIS

4 in 5 antibiotic prescriptions for adult bronchitis unnecessary.

Acute bronchitis, commonly known as a chest cold, is an acute respiratory infection manifested by a cough lasting for up to three weeks.[1] About 5 percent of adults report an episode of acute bronchitis each year, with 90 percent seeking treatment. Because fewer than 1 in 10 cases are bacterial,[1,2] antibiotic treatment is not warranted for this primarily viral condition.

ABOUT ANTIBIOTIC TREATMENT FOR ACUTE BRONCHITIS

- Antibiotics are commonly misused for a number of viral respiratory conditions where antibiotic treatment is not effective.[2]
- 4 in 5 antibiotics prescribed for acute respiratory infections in adults are unnecessary, according to CDC prevention guidelines.[3]
- In 2002, antibiotics were prescribed in 49 percent of U.S. adult acute bronchitis cases despite its typical viral origin.[4]

MEASURE DEFINITION

This measure--formerly named *Inappropriate Treatment for Adults with Adult Bronchitis*--assesses the percentage of healthy adults 18 to 64 years of age with a diagnosis of acute bronchitis who were *not* dispensed an antibiotic prescription on or three days after the Episode Date; a higher rate indicates better performance.

Antibiotics are not indicated in clinical guidelines for the treatment of adults with acute bronchitis who do not have a comorbidity or other infection for which antibiotics may be appropriate.

THE CASE FOR IMPROVEMENT

- Between 65 and 80 percent of all patients with acute bronchitis receive an antibiotic despite evidence that they are rarely effective. Elderly patients are particularly likely to receive unnecessary antibiotic prescriptions, and more than one-half of prescriptions are for extended-spectrum antibiotics.[1,5]
- Overuse of antibiotics contributes to antibiotic drug resistance, which diminishes the efficacy of antibiotics against bacterial infections, particularly in the sick and elderly.[3,6,7]
- Inappropriate antibiotic use represents wasted resources. Drug-resistant pathogens result in repeated health care visits, greater risk of disease complications and increased health care costs.[8]

RESULTS AND ANALYSIS

COMMERCIAL

Treatment Rate: **71.3** up 5.2 pts

Nationwide variability: 18.5 pts

Top state: **New Hampshire, 79.8**

MEDICAID

Treatment Rate: **72.0** up 2.6 pts

Nationwide variability: 22.4 pts

Top state: **Michigan, 74.1**

AVOIDANCE OF ANTIBIOTIC TREATMENT IN ADULTS WITH ACUTE BRONCHITIS

TRENDS, 2005 - 2006

YEAR	COMMERCIAL	MEDICAID
2006	**71.3**	**72.0**
2005	66.1	69.4

BETA-BLOCKER TREATMENT AND PERSISTENCE OF BETA-BLOCKER TREATMENT AFTER A HEART ATTACK

Beta-blocker treatment a measurement success story; treatment nearly universal.

An estimated 7.9 million Americans over 20 have a history of myocardial infarctions (MI) or heart attacks.[1] The American Heart Association and the American College of Cardiology strongly recommend beta-blocker treatment following a heart attack to reduce mortality during acute and long-term management.[2] The dramatic rise in beta-blocker treatment rates--more than 34 percent since 1996--is proof that sustained attention and effective initiatives saves lives and improves quality of life.

ABOUT BETA-BLOCKER TREATMENT

- Cardiovascular diseases are the single largest killer of Americans. About every 26 seconds, an American suffers a coronary event; about every minute someone dies from one.[1]
- Half of all heart attack survivors are readmitted to the hospital within one year of the event; recurrent heart attack rates remain exceedingly high.[3]
- If all heart attack survivors received timely beta-blocker therapy, an estimated 1,500 deaths could be avoided each year. If they continued treatment for twenty years, 4,300 fewer chronic heart disease deaths and 3,500 fewer heart attacks would result.[4]
- Beta-blockers reduce morbidity and mortality in patients surviving a heart attack including high risk patients such as the elderly, patients with diabetes and patients with heart failure.[5]

MEASURE DEFINITION

The *Beta-Blocker Treatment After a Heart Attack* measure estimates the percentage of members 35 years of age and older hospitalized and discharged after surviving a heart attack who received a prescription for beta blockers upon discharge.

The *Persistence of Beta-Blocker Treatment After a Heart Attack* measure estimates the percentage of members 35 years of age and older hospitalized and discharged after surviving a heart attack who received persistent beta-blocker treatment for six months after discharge.

RESULTS AND ANALYSIS

COMMERCIAL		
Beta-Blocker Treatment:	**97.7**	up 1.1 pts
Nationwide variability: 5.9 pts		
Top state: **Missouri, 99.6**		
Beta-Blocker Persistence:	**72.5**	up 2.2 pts
Nationwide variability: 22.7 pts		
Top state: **Massachusetts, 82.8**		
MEDICARE		
Beta-Blocker Treatment:	**93.7**	down 0.1 pts
Nationwide variability: 16.9 pts		
Beta-Blocker Persistence:	**69.6**	up 4.2 pts
Nationwide variability: 37.5 pts		
MEDICAID		
Beta-Blocker Treatment:	**88.4**	up 2.3 pts
Nationwide variability: 35.1 pts		
Top state: **Michigan, 96.5**		
Beta-Blocker Persistence:	**68.1**	down 1.7 pts
Nationwide variability: 26.9 pts		
Top state: **Pennsylvania, 71.8**		

BETA-BLOCKER TREATMENT AND PERSISTENCE OF BETA-BLOCKER TREATMENT AFTER A HEART ATTACK

THE CASE FOR IMPROVEMENT

- Estimated 2007 direct and indirect costs associated with heart disease total $277 billion; indirect costs account for more than $112 billion.[1]
- Prescribing a patient with heart failure beta-blockers saves nearly $4,000 over five years due to reduced hospitalization.[6]
- Use of beta-blockers following a heart attack decreases the probability of a recurrent heart attack, and increases the probability of long-term survival up to 40 percent.[7,8]
- Despite high rates of prescription in the acute phase, adherence to beta-blocker therapy declines significantly within the first year after a heart attack.[4]
- If all first-time heart attack survivors used a beta-blocker for 20 years, an estimated 62,000 heart attacks would be prevented, 72,000 deaths from coronary heart disease would be avoided, 447,000 life-years would be gained and $18 million would be saved.[4]

BETA-BLOCKER TREATMENT AFTER A HEART ATTACK

TRENDS, 1996 - 2006

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2006	**97.7**	**93.7**	**88.4**
2005	96.6	93.8	86.1
2004	96.2	94.0	84.8
2003	94.3	92.9	83.5
2002	93.5	93.0	90.1
2001	92.5	92.9	87.9
2000	89.4	89.3	82.7
1999	85.0	N/A	N/A
1998	79.7	N/A	N/A
1997	74.1	N/A	N/A
1996	62.6	N/A	N/A

PERSISTENCE OF BETA-BLOCKER TREATMENT AFTER A HEART ATTACK

TRENDS, 2004 - 2006

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2006	**72.5**	**69.6**	**68.1**
2005	70.3	65.4	69.8
2004	67.4	61.3	69.9

BREAST CANCER SCREENING

More than 178,000 new cases of breast cancer will be diagnosed in 2007.

Breast cancer is one of the most common types of cancer among American women. In 2007, an estimated 178,500 new cases will be identified. It is the second leading cause of cancer death for women with an estimated 40,000 deaths among women in 2007.[1] Fortunately, breast cancer mortality in women has been recently declining, due in part to early detection by screening with mammograms.[2]

ABOUT BREAST CANCER SCREENING

- A woman living in the U.S. has a 1 in 8 risk of developing breast cancer.[3]
- Regular mammograms for women ages 50 to 69 can reduce breast cancer mortality by up to 35 percent through early detection.[4]
- A mammogram can detect breast cancer 1 to 4 years before a woman can feel the lump.[5]
- Mammography can detect 80 to 90 percent of breast cancers in women without symptoms.[1]

MEASURE DEFINITION

This measure estimates the percentage of women between 40 and 69 years old who had at least one mammogram in the past two years.

Note: This measure is untrendable due to changes to the measure specifications. In 2007, the lower age limit was lowered to 40 years.

Debate continues regarding particular topics in mammography use, such as age of first and last screening, screening interval, screening of high-risk younger women, and screening accuracy.[6] NCQA will continue to monitor developments and revise the breast cancer screening measure as scientific and clinical consensus is achieved.

THE CASE FOR IMPROVEMENT

- In the U.S., breast cancer treatment costs nearly $7 billion per year.[9]
- The five-year survival rate for localized breast cancer, where cancer cells have not spread to the lymph nodes or outside the breast, is 98 percent; the five-year survival rate for breast cancer that has metastasized is 26 percent.[1]
- More than 70 percent of women diagnosed with breast cancer have no identifiable risk factors, such as a family history of breast cancer, that might alert their doctor to potential breast cancer without a mammogram.[8]

RESULTS AND ANALYSIS

COMMERCIAL		
Screening Rate:	**68.9**	untrendable
Nationwide variability: 14.9 pts		
Top state: **New Hampshire, 77.2**		
MEDICARE		
Screening Rate:	**69.5**	untrendable
Nationwide variability: 27.5 pts		
MEDICAID		
Screening Rate:	**49.1**	untrendable
Nationwide variability: 20.1 pts		
Top state: **New York, 58.7**		

BREAST CANCER SCREENING

TRENDS, 1996 - 2006

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2006*	**68.9**	**69.5**	**49.1**
2005	72.0	71.6	53.9
2004	73.4	74.0	54.1
2003	75.3	74.0	55.9
2002	74.9	74.5	55.8
2001	75.1	75.3	55.1
2000	74.5	73.9	54.9
1999	73.4	N/A	N/A
1998	72.1	N/A	N/A
1997	71.1	N/A	N/A
1996	70.4	N/A	N/A

** Due to measure specification changes in 2007, results for this measure cannot be trended to previous years' results.*

- Treatment for breast cancer detected in its earliest, pre-invasive stage costs significantly less than cancer detected in more advanced stages. Almost $2 billion is spent on late stage breast cancer treatment.[7]

CERVICAL CANCER SCREENING

Screening rates stall over four-year period.

Cervical cancer is one of the most successfully treatable cancers when detected early. Increased screening has led to a substantial decline in cervical cancer incidence and mortality over the past several decades; screening reduces cervical cancer mortality by up to 80 percent.[1] An estimated 11,150 new cases of cervical cancer will be diagnosed in 2007, resulting in more than 3,600 deaths.[2] Most of these deaths could have been avoided with timely screening and treatment, as screening can detect precancerous cells and lesions.[2]

ABOUT CERVICAL CANCER SCREENING

- About 50 million Pap tests are performed annually in the U.S.[3]
- The American Cancer Society, the National Cancer Institute, the American Medical Association and others all recommend that women who are sexually active or who have reached age 21 have Pap tests.
- One study estimated that screening for cervical cancer even at intervals of more than five years could prevent about 2 of every 3 cases of invasive cancer, while 4 of every 5 of cases could be prevented with screening every three to five years.[4]

MEASURE DEFINITION

The Cervical Cancer Screening rate estimates the percentage of women aged 21 to 64 enrolled in a health plan who had at least one Pap test in the past three years.

Note: This measure is untrendable due to changes to the measure specifications. In 2007, the lower age limit was raised to 21 years.

RESULTS AND ANALYSIS

COMMERCIAL		
Treatment Rate:	**81.0**	untrendable
Nationwide variability: 11.0 pts		
Top state: **New Hampshire, 88.1**		
MEDICAID		
Treatment Rate:	**65.7**	untrendable
Nationwide variability: 23.6 pts		
Top state: **New York, 72.7**		

THE CASE FOR IMPROVEMENT

- Early detection is critical; cervical cancer rarely causes pain or noticeable symptoms until it is so advanced that it is unresponsive to treatment.[5]
- Women with cervical cancer have a five-year survival rate of 92 percent; the rate drops to 13 percent once the cancer has metastasized (spread throughout the body).[6,7]
- Significant racial disparities are present in cervical cancer mortality. In women under age 65, cervical cancer mortality is about 40 percent higher in black women than in white women.[1] In women over age 65, cervical cancer mortality in black women is more than two and a half times higher than in white women.[1]
- Death from cervical cancer is rare among women who have regular screening.[1]

CERVICAL CANCER SCREENING
TRENDS, 1996 - 2006

YEAR	COMMERCIAL	MEDICAID
2006*	**81.0**	**65.7**
2005	81.8	65.0
2004	80.9	64.7
2003	81.8	64.0
2002	80.5	62.4
2001	80.0	61.1
2000	78.1	59.9
1999	71.8	N/A
1998	69.8	N/A
1997	70.9	N/A
1996	70.5	N/A

** Untrendable due to changes to measure specifications.*

CHILDHOOD IMMUNIZATION STATUS

Immunization rates climb for tenth consecutive year.

Immunizations are one of the safest, most effective ways to protect children from a variety of potentially serious childhood diseases. While immunization coverage is high among children in the U.S., it is vital to maintain these levels to eliminate the threat of vaccine-preventable diseases. Currently, over 26 percent of two-year-old children lack one or more recommended immunizations.[1]

ABOUT CHILDHOOD IMMUNIZATIONS

- Childhood immunizations are responsible for the control of many infectious diseases once common in the U.S., including polio, measles, diphtheria, pertussis (whooping cough), rubella (German measles), mumps, tetanus, and Haemophilus influenzae type b (Hib).[2]
- Prior to routine vaccination, hepatitis B infected 24,000 infants and children each year;[3] and measles caused about 3 deaths out of every 1,000 cases.[4]
- More than 90 percent of people who are not immune to measles will get the virus if they are exposed to it.[4]
- Pneumococcal disease, the main cause of bacterial meningitis, is found most frequently among children under the age of two, with a high associated mortality rate.[5]

MEASURE DEFINITION

These measures estimate the percentage of children who turned two years old during the measurement year, and received the following vaccinations by their second birthday:

1. Four doses of DTP or DTaP (diphtheria-tetanus)
2. Three doses of OPV or IPV (polio)
3. One dose MMR (measles-mumps-rubella)
4. Three doses of Hib
5. Three doses of hepatitis B
6. One dose of VZV (chicken pox)
7. Four doses of pneumococcal conjugate (first year measure)
8. Combination 2 [combination of (1)-(6)]
9. Combination 3 [combination of (1)-(7)]

THE CASE FOR IMPROVEMENT

- One-third of lifelong hepatitis B virus infections, which can lead to liver failure and death, result from infections in infants and young children.[4]
- The risk of death from measles or its complications is greatest for infants and young children under two years old.[3]
- A child with chicken pox misses an average of five to six days of school; adult caretakers miss an average three to four days of work.[6]
- If the measles vaccine were to be discontinued in the U.S., up to four million measles cases would occur annually and result in more than 1,800 deaths, 1,000 cases of encephalitis and 80,000 cases of pneumonia.[7]
- Every dollar spent on Hib vaccine saves $3.40,[8] every dollar spent on hepatitis B vaccine saves $3.60,[8] and every dollar spent on varicella vaccine saves $6.30.[8]
- Childhood immunizations of DTaP, Td, Hib, IPV, MMR, HB and VZV vaccines show a direct cost savings of almost $10 billion and societal cost savings, including indirect costs such as time away from work, of more than $43 billion.[9]
- Discontinuing Hib immunization would result in approximately 20,000 cases per year of invasive disease, and 600 deaths.[7]

CHILDHOOD IMMUNIZATION STATUS

RESULTS AND ANALYSIS

COMMERCIAL

Combination 2 Rate:	**79.8**	up 2.1 pts
Nationwide variability:16.6 pts Top state: **Georgia, 86.3**		
Combination 3 Rate:	**65.6**	up 12.5 pts
Nationwide variability: 33.5 pts Top state: **Wisconsin, 78.5**		
Diphtheria/Tetanus:	**87.2**	up 1.1 pts
Nationwide variability: 11.7 Top state: **Massachusetts, 92.4**		
Polio Vaccination:	**91.5**	up 1.2 pts
Nationwide variability: 9.7 pts Top state: **Iowa, 95.4**		
Measles/Mumps/Rubella:	**93.6**	up 0.6 pts
Nationwide variability: 5.9 pts Top state: **New Hampshire, 95.6**		
Hib Vaccination:	**93.5**	up 0.6 pts
Nationwide variability: 7.8 pts Top state: **New Hampshire, 96.7**		
Hepatitis B Vaccination:	**91.1**	up 1.1 pts
Nationwide variability: 11.9 pts Top state: **Michigan, 96.0**		
Chicken Pox Vaccination:	**90.9**	up 1.0 pts
Nationwide variability: 8.6 pts Top state: **Georgia, 95.3**		
Pneumococcal conjugate:	**72.6**	up 13.8 pts
Nationwide variability: 34.4 pts Top state: **Wisconsin, 85.7**		

RESULTS AND ANALYSIS

MEDICAID

Combination 2 Rate:	**73.4**	up 3.0 pts
Nationwide variability: 26.1 pts Top state: **Michigan, 80.4**		
Combination 3 Rate:	**60.9**	up 18.4 pts
Nationwide variability: 32.7 pts Top state: **Maryland, 68.4**		
Diphtheria/Tetanus:	**79.3**	up 2.5 pts
Nationwide variability: 19.0 Top state: **Minnesota, 86.9**		
Polio Vaccination:	**87.9**	up 3.4 pts
Nationwide variability: 15.8 pts Top state: **Minnesota, 92.1**		
Measles/Mumps/Rubella:	**91.1**	up 1.6 pts
Nationwide variability: 10.0 pts Top state: **Minnesota, 94.0**		
Hib Vaccination:	**89.1**	up 2.4 pts
Nationwide variability: 12.3 pts Top state: **Washington, 92.4**		
Hepatitis B Vaccination:	**88.4**	up 3.2 pts
Nationwide variability: 17.0 pts Top state: **Michigan, 94.1**		
Chicken Pox Vaccination:	**88.9**	up 2.5 pts
Nationwide variability: 14.6 pts Top state: **California, 92.3**		
Pneumococcal conjugate:	**68.3**	up 21.7 pts
Nationwide variability: 28.2 pts Top state: **Washington, 76.5**		

CHILDHOOD IMMUNIZATION STATUS

COMBINATION 2: TRENDS, 1997 - 2006

YEAR	COMMERCIAL	MEDICAID
2006	**79.8**	**73.4**
2005	77.7	70.4
2004	72.5	63.1
2003	69.8	58.5
2002	62.5	53.2
2001	57.6	52.5
2000	53.5	47.2
1999	47.5	N/A
1998	37.0	N/A
1997	29.6	N/A

CHLAMYDIA SCREENING

Screening rates trend upward; nearly three million new cases occur annually.

Chlamydia is the most commonly reported sexually-transmitted infection in the U.S., with an estimated 2.8 million new infections each year.[1] Screening for chlamydia is particularly important as most infected men and women have no discernible symptoms[1] and the disease is easily treated with antibiotics.

ABOUT CHLAMYDIA SCREENING

- More than 975,000 cases of chlamydia were reported to the Centers for Disease Control and Prevention in 2005.[2]
- A woman with chlamydia is up to five times more likely to acquire HIV if exposed to the virus.[1]
- In a study of pregnant women, 9 percent had asymptomatic chlamydia, highlighting the importance of screening during pregnancy.[3]

MEASURE DEFINITION

This measure estimates the percentage of sexually active females 16 to 25 years of age who had at least one test for chlamydia during the measurement year.

THE CASE FOR IMPROVEMENT

- Broad-based screening programs have decreased chlamydia and pelvic inflammatory disease (PID) in young women by 60 percent, lowering hospitalization and complication rates.[4]
- 20 to 25 percent of newborns exposed to their mother's chlamydia develop chlamydial conjunctivitis.
- Up to 40 percent of women with untreated chlamydia develop PID.[1] Untreated pregnant women are also at greater risk for premature delivery.[1]
- Screening all sexually active women 18 to 24 would prevent about 140,000 cases of PID each year and save $45 for every woman screened.[6] In 2000, chlamydia was the fourth most costly sexually-transmitted disease, accounting for total costs of $248 million among Americans aged 15-24.[5]

RESULTS AND ANALYSIS

COMMERCIAL

Screening, ages 16-20: **36.2** up 1.8 pts
Nationwide variability: 20.5 pts
Top state: **Massachusetts, 46.8**

Screening, ages 21-25: **38.0** up 2.8 pts
Nationwide variability: 24.9 pts
Top state: **Georgia, 48.3**

MEDICAID

Screening, ages 16-20: **50.5** up 1.4 pts
Nationwide variability: 28.6 pts
Top state: **Missouri, 57.6**

Screening, ages 21-25: **55.0** up 2.6 pts
Nationwide variability: 32.4 pts
Top state: **Maryland, 64.3**

CHLAMYDIA SCREENING: AGES 16 - 20
TRENDS, 1999 - 2006

YEAR	COMMERCIAL	MEDICAID
2006	**36.2**	**50.5**
2005	34.4	49.1
2004	32.6	45.9
2003	30.4	44.3
2002	26.7	41.3
2001	24.5	39.6
2000	23.6	37.4
1999	18.5	N/A

CHLAMYDIA SCREENING: AGES 21 - 25
TRENDS, 1999 - 2006

YEAR	COMMERCIAL	MEDICAID
2006	**38.0**	**55.0**
2005	35.2	52.4
2004	31.7	49.0
2003	29.1	46.0
2002	24.5	41.9
2001	22.1	41.1
2000	20.7	37.9
1999	16.0	N/A

CHOLESTEROL MANAGEMENT FOR PATIENTS WITH CARDIOVASCULAR CONDITIONS

Less than 20 percent of all coronary heart disease patients meet LDL control goals.

One in three Americans have some form of cardiovascular disease, which includes coronary heart disease, high blood pressure, heart failure and stroke.[1] Cardiovascular disease causes more deaths every year than cancer, chronic lower respiratory diseases, accidents and diabetes combined, and caused 1 of every 5 deaths in the U.S. in 2004.[1] High cholesterol is a major risk factor for cardiovascular disease, particularly coronary heart disease. Coronary heart disease is the primary cause of heart attacks, and studies have shown cholesterol control to be especially critical after suffering a first heart attack due to the increased risk of a subsequent attack or stroke.[2] Screening and managing cholesterol levels in patients with cardiovascular conditions is very effective at reducing harm caused by coronary heart disease and other cardiovascular disease.

ABOUT CHOLESTEROL MANAGEMENT

- 1 in 3 American adults has an LDL cholesterol level of 130 mg/dL or higher.[1]
- Therapy to lower LDL cholesterol levels in patients with coronary heart disease, ranging from low-fat diet plans to drug therapy, reduces the risk of further heart events or stroke.[3] Patients are 24 to 42 percent less likely to die from a heart-related event when they use a cholesterol-lowering drug.[3]
- Less than half of those who qualify for cholesterol-lowering treatment for coronary heart disease risk reduction receive it;[3] less than half of those with symptomatic coronary heart disease at the highest risk receive cholesterol-lowering treatment.[3] Less than 20 percent of all coronary heart disease patients are at their LDL goal.[3]

MEASURE DEFINITION

This measure assesses the percentage of members 18-75 years of age who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG), percutaneous translumina coronary angioplasty (PTCA); or who had a diagnosis of ischemic vascular disease (IVD) who received an LDL-C screening and whose LDL-C level was controlled to <100mg/dL.

Due to measure specification changes in 2007, results for this measure cannot be trended to previous years' results.

RESULTS AND ANALYSIS

COMMERCIAL		
Screening Rate:	**87.5**	untrendable
Nationwide variability: 9.9 pts Top state: **New Hampshire, 91.4**		
Control Rate:	**56.6**	untrendable
Nationwide variability: 22.0 pts Top state: **Connecticut, 64.8**		
MEDICARE		
Screening Rate:	**88.0**	untrendable
Nationwide variability: 13.0 pts		
Control Rate:	**56.0**	untrendable
Nationwide variability: 29.7 pts		
MEDICAID		
Screening Rate:	**75.5**	untrendable
Nationwide variability: 28.0 pts Top state: **New York, 88.2**		
Control Rate:	**35.5**	untrendable
Nationwide variability: 36.1 pts Top state: **New York, 45.8**		

CHOLESTEROL MANAGEMENT FOR PATIENTS WITH CARDIOVASCULAR CONDITIONS

THE CASE FOR IMPROVEMENT

- The cost of cardiovascular disease will total approximately $432 billion in 2007; coronary heart disease alone will cost $151.6 billion.[1]
- In 2001, Medicare paid $11.6 billion for hospital costs where coronary heart disease was the principal diagnosis.[1]
- A 10 percent decrease in total cholesterol levels in the U.S. population could result in an estimated 30 percent reduction in coronary heart disease incidence.[4]
- Aggressive lowering of cholesterol after a cardiac event can result in a 31 percent reduction in heart attacks.[5]
- Coronary heart disease is the leading cause of premature, permanent disability in the U.S. labor force, accounting for almost 1 in 5 of disability allowances by the Social Security Administration.[6]

CHOLESTEROL SCREENING

TRENDS, 2000 - 2006

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2006*	**87.5**	**88.0**	**75.5**
2005	N/A	N/A	N/A
2004	81.8	82.1	61.6
2003	80.3	81.0	57.7
2002	79.4	77.7	57.8
2001	77.1	75.5	50.6
2000	74.2	70.6	43.8

CHOLESTEROL CONTROL <100 mg/dL

TRENDS, 2003 - 2006

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2006*	**56.6**	**56.0**	**35.5**
2005	N/A	N/A	N/A
2004	50.9	54.3	28.5
2003	47.6	49.6	27.4

** Due to measure specification changes in 2007, results for this measure cannot be trended to previous years' results.*

COLORECTAL CANCER SCREENING

Early detection critical to effective treatment of third most prevalent cancer.

Colorectal cancer is the third most common cancer among both men and women in the U.S.[1] In 2007, an estimated 112,000 new cases will be diagnosed, causing 52,000 deaths.[1] Colorectal cancer accounts for about 1 in 10 new cancer cases and cancer deaths in the U.S.[1] Colorectal cancer develops slowly and is often asymptomatic in its early stages. Treatment for early-stage colorectal cancer is extremely effective, with a five-year survival rate over 90 percent.[1] Fewer than 1 in 6 cases are associated with a family history of the disease.[2]

ABOUT COLORECTAL CANCER SCREENING

- Colorectal cancer screening rates are lower than those for other common cancers, such as breast or cervical cancer. About 1 in 4 survey respondents had received a fecal occult blood test (FOBT) within the past two years, and only 43 percent of respondents had ever received a sigmoidoscopy or colonoscopy.[3]
- A large prospective randomized control trial showed annual FOBT screening reduced the incidence of colorectal cancer by 20 percent.[4]
- Symptoms are uncommon in early-stage colorectal cancer. A patient's chance of survival decreases once symptoms occur.[5] In 10 to 15 percent of patients who present with symptoms, the cancer has already spread to other parts of the body.[5]
- Place of birth, ethnicity, education, health coverage, smoking[6] and gender[7] have all been shown to affect prevalence of colorectal cancer screening rates.

MEASURE DEFINITION

The colorectal cancer screening measure estimates the percentage of adults 50 to 80 years of age who have had appropriate screening for colorectal cancer with any of the four following tests:

- FOBT during the measurement year;
- Flexible sigmoidoscopy during the measurement year or the four years prior;
- Double contrast barium enema during the measurement year or the four years prior;
- Colonoscopy during the measurement year or the nine years prior.

RESULTS AND ANALYSIS

COMMERCIAL		
Testing Rate:	**54.5**	up 2.2 pts
Nationwide variability: 22.0 pts		
Top state: **Massachusetts, 66.3**		
MEDICARE		
Testing Rate:	**53.3**	down 0.6 pts
Nationwide variability: 26.8 pts		

COLORECTAL CANCER SCREENING
TRENDS, 2003 - 2006

YEAR	COMMERCIAL	MEDICARE
2006	**54.5**	**53.3**
2005	52.3	53.9
2004	49.0	52.6
2003	47.4	49.5

THE CASE FOR IMPROVEMENT

- If detected in stage 1, 85 to 95 percent of patients with colorectal cancer can be cured. If detected in a later stage, the five-year survival rate drops to 50 percent or less.[5]
- An annual FOBT plus sigmoidoscopy every five years can reduce cancer-related mortality by 80 percent compared to no screening.[7]
- Colorectal cancer treatment costs Americans over $6.5 billion per year,[8] second only to breast cancer treatment ($6.6 billion).[5]
- Since colorectal cancer occurs primarily in the elderly, the number of cases in the U.S. is likely to rise as the population ages.[5] Colorectal cancer-related hospital admissions are expected to double by 2050, owing to demographic shifts.[9]

COMPREHENSIVE DIABETES CARE

Direct, indirect costs of care for diabetes top $130 billion per year.

Diabetes one of the leading causes of death and disability in the U.S., and is likely to be under-reported as a cause of death.[1] As of 2005, there were 20.8 million Americans living with diabetes and 6.2 million people were undiagnosed.[2] One-third of people with diabetes are undiagnosed[3]; the estimated number of Americans living with diabetes may total 24 million. Much of the burden of illness and cost of diabetes treatment is attributed to potentially preventable long-term complications including heart disease, blindness, kidney disease and stroke.[4] Appropriate and timely screening and treatment can significantly reduce the disease burden.

ABOUT DIABETES

- Almost 2 in 3 Americans living with diabetes will die from heart disease or stroke.[4]
- For every 1 percent reduction in blood sugar level (HbA1c), the risk of developing eye disease, nerve disease and kidney disease is reduced by 40 percent.[1]
- Every 10 millimeters of mercury reduction in systolic blood pressure in diabetics results in a 12 percent reduction in diabetic complications.[1]
- In the U.S., diabetes accounts for almost 45 percent of new cases of kidney failure.[5]
- About 65 percent of people with diabetes have mild to severe forms of nervous system damage. Long-term effects include impaired sensation in the feet and hands, carpal tunnel syndrome and other nerve problems.[6]
- Diabetics are more likely to die from acute illness such as pneumonia or influenza than those who do not have diabetes.[7]
- Diabetic retinopathy causes 12,000 to 24,000 new cases of blindness annually.[1]

MEASURE DEFINITION

These measures assess several important features of effective, multi-risk factor management of diabetes and its potential complications. The measures estimate the percentage of members 18 to 75 years of age with diabetes (type 1 and type 2) who had each of the following:

- Hemoglobin A1c (HbA1c) testing
- Poorly controlled HbA1c (greater than 9.0)*
- Good HbA1c control (level less than 7.0)
- Eye exam (retinal) performed
- Serum cholesterol level (LDL-C) screening
- Cholesterol level (LDL-C) controlled to less than 100 mg/dL
- Medical attention for kidney disease (nephropathy)
- Blood Pressure control (<130/80 mm Hg)
- Blood Pressure control (< 140/90 mm Hg)

** Lower rates are better for this measure.*

COMPREHENSIVE DIABETES CARE

RESULTS AND ANALYSIS

MEASURE	COMMERCIAL	MEDICARE	MEDICAID
HbA1c Testing:	**87.5** unchanged Nationwide variability: 11.1 pts Top state: **New Hampshire, 92.5**	**87.2** down 1.7 pts Nationwide variability: 15.4 pts	**78.0** up 1.8 pts Nationwide variability: 21.5 pts Top state: **Minnesota, 88.0**
Poor HbA1c Control:*	**29.6** down 0.1 pt Nationwide variability: 21.0 pts Top state: **New Hampshire, 20.5**	**27.3** up 3.7 pts Nationwide variability: 32.9 pts	**48.7** down 0.3 pts Nationwide variability: 37.5 pt Top state: **Minnesota, 35.2**
Good HbA1c Control:	**41.8** new measure Nationwide variability: 14.6 pts Top state: **New Hampshire, 48.2**	**45.9** new measure Nationwide variability: 27.9 pts	**30.2** new measure Nationwide variability: 26.0 pts Top state: **Minnesota, 37.4**
Eye Exams:	**54.7** down 0.1 pt Nationwide variability: 32.0 pts Top state: **New Hampshire, 73.2**	**62.3** down 4.2 pts Nationwide variability: 41.2 pts	**51.4** up 2.8 pts Nationwide variability: 37.7 pts Top state: **Minnesota, 61.9**
LDL-C Screening:**	**83.4** untrendable Nationwide variability: 10.0 pts Top state: **New Hampshire, 88.1**	**84.8** untrendable Nationwide variability: 17.3 pts	**71.1** untrendable Nationwide variability: 22.3 pts Top state: **New York, 80.8**
LDL-C Control (<100):	**43.0** down 0.8 pts Nationwide variability: 16.3 pts Top state: **New Hampshire, 49.2**	**46.9** down 3.1 pts Nationwide variability: 25.8 pts	**30.6** down 2.0 pts Nationwide variability: 28.9 pts Top state: **Pennsylvania, 37.8**
Monitoring Nephropathy:**	**79.7** untrendable Nationwide variability: 14.3 pt Top state: **Idaho, 85.4**	**85.4** untrendable Nationwide variability: 16.5 pts	**74.6** untrendable Nationwide variability: 25.2 pts Top state: **Minnesota, 81.3**
Blood Pressure Control: (<130/80)	**29.9** new measure Nationwide variability: 14.4 pts Top state: **Minnesota, 42.2**	**30.2** new measure Nationwide variability: 20.7 pts	**30.4** new measure Nationwide variability: 22.2 pts Top state: **Minnesota, 42.4**
Blood Pressure Control: (<140/90)	**61.4** new measure Nationwide variability: 20.1 pts Top state: **Minnesota, 70.7**	**57.8** new measure Nationwide variability: 23.5 pts	**57.3** new measure Nationwide variability: 28.3 pts Top state: **Minnesota, 69.1**

** Lower rates are better for this measure.*
*** Due to measure specification changes in 2007, results for this measure cannot be trended to previous years' results.*

THE CASE FOR IMPROVEMENT

- Adequate cholesterol control can reduce cardiovascular complications 20 to 50 percent.[8]
- Diabetes patients who maintain near-normal HbA1c levels can gain an average extra five years of life, eight years of sight and six years free from kidney disease.[4]
- A large long-term clinical trial found lowering blood glucose reduced the risk of eye disease by 76 percent, kidney disease by 54 percent and nerve disease by 69 percent.[8]
- A worker's decreased productivity due to diabetes can cost the worker between $3,700 and $8,700 in annual earnings.[9]
- In 2002, medical expenditures incurred by people with diabetes averaged $13,243 per person, compared to $2,560 per person without diabetes. After accounting for demographic differences, the diabetic group still had 2.4 times more medical expenditures.[10]
- In 2002, economic costs associated with diabetes totaled $132 billion. Direct medical costs totaled $91.8 billion; indirect costs such as work loss, mortality and disability totaled $40 billion.[10]

COMPREHENSIVE DIABETES CARE

EYE EXAMS
TRENDS, 1996 - 2006

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2006	**54.7**	**62.3**	**51.4**
2005	54.8	66.5	48.6
2004	51.0	67.1	44.9
2003	48.8	64.9	45.0
2002	51.7	68.4	47.1
2001	52.1	66.0	46.4
2000	48.1	62.8	43.1
1999	45.4	N/A	N/A
1998	40.9	N/A	N/A
1997	38.8	N/A	N/A
1996	38.0	N/A	N/A

LDL-C CONTROL (<100 mg/dL)
TRENDS, 2003 - 2006

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2006	**43.0**	**46.9**	**30.6**
2005	43.8	50.0	32.6
2004	40.2	47.5	30.6
2003	34.7	41.9	27.8

HbA1c TESTING
TRENDS, 1998 - 2006

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2006	**87.5**	**87.2**	**78.0**
2005	87.5	88.9	76.2
2004	86.5	89.1	76.0
2003	84.6	87.9	74.8
2002	82.6	85.0	74.0
2001	81.4	85.7	71.7
2000	78.4	82.5	68.5
1999	75.0	N/A	N/A
1998	72.7	N/A	N/A

LDL-C SCREENING
TRENDS, 1998 - 2006

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2006*	**83.4**	**84.8**	**71.1**
2005	92.3	93.3	80.5
2004	91.0	93.5	79.6
2003	88.4	91.1	75.9
2002	85.1	87.9	71.7
2001	81.4	85.7	66.6
2000	76.5	80.5	59.6
1999	69.0	N/A	N/A
1998	60.3	N/A	N/A

MONITORING DIABETIC NEPHROPATHY
TRENDS, 1998 - 2006

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2006*	**79.7**	**85.4**	**74.6**
2005	55.1	60.2	48.8
2004	52.0	58.5	46.7
2003	48.2	53.6	43.7
2002	51.8	57.9	47.8
2001	46.3	51.9	42.3
2000	41.4	45.0	38.9
1999	36.0	N/A	N/A
1998	28.4	N/A	N/A

** Due to measure specification changes in 2007, results for these measures cannot be trended to previous years' results.*

POOR HbA1c CONTROL
TRENDS, 1998 - 2006; LOWER IS BETTER FOR THIS MEASURE

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2006	**29.6**	**27.3**	**48.7**
2005	29.7	23.6	49.1
2004	30.7	22.5	48.6
2003	32.0	23.4	48.6
2002	33.9	24.5	48.2
2001	36.9	26.8	48.3
2000	42.5	33.4	54.9
1999	44.9	N/A	N/A
1998	38.3	N/A	N/A

CONTROLLING HIGH BLOOD PRESSURE

Hypertension costs in excess of $66 billion annually.

High blood pressure or hypertension is a common medical condition affecting 1 in 4 Americans.[1] More than 90 percent of Americans will be affected by it at some point in their lives.[2] Hypertension is a significant risk factor for cardiovascular disease that increases with age.[3] Despite available effective treatment options, 2 in 3 people with hypertension are untreated or undertreated.[3] Patients with hypertension are at risk for stroke, heart disease and other cardiovascular diseases; vulnerable populations such as the elderly and those with comorbidities (e.g., diabetes, kidney disease) are at even greater risk.

ABOUT HIGH BLOOD PRESSURE

- Almost half of Americans age 45 or older have high blood pressure.[4]
- Hypertension doubles the lifetime risk of stroke.[5]
- Nearly one third of adults with high blood pressure are unaware of their condition, increasing the risk of complications and diseases.[4]
- High blood pressure was listed as a primary or contributing cause of death in approximately 278,000 deaths in the U.S. in 2003.[6]

MEASURE DEFINITION

This measure estimates the percentage of hypertensive adults ages 18 to 85 whose blood pressure was controlled. Adequate control is defined as a blood pressure reading less than 140/90 mmHg during the past year. Both systolic and diastolic pressure must be at or under this threshold for blood pressure to be considered controlled.

*Due to measure specification changes in 2007, results for this measure cannot be trended to prior years' results.

THE CASE FOR IMPROVEMENT

- In 2007, the estimated direct and indirect costs associated with high blood pressure in the U.S. totaled $66.4 billion.[6]
- Antihypertensive therapy has been associated with a 35 to 40 percent reduction in stroke incidence, 20 to 25 percent reduction in heart attack and a more than 50 percent reduction in heart failure.[7]

RESULTS AND ANALYSIS

COMMERCIAL		
Control Rate:*	**59.7**	untrendable
Nationwide variability: 19.2 pts		
Top state: **Pennsylvania, 63.7**		
MEDICARE		
Control Rate:*	**56.8**	untrendable
Nationwide variability: 20.9 pts		
MEDICAID		
Control Rate:*	**53.1**	untrendable
Nationwide variability: 27.5 pts		
Top state: **New York, 59.4**		

CONTROLLING HIGH BLOOD PRESSURE

TRENDS, 1999 - 2006

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2006*	**59.7**	**56.8**	**53.1**
2005	68.8	66.4	61.4
2004	66.8	64.6	61.4
2003	62.2	61.4	58.6
2002	58.4	56.9	53.4
2001	55.4	53.6	53.0
2000	51.5	46.7	45.4
1999	39.0	N/A	N/A

** Due to measure specification changes in 2007, results for this measure cannot be trended to previous years' results.*

- A large study estimated that an intervention reducing blood pressure by 5 mmHg reduced death due to stroke by 14 percent, death due to coronary heart disease by 9 percent and death from all causes by 7 percent.[7]
- The decrease in life expectancy for individuals with high blood pressure is 5.1 years in men and 4.9 years in women.[8]

DISEASE MODIFYING ANTI-RHEUMATIC THERAPY IN RHEUMATOID ARTHRITIS

DMARDs slow disease progression; treatment rates tick upward in 2006.

Rheumatoid arthritis (RA) is a chronic autoimmune disorder often characterized by progressive joint destruction and multisystem involvement.[1] RA is the most common type of arthritis triggered by the immune system.[2] It affects approximately 2.5 million Americans, 75 percent of whom are women.[3,4] Since there is no cure, the goal of treatment is to slow the progression of disease and prevent joint destruction, relieve pain and maintain functional capacity.

ABOUT RHEUMATOID ARTHRITIS

- Although the course of RA in individual patients is highly variable, most patients with persistent RA develop progressive functional limitation and physical disability. In addition, there is greater mortality among patients with persistent RA.[5-7]
- Disease-modifying anti-rheumatic drugs (DMARDs) slow the progression of RA by slowing down bone erosions, and reducing inflammation and long-term structural damage. Studies have shown the use of DMARDs improve functional status and health-related quality of life.[8]

MEASURE DEFINITION

This measure assesses the percentage of patients ages 18 and over diagnosed with RA who have been prescribed a DMARD.

THE CASE FOR IMPROVEMENT

- Early DMARD treatment for RA within three to six months after onset greatly decreases long-term disability.[8]
- Individuals with RA have three times the direct medical costs, two times the hospitalization rate and 10 times the work disability rate of those without RA. Indirect costs related to disability and work loss have been estimated to be three times higher than direct medical costs associated with the disease.[9]
- Costs of RA amount to approximately 1 percent of the U.S. gross national product.[8]
- DMARDs have the potential to reduce or prevent joint damage, preserve joint integrity and function and ultimately, reduce the total costs of health care for RA patients.[9]

RESULTS AND ANALYSIS

COMMERCIAL		
Treatment Rate:	**84.8**	up 3.9 pts
Nationwide variability: 16.0 pts		
Top state: **Iowa, 91.2**		
MEDICARE		
Treatment Rate:	**68.2**	up 4.0 pts
Nationwide variability: 37.2 pts		
MEDICAID		
Treatment Rate:	**67.6**	up 0.1 pt
Nationwide variability: 26.8 pts		
Top state: **Pennsylvania, 72.9**		

DISEASE MODIFYING ANTI-RHEUMATIC THERAPY IN RHEUMATOID ARTHRITIS

TRENDS, 2005 - 2006

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2006	**84.8**	**68.2**	**67.6**
2005	80.9	64.2	67.5

FLU SHOTS FOR ADULTS

As vaccine shortage eases, rates rise dramatically.

Every year, 5 to 20 percent of Americans contract influenza, commonly known as the flu.[1] While rates of infection are highest among children, the risk of serious illness and death from the flu is highest among adults over 64, children under 2 and those with chronic medical conditions.[2] More than 200,000 people are hospitalized for flu-related complications each year;[3] 63 percent are 65 years or older.[4] Vaccination is the most effective way to prevent severe illness complications and death due to influenza.[5]

ABOUT FLU SHOTS FOR ADULTS

- One third of Americans aged 50 to 64 have one or more chronic medical conditions that put them at increased risk for serious flu complications.[2]
- Rates of influenza vaccinations vary by race and ethnicity. Among adults aged 50 to 64, whites were more than 8.1 percent more likely than blacks and 8.2 percent more likely than Hispanics to have been vaccinated.[6]
- Among adults aged 65 and older, whites were 18.4 percent more likely than blacks and 13.2 percent more likely than Hispanics to have received an influenza vaccination.[6]
- In 2003, 36.8 percent of adults aged 50 to 64 received a flu shot, compared to 65.5 percent of adults over 64 years.[7]

MEASURE DEFINITION

This measure estimates the percentage of members 50 years of age and older who received an influenza vaccination during the most recent flu season. The commercial rates represent adults ages 50 to 64 while the reported results for Medicare represent adults 65 and older.

RESULTS AND ANALYSIS

COMMERCIAL		
Screening Rate:	**45.6**	up 9.3 pts
Nationwide variability: 19.1 pts		
Top state: **Colorado, 57.0**		
MEDICARE		
Screening Rate:	**N/A**	N/A
Nationwide variability: N/A		

FLU SHOTS FOR ADULTS

TRENDS, 2003 - 2006

YEAR	COMMERCIAL	MEDICARE
2006	**45.6**	**N/A**
2005	36.3	70.3
2004	38.9	74.8
2003	48.0	74.4

THE CASE FOR IMPROVEMENT

- Influenza vaccines can prevent between 50 and 60 percent of hospitalizations and 80 percent of deaths from flu-related complications among the elderly.[8]
- Estimated total direct hospitalization costs of a severe influenza epidemic are over $3 billion.[9]
- The cost of delivering the influenza vaccine is estimated to be $16.70 per person vaccinated, including direct and indirect medical costs and costs associated with potential side effects.[10]
- Cost of treatment for flu-like illnesses including office visits, tests, procedures and medications is an estimated $145 per case.[11]

FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS

1 in 4 adults affected by mental illness; 7-day follow-up rates maintain upward trend.

Mental illnesses affect about one in four adults.[1] Mental illnesses such as depression, bipolar disorder and schizophrenia are significant causes of disability in the U.S. Mental disorders can lead to suicide, one of the leading preventable causes of death in America. Appropriate treatment and follow-up of mental illness can reduce the duration of disability and the likelihood of recurrence.

ABOUT MENTAL ILLNESS AND HOSPITALIZATION

- Mood disorders such as major depression and bipolar disorder affect nearly 21 million Americans over 18.[2]
- Mortality rates, primarily from suicide, are as high as 15 percent for the most severe forms of depression.[3]
- Appropriate follow-up care reduces the risk of repeat hospitalization for some and identifies those in need of further hospitalization before they reach a crisis point.[4]
- More than 51 percent of first-time psychiatric patients are readmitted within two years.[5]
- The number of days between hospital discharge and follow-up appointment is a significant predictor of non-adherence independent of mental illness and severity.[6]

MEASURE DEFINITION

This measure indicates the percentage of members age 6 and older who received inpatient treatment for a mental health disorder and who had an ambulatory or other specified type of follow-up after discharge. It separately measures the percentage of members who received follow-up care within 7 and 30 days.

RESULTS AND ANALYSIS

COMMERCIAL

Follow-up in 7 Days: **56.7** — up 0.9 pts
Nationwide variability: 30.4 pts
Top state: **New Hampshire, 73.7**

Follow-up in 30 Days: **75.8** — down 0.1 pt
Nationwide variability: 24.6 pts
Top state: **New Hampshire, 89.3**

MEDICARE

Follow-up in 7 Days: **36.5** — down 2.6 pts
Nationwide variability: 49.9 pts

Follow-up in 30 Days: **55.8** — down 3.5 pts
Nationwide variability: 52.4 pts

MEDICAID

Follow-up in 7 Days: **39.1** — up 0.1 pt
Nationwide variability: 54.8 pts
Top state: **New York, 54.4**

Follow-up in 30 Days: **57.7** — up 0.9 pts
Nationwide variability: 62.6 pts
Top state: **New York, 69.2**

FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS

THE CASE FOR IMPROVEMENT

- Mental illnesses account for more than 15 percent of the overall disease burden in the U.S. -- more than the burden associated with all forms of cancer. 'Disease burden' assesses the size of a health problem measured by cost, mortality, morbidity, and other indicators and is expressed in terms of disability-adjusted life years.[7]
- In 2004, there were over 51 million ambulatory visits for mental disorders in the U.S.[8]
- Mental illness and substance abuse cost Americans an estimated $77.2 billion in lost income.[9]
- Individuals with major depression were found to be more than four times more likely to take disability days than non-depressed employees and three times more likely to miss time from work.[9]
- In 2002, the total cost from schizophrenia in the U.S. was estimated at $62.7 billion, with $22.7 billion excess direct health care costs.[10]

FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS: 7 DAYS

TRENDS, 1998 - 2006

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2006	**56.7**	**36.5**	**39.1**
2005	55.8	39.1	39.2
2004	55.9	40.2	38.0
2003	54.4	38.8	37.7
2002	52.7	38.7	36.9
2001	51.3	37.2	33.2
2000	48.2	37.5	34.6
1999	47.4	N/A	N/A
1998	44.4	N/A	N/A

FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS: 30 DAYS

TRENDS, 1996 - 2006

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2006	**75.8**	**55.8**	**57.7**
2005	75.9	59.3	56.8
2004	76.0	60.7	54.9
2003	74.4	60.3	56.4
2002	73.6	60.6	56.3
2001	73.2	60.6	52.2
2000	71.2	59.3	54.9
1999	70.1	N/A	N/A
1998	67.3	N/A	N/A
1997	66.9	N/A	N/A
1996	71.7	N/A	N/A

FOLLOW-UP CARE FOR CHILDREN PRESCRIBED ADHD MEDICATION

10 percent of pediatric behavioral problems attributable to ADHD; follow-up key.

Attention deficit/hyperactivity disorder (ADHD) is the most commonly treated childhood neurobehavioral disorder. ADHD is found in 3 to 6 percent of school-age children; at least 10 percent of behavioral problems seen in general pediatric settings are due to the disorder.[1] Children with ADHD may experience difficulties in school, troublesome relationships with family members and peers, and behavioral problems.[2] Follow-up care and surveillance is a key aspect of ADHD treatment.

ABOUT ADHD MEDICATION AND FOLLOW-UP

- Given the high prevalence of ADHD among school-age children, primary care clinicians should have a strategy for diagnosis and long-term management of this condition.[3]
- 1 in 4 patients have a follow-up visit with their primary care physician within the 30 days following the first ADHD prescription. For patients receiving a prescription from a psychiatrist, only 29 percent reported a follow-up visit with the psychiatrist within 30 days.[4]
- Half of physicians in a recent survey reported routine follow-up visits for children diagnosed with ADHD.[5]

MEASURE DEFINITION

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

Initiation Phase Management: The percentage of children 6 to 12 years of age with a prescription for ADHD medication who had one follow-up visit with a practitioner during the 30-day Initiation Phase.

Continuation and Maintenance (C&M) Phase: The percentage of children 6 to 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 in the nine months after the end of the Initiation Phase.

- *Note:* This year's specifications for the C&M Phase of the ADHD measure misstated the denominator. These rates will be first reported in HEDIS 2008.

RESULTS AND ANALYSIS

COMMERCIAL		
Initiation Phase:	**33.0**	up 1.0 pt
Nationwide variability: 18.7 pts Top state: **New Hampshire, 44.4**		
MEDICAID		
Initiation Phase:	**31.8**	up 0.4 pts
Nationwide variability: 25.5 pts Top state: **Minnesota, 35.6**		

FOLLOW-UP CARE FOR CHILDREN PRESCRIBED ADHD MEDICATION

INITIATION PHASE: TRENDS, 2005 - 2006

YEAR	COMMERCIAL	MEDICAID
2006	**33.0**	**31.8**
2005	32.0	31.4

THE CASE FOR IMPROVEMENT

- More than 4 million children ages 4 to 17 have been diagnosed with ADHD; more than half diagnosed are receiving medication treatment for the disorder.[6]
- 70 to 90 percent of children respond to ADHD drug treatment without major side effects.[1]
- Among children with ADHD, those on medication have shown to have less frequent and less costly emergency department visits.[7]
- Estimates of the total annual economic cost for treating children with ADHD in the U.S. range from $2 billion to $11 billion.[8]

GLAUCOMA SCREENING IN OLDER ADULTS

Federal spending on glaucoma exceeds $1.5 billion per year.

Glaucoma is a group of eye diseases which result in irreversible damage to the optic nerve. Untreated glaucoma leads to vision loss and blindness.[1] An estimated 80,000 Americans are legally blind due to glaucoma; it is the second leading cause of blindness in the U.S.[2] More than 2 million Americans over age 40 have glaucoma, but nearly half are unaware they have it.[1] Early-stage glaucoma shows no symptoms; however, if diagnosed at this stage, glaucoma can be easily treated and disease progression can be significantly delayed or prevented.

ABOUT GLAUCOMA SCREENING

- 3 of 4 people legally blind due to glaucoma are over 65.[3]
- About 3 percent of elderly people suffer from glaucoma, which impacts quality of life and ability to function independently.[4]
- Glaucoma accounts for more than seven million visits to physicians each year.[5]
- Screening for glaucoma is clinically important for early detection and treatment to prevent and delay glaucomatous damage.[3] Most people with glaucoma are identified through routine eye exams.[3]

MEASURE DEFINITION

This measure assesses the percentage of adults age 65 and over enrolled in Medicare plans who received one or more eye exams for glaucoma by an eye-care professional in the last two years. Enrollees with a prior diagnosis of glaucoma or a glaucoma suspect are excluded.

RESULTS AND ANALYSIS

MEDICARE		
Screening Rate:	**62.2**	up 0.6 pts
Nationwide variability: 35.9 pts		

GLAUCOMA SCREENING IN OLDER ADULTS

TRENDS, 2004 - 2006

YEAR	MEDICARE
2006	**62.2**
2005	61.6
2004	62.3

THE CASE FOR IMPROVEMENT

- The number of Americans with glaucoma is estimated to increase to 3.3 million by 2020.[1]
- Early detection can prevent glaucoma-caused visual impairment.[6] The difference between early-stage and late-stage glaucoma treatment is close to $2,000 per patient per year.[7]
- Vision loss due to glaucoma can lead to an increased risk of injuries arising from falls among the elderly.[8]
- Including Social Security benefits, lost income tax revenues, and health care expenditures, U.S. government spending on glaucoma is estimated to exceed $1.5 billion a year.[5]

IMAGING STUDIES FOR LOW BACK PAIN

Inappropriate, costly imaging studies increase in 2006.

Low back pain, the most common and expensive reason for work disability in the U.S., affects two-thirds of adults at some time in their lives.[1] Back pain is second only to coughing among symptoms of people who seek medical care.[2] In a given year, about 15 percent of all Americans will have low back pain lasting two weeks; of those, 5 to 10 percent will have low back pain lasting three or more months.[3] When low back pain is not attributed to potentially serious spinal pathology or non-spinal pathology, there is a poor correlation of X-ray findings with low back problems. According to the American College of Radiology, uncomplicated acute low back pain is a benign, self-limited condition that warrants no imaging studies (e.g. X-ray, MRI, CT scan). The challenge is to distinguish the small segment within this large patient population that should be evaluated further for a more serious problem.[4]

ABOUT IMAGING STUDIES FOR LOW BACK PAIN

- Experts consider imaging studies to be overused in the evaluation of patients with acute low back pain. The vast majority of patients with nonspecific low back pain have no identifiable cause. [5]
- Fewer than one percent of radiographs find the cause of a case of low back pain.[6]
- Patients given recommended care (no radiograph) experience no difference in health outcomes compared to those given lower back radiographs, other than patient satisfaction.[7]
- Disc protrusions detected by X-rays are often blamed for low back pain, but disc protrusions are rarely responsible for the pain, and surgery seldom alleviates it.[8]
- CT and MRI studies do not identify where pain is located, except in patients where specific disease is suspected.[9]

MEASURE DEFINITION

This measure estimates the percentage of people ages 18 to 50 years of age who had an episode of acute low back pain with no risk factors or signs of serious pathology identified in the diagnostic visit and did *not* receive an imaging study in the following 28 days. Higher scores indicate fewer potentially inappropriate imaging studies.

RESULTS AND ANALYSIS

COMMERCIAL		
Appropriate Use Rate:	**73.9**	down 1.5 pts
Nationwide variability: 16.4 pts		
Top state: **Washington, 80.8**		

MEDICAID		
Appropriate Use Rate:	**78.3**	down 0.7 pts
Nationwide variability: 13.9 pts		
Top state: **Virginia, 82.0**		

IMAGING STUDIES FOR LOW BACK PAIN

TRENDS, 2004 - 2006

YEAR	COMMERCIAL	MEDICAID
2006	**73.9**	**78.3**
2005	75.4	79.0
2004	74.9	78.1

THE CASE FOR IMPROVEMENT

- Low back pain is the most costly ailment in the workplace, averaging of $8,000 per claim.[10]
- Complications from unnecessary surgery can increase the duration of low back pain.[11]
- Costs associated with back pain range between an estimated $50 billion and $100 billion per year. Medical care accounts for about one-third of costs; the remainder includes lost wages, disability payments, and retraining costs.[2]
- Total health care expenditures by Americans with back pain in 1998 totaled $91 billion. Expenditures attributable to back pain totaled $26 billion.[9]

INITIATION AND ENGAGEMENT OF ALCOHOL AND OTHER DRUG DEPENDENCE TREATMENT

Alcohol and other drugs, combined with tobacco, account for 1 in 4 deaths.

More than 9 percent of Americans age 12 and over are dependent on or abuse alcohol or illicit drugs.[1] Research supports the need for those with alcohol and other drug dependence to engage in ongoing treatment to prevent relapse. Individuals who complete treatment or receive more days of treatment typically show more improvement than those who leave care prematurely.[2] The acute stage of treatment is associated with lasting improvements only with continued rehabilitative treatment.[3]

ABOUT ALCOHOL AND OTHER DRUG DEPENDENCE

- 77 percent of adults with substance dependence or abuse are employed full or part time.[1]
- Fewer than 1 in 4 patients who need treatment for alcohol and/or drug abuse get it.[4]
- Alcoholism is one of the most common psychiatric disorders, with a prevalence of 8 to 14 percent.[5] Alcohol use accounts for 85,000--or nearly 1 in 25--deaths annually and is one of the most common preventable causes of death in United States.[6]
- Brief intervention of four or fewer sessions by a health professional helps socially stable problem drinkers to reduce or stop drinking, motivate alcohol-dependent patients to enter long-term alcohol treatment, and help some alcohol-dependent patients to abstain completely.[5]

MEASURE DEFINITION

These measures assess the degree to which plans initiate and engage adolescents (13-17 years) and adults (18 years and over) identified with alcohol and other drug (AOD) dependence.

Initiation: The percentage of eligible members diagnosed with AOD dependence who initiate treatment through either inpatient admission or outpatient treatment and additional AOD treatment within 14 days.

Engagement: The percentage of eligible members diagnosed with AOD disorders who receive two additional AOD services within 30 days after treatment initiation.

RESULTS AND ANALYSIS

COMMERCIAL		
Initiation:	**43.2**	down 1.3 pts
Nationwide variability: 20.2 pts Top state: **Tennessee, 50.6**		
Engagement:	**13.8**	down 0.3 pts
Nationwide variability: 17.1 pts Top state: **New York, 20.6**		
MEDICARE		
Initiation:	**50.3**	down 0.6 pts
Nationwide variability: 30.4 pts		
Engagement:	**4.5**	down 0.2 pts
Nationwide variability: 10.8 pts		
MEDICAID		
Initiation:	**43.3**	up 2.6 pts
Nationwide variability: 25.7 pts Top state: **New York, 41.8**		
Engagement:	**11.7**	up 2.0 pts
Nationwide variability: 22.3 pts Top state: **Minnesota, 10.1**		

INITIATION AND ENGAGEMENT OF ALCOHOL AND OTHER DRUG DEPENDENCE TREATMENT

THE CASE FOR IMPROVEMENT

- One of every four deaths can be attributed to alcohol, tobacco, or illicit drug use.[7]
- Studies have shown that from $4 to $7 are saved for every dollar spent on treatment.[10]
- Frequency and intensity of engagement is important in treatment outcomes and reducing drug-related illnesses; addiction intervention reduces utilization of health care services and criminal activity.[9]
- The annual cost of illicit drug abuse is $181 billion. When combined with alcohol and tobacco costs, costs exceed $500 billion including health care, criminal justice, and lost productivity.[8]
- It costs approximately $3,600 per month to leave a drug abuser untreated in the community, and incarceration costs approximately $3,300 per month.[8]

INITIATION OF ALCOHOL AND OTHER DRUG DEPENDENCE TREATMENT

TRENDS, 2004 - 2006

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2006	**43.2**	**50.3**	**43.3**
2005	44.5	50.9	40.7
2004	45.9	54.7	45.7

ENGAGEMENT OF ALCOHOL AND OTHER DRUG DEPENDENCE TREATMENT

TRENDS, 2004 - 2006

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2006	**13.8**	**4.5**	**11.7**
2005	14.1	4.7	9.7
2004	15.5	7.0	12.0

MEDICAL ASSISTANCE WITH SMOKING CESSATION

World's second-leading cause of death; 440,000 Americans die annually as a result.

Tobacco is the second leading cause of death in the world.[1] In 2005, over 20 percent of Americans over 18 smoked.[1] Smoking has a detrimental affect on virtually every organ in the body. Diseases caused or made worse by smoking include bladder, esophageal, laryngeal, lung, cervical, kidney, pancreatic, stomach, oral and throat cancers, chronic lung diseases, coronary heart and cardiovascular diseases, sudden infant death syndrome, abdominal aortic aneurysm, cataracts, and pneumonia.[1] Smoking is one of the most preventable causes of death: 440,000 Americans die each year as a result of smoking.[2] On average, smokers' lives are cut short by 13.2 to 14.5 years.[3]

ABOUT SMOKING CESSATION

- At least 70 percent of smokers see a physician each year,[4] but only 61.8 percent of current smokers trying to quit received advice to quit from their health care providers.[5]
- Counseling smokers on cessation increases the patient's potential to quit smoking and is a cost-effective intervention. More intensive interventions, such as discussing strategies and use of a nicotine patch increases the potential for smoking cessation.[6]

MEASURE DEFINITION

This measure evaluates three components:

Advising Smokers to Quit: The percentage of current smokers 18 and older who received advice to quit smoking from their practitioner within the past year.

Discussing Smoking Cessation Medications: The percentage of current smokers 18 and older whose practitioner discussed or recommended smoking cessation medications with them over the past year.

Discussing Smoking Cessation Strategies: The percentage of current smokers 18 and older whose practitioner discussed or recommended smoking cessation methods or strategies with them over the past year.

RESULTS AND ANALYSIS

COMMERCIAL		
Advising Smokers to Quit: Nationwide variability: 13.3 pts Top state: **Massachusetts, 79.9.**	**73.8**	up 2.6 pts
Discussing Medications: Nationwide variability: 17.4 pts Top state: **Massachusetts, 52.5**	**43.9**	up 4.5 pts
Discussing Strategies: Nationwide variability: 19.3 pts Top state: **Massachusetts, 52.7**	**43.2**	up 4.2 pts
MEDICARE		
Advising Smokers to Quit: Nationwide variability: N/A	**N/A**	N/A
MEDICAID		
Advising Smokers to Quit: Nationwide variability: 14.7 pts	**68.2**	up 2.6 pts
Discussing Medications: Nationwide variability: 21.7 pts	**35.1**	up 3.2 pts
Discussing Strategies: Nationwide variability: 17.8 pts	**36.7**	up 2.6 pt

MEDICAL ASSISTANCE WITH SMOKING CESSATION

THE CASE FOR IMPROVEMENT

- Ten years after quitting, an ex-smoker's risk of dying from lung cancer is 30 to 50 percent lower than that of those who continue to smoke.[6]
- The life extension from smoking cessation at age 35 is 8.5 years for men and 7.7 years for women. At age 65, the life extension is 2 years for men and 3.7 years for women.[7]
- In 2003, 14.6 million Americans attempted to stop smoking.[1]
- Smoking cessation treatment doubles quitting success rates.[1]
- Women who stop smoking before becoming pregnant or quit in the first three months of pregnancy can reverse the risk of low birth weight for the baby and reduce other pregnancy risks associated with smoking.[6]
- Current smokers incur 18 percent higher health care charges than people who never smoked.[8]
- Smoking-attributed health care expenditures and productivity losses exceed $167 billion annually.[8]

ADVISING SMOKERS TO QUIT
TRENDS, 2003 - 2006

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2006	**73.8**	**N/A**	**68.2**
2005	71.2	75.5	65.6
2004	69.6	64.7	66.9
2003	68.6	63.3	65.8

DISCUSSING SMOKING CESSATION MEDICATIONS
TRENDS, 2003 - 2006

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2006	**43.9**	**N/A**	**35.1**
2005	39.4	N/A	31.9
2004	37.8	N/A	31.5
2003	37.6	N/A	31.5

DISCUSSING SMOKING CESSATION STRATEGIES
TRENDS, 2003 - 2006

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2006	**43.2**	**N/A**	**36.7**
2005	39.0	N/A	34.1
2004	36.9	N/A	33.0
2003	36.0	N/A	32.3

MEDICATION MANAGEMENT IN THE ELDERLY

2 in 5 adverse drug events in the elderly are preventable.

Despite widely-accepted medical consensus that certain drugs increase the risk of harm to the elderly and should generally be avoided,[1-3] these drugs are still frequently prescribed. Studies have found 21 to 37 percent of elderly patients filled at least one potentially inappropriate prescription and more than 15 percent filled at least two.[4,5] While expenditures for prescription drugs are disproportionately clustered among those 65 years and older,[6] this population is twice as likely as those below age 65 to experience adverse drug effects and is almost seven times as likely to be hospitalized.[7] Clinical guidelines identify drugs that are generally inappropriate for the elderly, as well as drugs that are inappropriate for elderly populations with specific diagnoses or conditions.[1,3]

ABOUT MEDICATION MANAGEMENT IN THE ELDERLY

- Seniors receiving inappropriate medications are more likely to report poorer health status at follow-up.[8]
- Prescriptions for inappropriate drugs are linked to increased risk of harmful drug effects, hospitalization, increased length of illness, nursing home placement; and falls and fractures that can further cause physical, functional and social decline.[6,8-10]
- 40 percent of fatal or life-threatening adverse drug events in the elderly are preventable.[10]
- About 5 percent of prescriptions filled for the elderly are for drugs classified as "always avoid"; 13 percent are for drugs that would rarely be considered appropriate.[5]

MEASURE DEFINITION

These measures assess two dimensions of medication management in the elderly: use of high-risk medications and potentially harmful drug-disease interactions.

The *Use of High-Risk Medications in the Elderly* measure assesses the percentage of Medicare members who received at least one drug to be avoided in the elderly and the percentage of Medicare members who received at least two different drugs to be avoided in the elderly.

A lower rate represents better performance.

A complete list of medications considered to be high risk is available at www.ncqa.org.

The *Potentially Harmful Drug-Disease Interactions* measure assesses the percentage of Medicare members with evidence of an underlying disease, condition or health concern and who were dispensed an ambulatory prescription for a contraindicated medication, with or after the diagnosis.

The following rates are reported:

- A history of falls and a prescription for tricyclic antidepressants, antipsychotics or sleep agents
- Dementia and a prescription for tricyclic antidepressants or anticholinergic agents
- Chronic renal failure and prescription for nonaspirin NSAIDs or Cox-2 Selective NSAIDs

A combined rate is also reported.

A lower rate represents better performance.

THE CASE FOR IMPROVEMENT

- Current rates of potentially inappropriate medication use in the elderly are as high or higher than in a 1996 national sample, highlighting the need for progress in this area.[5]
- Between 30 and 80 percent of all adverse drug events in the elderly are preventable.[11]
- Almost 3 percent of elderly patients enrolled in a managed care organization suffered a preventable adverse drug event in a year.[12]
- Extra costs due to potentially inappropriate medications in the elderly average $7.2 billion a year.[13]

MEDICATION MANAGEMENT IN THE ELDERLY

USE OF HIGH-RISK MEDICATIONS IN THE ELDERLY RESULTS AND ANALYSIS

MEDICARE

One Drug to Be Avoided*: **23.1** down 0.8 pts
Nationwide variability: 20.4 pts

Two Drugs to Be Avoided*: **5.9** down 0.7 pts
Nationwide variability: 8.4 pts

USE OF HIGH-RISK MEDICATIONS IN THE ELDERLY

ONE HIGH-RISK MEDICATION - TRENDS, 2005 - 2006

YEAR	MEDICARE
2006*	**23.1**
2005	23.9

USE OF HIGH-RISK MEDICATIONS IN THE ELDERLY

TWO OR MORE HIGH-RISK MEDICATIONS - TRENDS, 2005 - 2006

YEAR	MEDICARE
2006*	**5.9**
2005	6.6

POTENTIALLY HARMFUL DRUG-DISEASE INTERACTIONS IN THE ELDERLY

DEMENTIA + TRICYCLIC ANTIDEPRESSANT, ANTIPSYCHOTICS OR SLEEP AGENTS - TRENDS, 2006

YEAR	MEDICARE
2006	**24.6**

THIS IS A FIRST-YEAR MEASURE.

** Lower rates are better for this measure.*

POTENTIALLY HARMFUL DRUG-DISEASE INTERACTIONS IN THE ELDERLY RESULTS AND ANALYSIS

MEDICARE

Falls + Tricyclic Antidepressant, antipsychotics or sleep agents:* **14.6** new measure
Nationwide variability: 13.5 pts

Dementia + Tricyclic Antidepressant, antipsychotics or sleep agents:* **24.6** new measure
Nationwide variability: 17.8 pts

Chronic renal failure + NSAIDS:* **9.5** new measure
Nationwide variability: 12.3 pts

Combination Rate:* **19.4** new measure
Nationwide variability: 13.9 pts

POTENTIALLY HARMFUL DRUG-DISEASE INTERACTIONS IN THE ELDERLY

FALLS + TRICYCLIC ANTIDEPRESSANT, ANTIPSYCHOTICS OR SLEEP AGENTS - TRENDS, 2006

YEAR	MEDICARE
2006	**14.6**

THIS IS A FIRST-YEAR MEASURE.

POTENTIALLY HARMFUL DRUG-DISEASE INTERACTIONS IN THE ELDERLY

CHRONIC RENAL FAILURE + NSAIDS - TRENDS, 2006

YEAR	MEDICARE
2006	**9.5**

THIS IS A FIRST-YEAR MEASURE.

POTENTIALLY HARMFUL DRUG-DISEASE INTERACTIONS IN THE ELDERLY

COMBINED RATE - TRENDS, 2006

YEAR	MEDICARE
2006	**19.4**

THIS IS A FIRST-YEAR MEASURE.

OSTEOPOROSIS MANAGEMENT IN WOMEN WHO HAD A FRACTURE

Half of all women will have an osteoporotic fracture in their lifetime.

An estimated 10 million Americans--eight million of whom are women over 50 -- have osteoporosis; 34 million more are estimated to have low bone mass, placing them at increased risk for osteoporosis.[1] Osteoporosis contributes to more than 1.5 million fractures annually.[2] A woman over the age of 50 has a 50 percent chance of having an osteoporosis-related fracture.[3]

ABOUT OSTEOPOROSIS MANAGEMENT

- Total fracture rates are reduced according to the degree to which bone density testing is offered to women 60 to 80 years of age.[4]
- 90 to 95 percent of all hip and spine fractures and 70 to 80 percent of all forearm fractures in women over the age of 65 have been estimated to be attributable to osteoporosis.[5]
- Postmenopausal women are at highest risk for fractures if they have experienced previous fractures of the vertebra, hip, and wrist, but often remain untested for osteoporosis.[6]

MEASURE DEFINITION

This measure estimates 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 date of the fracture. This is not a measure of fractures "caused" by osteoporosis, but rather uses the presence of any fracture as a "trigger" to look for underlying osteoporosis.

THE CASE FOR IMPROVEMENT

- More than 1.5 million Americans experience osteoporotic fractures each year, half of which are vertebral fractures; such fractures cost Americans a collective $14 billion annually.[7]
- Treatment of osteoporotic fractures reduces the risk of subsequent fractures 40 to 60 percent.[8]
- Half of all women and 1 in 4 men will have an osteoporosis-related fracture in their lifetime. At least 90 percent of all hip and spine fractures among older white women can be attributed to underlying bone fragility.[3]
- Hip and vertebral osteoporotic fractures are linked to increased mortality, while all osteoporotic fractures may lead to disability and a reduced quality of life.[9,10]
- Osteoporotic fractures are responsible for approximately 500,000 hospitalizations, 800,000 emergency room visits, 2.6 million physician visits and 180,000 nursing home placements per year.[11]

RESULTS AND ANALYSIS

MEDICARE	
Management Rate: **21.8**	up 1.7 pts
Nationwide variability: 17.7 pts	

OSTEOPOROSIS MANAGEMENT

TRENDS, 2004 - 2006

YEAR	MEDICARE
2006	**21.8**
2005	20.1
2004	19.0

PRENATAL AND POSTPARTUM CARE

Commercial rates of prenatal care, check-ups after delivery stall in 2006.

There are over four million births in the U.S. annually.[1] Early, effective prenatal care can identify mothers at risk of delivering a preterm infant and provide an array of medical and educational interventions. Poor pregnancy outcomes can be costly, but many are preventable with early intervention. Early infancy is a critical time for the health of both baby and mother; continuity of care can help detect problems early and prevent complications.

ABOUT PRENATAL AND POSTPARTUM CARE

- Every week, more than 9,800 infants are born preterm and 6,400 babies are born low birthweight, placing them at increased risk for neurodevelopmental handicaps, congenital anomalies and respiratory illness.[2]
- Comprehensive prenatal care has been shown to help reduce low birth weight and infant mortality.[1]
- Women who receive no prenatal care are three to four times more likely to die from complications from pregnancy than women who received prenatal care.[3]

MEASURE DEFINITION

This measure has two indicators:

Timeliness of Prenatal Care: The percentage of pregnant women who who received a prenatal care visit in either the first trimester or within 42 days of enrollment.

Postpartum Care: The percentage of women who had a postpartum visit between 21 and 56 days after delivery.

RESULTS AND ANALYSIS

COMMERCIAL		
Timely Prenatal Care:	**90.6**	down 1.2 pts
Nationwide variability: 14.8 pts Top state: **New Hampshire, 95.6**		
Postpartum Checkups:	**79.9**	down 1.6 pts
Nationwide variability: 20.2 pts Top state: **Iowa, 86.6**		
MEDICAID		
Timely Prenatal Care:	**81.2**	up 2.1 pts
Nationwide variability: 21.2 pts Top state: **Maryland, 89.4**		
Postpartum Checkups:	**59.1**	up 2.1 pts
Nationwide variability: 23.7 pts Top state: **Minnesota, 65.7**		

PRENATAL AND POSTPARTUM CARE

THE CASE FOR IMPROVEMENT

- Mothers who receive no prenatal care have an infant mortality rate more than five times that of mothers whose prenatal care is initiated in the first trimester of pregnancy.[4]
- In 2003, the infant mortality rate for very preterm infants was 188 per 1,000 live births, nearly 78 times the rate for infants born at term.[4]
- Every dollar of prenatal care results in expected savings of $3.33 for postpartum care and $4.63 in long-term morbidity costs.[5]
- Hospitalizations for pregnancy complications cost over $1 billion annually and account for more than two million hospital days of care.[1]
- Infants whose mothers receive prenatal care have a predicted hospital cost of $1,065, compared with $2,069 for those whose mothers do not receive care prior to the onset of labor.[6] When mothers do not receive prenatal care, low birth weight infants incurred almost six times the medical costs of normal birth weight infants, and very low birth weight infants had costs of more than 70 times normal.[6]

TIMELINESS OF PRENATAL CARE
TRENDS, 1996 - 2006

YEAR	COMMERCIAL	MEDICAID
2006	**90.6**	**81.2**
2005	91.8	79.1
2004	90.8	78.2
2003	89.4	76.5
2002	86.7	70.1
2001	85.1	72.9
2000	83.3	72.6
1999	85.0	N/A
1998	83.4	N/A
1997	83.1	N/A
1996	83.8	N/A

POSTPARTUM CARE
TRENDS, 1997 - 2006

YEAR	COMMERCIAL	MEDICAID
2006	**79.9**	**59.1**
2005	81.5	57.0
2004	80.7	56.5
2003	80.3	55.3
2002	77.0	52.9
2001	77.0	53.0
2000	74.1	49.8
1999	72.3	N/A
1998	70.1	N/A
1997	66.2	N/A

USE OF APPROPRIATE MEDICATIONS FOR PEOPLE WITH ASTHMA

Asthma accounts for more than 14 million lost work days annually.

Asthma is one of the nation's most common, costly and increasingly prevalent diseases. More than 30 million Americans, including 8.5 million children, will suffer from asthma.[1] Asthma medications help reduce underlying airway inflammation, and relieve or prevent airway narrowing. Many asthma-related hospitalizations, emergency room visits, and missed work and school days can be avoided if patients have appropriate medications and medical management.

ABOUT ASTHMA

- In 2004, asthma accounted for 13.6 million physician office visits, 1 million hospital outpatient visits and 1.8 million emergency room visits.[1]
- Asthma is the leading cause of school absenteeism attributed to chronic conditions.[2]
- Asthma is the third leading cause of hospitalization among children under the age of 15.[3]

MEASURE DEFINITION

This measure assesses the percentage of enrolled members 5 to 56 years with persistent asthma who were prescribed medications acceptable as primary therapy for long-term control of asthma.

The measure is collected separately for children (ages 5-9), adolescents (ages 10-17) and adults (ages 18-56). A combined rate is also reported.

THE CASE FOR IMPROVEMENT

- Nearly 5,000 Americans die of asthma each year. Some of those deaths could be avoided with improved disease management.[4]
- The economic cost of asthma is $14 billion annually, including $4.6 billion in lost productivity.[1]
- Children miss an estimated 14 million school days each year because of asthma.[1]
- Asthma accounts for an estimated 14.5 million lost workdays for adults.[1]
- Most asthma-related hospitalizations and emergency department visits are preventable, non-acute asthma care can be shifted to the ambulatory setting to decrease costs.[5]

RESULTS AND ANALYSIS

COMMERCIAL

Combined Rate: **91.6** up 1.7 pts
Nationwide variability: 6.9 pts
Top state: **Maryland, 93.8**

MEDICAID

Combined Rate: **87.1** up 1.4 pts
Nationwide variability: 10.5 pts
Top state: **New York, 90.8**

ASTHMA MEDICATION USE
TRENDS, 1998 - 2006

YEAR	COMMERCIAL	MEDICAID
2006	**91.6**	**87.1**
2005*	89.9	85.7
2004	72.9	64.5
2003	71.4	64.1
2002	67.9	62.8
2001	65.6	60.1
2000	N/A	N/A
1999	62.6	57.4
1998	57.7	N/A

**Due to a change in measure specifications, rates are untrendable from 2004 to 2005.*

USE OF SPIROMETRY IN THE ASSESSMENT AND DIAGNOSIS OF COPD

COPD, fourth-leading cause of death in U.S., should be diagnosed with simple test.

Chronic obstructive pulmonary disease (COPD), a group of diseases characterized by airflow obstruction and includes chronic bronchitis and emphysema[1], is the fourth leading cause of death in the U.S. and is projected to be the third-leading cause by 2020.[2,3] Spirometry is a simple test that measures the total amount and speed at which a person can breathe out air.[4] Both symptomatic and asymptomatic patients suspected of COPD should have spirometry performed to establish airway limitation and severity.[5]

ABOUT COPD AND SPIROMETRY

- COPD can be present with or without physical impairment or symptoms. It is often a silent and unrecognized disease, and in its milder forms difficult to detect and diagnose clinically without the use of spirometry.[1,6,7]
- Spirometry assessments are essential to confirm the presence and reversibility of airflow obstruction and to distinguish COPD from asthma.[8,9]

MEASURE DEFINITION

This measure estimates the percentage of members 40 and older with a new diagnosis of COPD who received spirometry testing to confirm this diagnosis.

THE CASE FOR IMPROVEMENT

- In 2004, 11.4 million adults were estimated to have COPD. However, close to 24 million adults have evidence of impaired lung function, indicating an under diagnosis of COPD.[10]
- The total annual estimated cost of COPD in 2004 was $37.2 billion, including $20.9 billion in direct medical costs.[10] Diagnostic spirometers cost about $2,000; office spirometers costs less than $800 and requires less testing time than diagnostic spirometers.[11]
- Compared to diagnosis and treatment based on clinical examination alone, spirometry may reduce the number of symptomatic individuals who are diagnosed with and treated for COPD but do not have airflow obstruction of severity that is likely to benefit from treatment.

RESULTS AND ANALYSIS

COMMERCIAL		
Spirometry Rate:	**36.1**	up 1.3 pts
Nationwide variability: 20.3 pts		
Top state: **New York, 46.3**		
MEDICARE		
Spirometry Rate:	**26.2**	down 0.1 pt
Nationwide variability: 20.0 pts		
MEDICAID		
Spirometry Rate:	**27.3**	up 0.8 pts
Nationwide variability: 23.4 pts		
Top state: **New York, 38.8**		

SPIROMETRY IN THE ASSESSMENT AND DIAGNOSIS OF COPD

TRENDS, 2005 - 2006

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2006	**36.1**	**26.2**	**27.3**
2005	34.8	26.3	26.5

CAHPS® MEASURES OF CONSUMER EXPERIENCE

CAHPS® 4.0H measures members' satisfaction with their commercial and Medicaid organizations. It addresses areas such as the ability to obtain information from a health plan, the timeliness of service and the speed and accuracy by which health plans process claims. The CAHPS results offer an indication of how well health care organizations are meeting their members' expectations.

The CAHPS surveys were developed with the Agency for Healthcare Research and Quality (AHRQ) and are part of the Consumer Assessment of Healthcare Providers and Systems program.

The CAHPS 4.0H survey fielded this year was substantially updated from years past in order to improve the clarity of the items, make the survey more responsive to stakeholders and to clarify the referenced provider. The number of core items, wording and order of questions were among the changes made this year. Interpretation of year-over-year results for any CAHPS results from this year should be made with changes to the survey in mind.

Although the Customer Service composite was collected in the CAHPS 4.0H survey, the results will not be reported in this year's report; NCQA is examining the impact of the changes of the survey on the Customer Service composite.

Further, Medicare CAHPS data was not available as of the press time of this report. Medicare CAHPS data will be published in an updated version of this report to be released later this year.

RATING OF HEALTH PLAN

Respondents were asked to rate their health plan overall, 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 plans either 8 or higher, or 9 or higher.

In 2006, the percentage of enrollees who rated their health plan an 8, 9 or 10 decreased by almost 2 percentage points for commercial plans and Medicaid plans. The percentage of enrollees who rated their plan a 9 or 10 decreased more than 2 percentage points for commercial plans and 1 percentage point for Medicaid plans.

RATING OF HEALTH PLAN: 8, 9 OR 10
TRENDS, 1999 - 2006

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2006	63.0	N/A	70.1
2005	65.2	N/A	72.0
2004	64.1	N/A	71.6
2003	61.8	N/A	69.9
2002	61.3	N/A	69.7
2001	61.8	N/A	69.3.
2000	59.3	N/A	67.0
1999	56.7	N/A	N/A

RATING OF HEALTH PLAN: 9 OR 10
TRENDS, 1999 - 2006

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2006	38.0	N/A	52.5
2005	39.8	N/A	53.9
2004	38.4	N/A	52.6
2003	36.6	N/A	51.6
2002	36.2	N/A	51.8
2001	37.3	N/A	52.4
2000	35.8	N/A	50.2
1999	33.7	N/A	N/A

RATING OF HEALTH CARE

Respondents were asked to rate their health care overall, 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 8 or higher, or 9 or higher.

In 2006, the percentage of enrollees who rated their health care an 8, 9 or 10 decreased by over 4 percentage points for commercial plans and more than 7 percentage points for Medicaid plans. The percentage of enrollees who rated their health care a 9 or 10 decreased more than 6 percentage points for commercial plans and over seven percentage points for Medicaid plans.

RATING OF HEALTH CARE: 8, 9 OR 10
TRENDS, 1998 - 2006

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2006	73.6	N/A	65.6
2005	78.0	N/A	72.8
2004	77.6	N/A	72.9
2003	76.3	N/A	72.1
2002	75.1	N/A	71.6
2001	73.2	N/A	71.3
2000	72.0	N/A	70.0
1999	70.2	N/A	N/A
1998	70.3	N/A	N/A

RATING OF HEALTH CARE: 9 OR 10
TRENDS, 2001 - 2006

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2006	47.0	N/A	46.3
2005	53.5	N/A	54.1
2004	52.1	N/A	53.8
2003	51.5	N/A	52.9
2002	49.4	N/A	N/A
2001	37.3	N/A	52.6

GETTING NEEDED CARE

The Getting Needed Care composite measures the experiences members had in the last 12 months when attempting to get care from doctors and specialists. The rates displayed represent the average percentage of health plan members nationwide who responded "Usually" or "Always."

Topics that were measured include:

- Getting to see a specialist when needed
- Obtaining the care, tests, or treatment believed necessary

Responses included:

- Never
- Sometimes
- Usually
- Always

In 2006, the national average for the Getting Needed Care composite increased by 4 percentage points for commercial plans and less than 1 percentage point for Medicaid plans.

GETTING NEEDED CARE: RESPONDENTS ANSWERING "USUALLY" OR "ALWAYS"
TRENDS, 1999 - 2006

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2006	84.2	N/A	74.2
2005	80.2	N/A	73.9
2004	79.4	N/A	74.1
2003	78.4	N/A	72.1
2002	76.9	N/A	72.4
2001	76.7	N/A	75.5
2000	75.4	N/A	74.2
1999	74.0	N/A	N/A

GETTING NEEDED CARE: RESPONSES TO INDIVIDUAL QUESTIONS
COMMERCIAL, 2006

QUESTION	USUALLY OR ALWAYS	ALWAYS ONLY
In the last 12 months, not counting the times you needed care right away, did you make any appointments for your health care at a doctor's office or clinic?	87.3	60.9
In the last 12 months, not counting the times you needed care right away, how often did you get an appointment for your health care at a doctor's office or clinic as soon as you thought you needed?	85.0	52.8
In the last 12 months, how often was it easy to get care, tests, or treatment you thought you needed through your health plan?	86.7	53.7

HEDIS MEASURES OF RELATIVE RESOURCE USE

VARIATION IN COSTS AND QUALITY POINT TO INEFFICIENCY

In 2006, in an effort to help consumers and purchasers assess the value plans add, NCQA fielded a new set of standardized measures of Relative Resource Use (RRU) focused on six costly chronic conditions: diabetes, acute low back pain, asthma, COPD, uncomplicated hypertension, and cardiovascular conditions. Taken together, these conditions account for 60 percent of all private health care spending. RRU measures are being phased in over two years; this year, health plans reported on resource use for the care of people with diabetes, asthma and low back pain.

Insurance premiums are a poor gauge of health care costs, masked by market competition and plans' ability to negotiate provider discounts. Yet most employers and consumers choose a plan based on the lowest premium offered. A more accurate measure is the value a plan adds by delivering high-quality care while using the fewest possible resources in doing so.

These measures assess resource consumption using a standardized table of prices to eliminate the often short-term impact of discounts and other factors. Coupled with HEDIS quality measures, RRUs yield information that allows comparison of plans based on value.

HOW RELATIVE RESOURCE USE MEASURES WORK

Using standardized price tables, health plans calculate and report total standardized costs and utilization rates across several categories. NCQA then calculates an expected total standard cost for each chronic condition by plan type and product line (e.g., commercial, Medicare, Medicaid.)

Resource use is adjusted for a plan's population composition pertaining to age, gender and presence of comorbidities, so that plans that serve patients that are older or with a greater burden of illness are not at a disadvantage.

A ratio of observed-to-expected resource use is then calculated within each clinical condition. A ratio result of 1.00, for instance, indicates that a health plan spent or used the same level of resources in treating its population as the average used to treat all eligible members with a given condition. A ratio of 1.12 indicates that a health plan used 12 percent more resources than the national average; a ratio of 0.73 indicates that a plan used 27 percent fewer resources than average.

To determine value, NCQA used a composite of HEDIS measures for each condition including process and intermediate outcome measures across four categories of service:

- inpatient facility costs, exclusive of surgery and other procedures;
- evaluation and management costs (i.e., office visits with a primary care physician or specialist);
- inpatient and outpatient surgery costs; and
- ambulatory pharmacy costs.

This year's report rolls up the first three categories into a measure of medical costs and displays pharmacy costs separately due to the fact that pharmacy benefits are frequently administered separately from other medical benefits.

These measures assess total resource use for patients with a given condition. For instance, if a patient with diabetes were to undergo a surgical procedure unrelated to their diabetes, those costs would be reflected in the RRU data for that patient's health plan.

RELATIVE RESOURCE USE: DIABETES

DIABETES CARE: MORE CARE ISN'T NECESSARILY BETTER

This year's *State of Health Care Quality* report examines quality and associated resource use for diabetics enrolled in commercial HMO and point-of-service plans. More information about the other two conditions for which health plans submitted resource use data in 2007, asthma and low back pain, as well as data for Medicare Advantage plans, will be released in the coming months as NCQA continues its analysis of these measures.

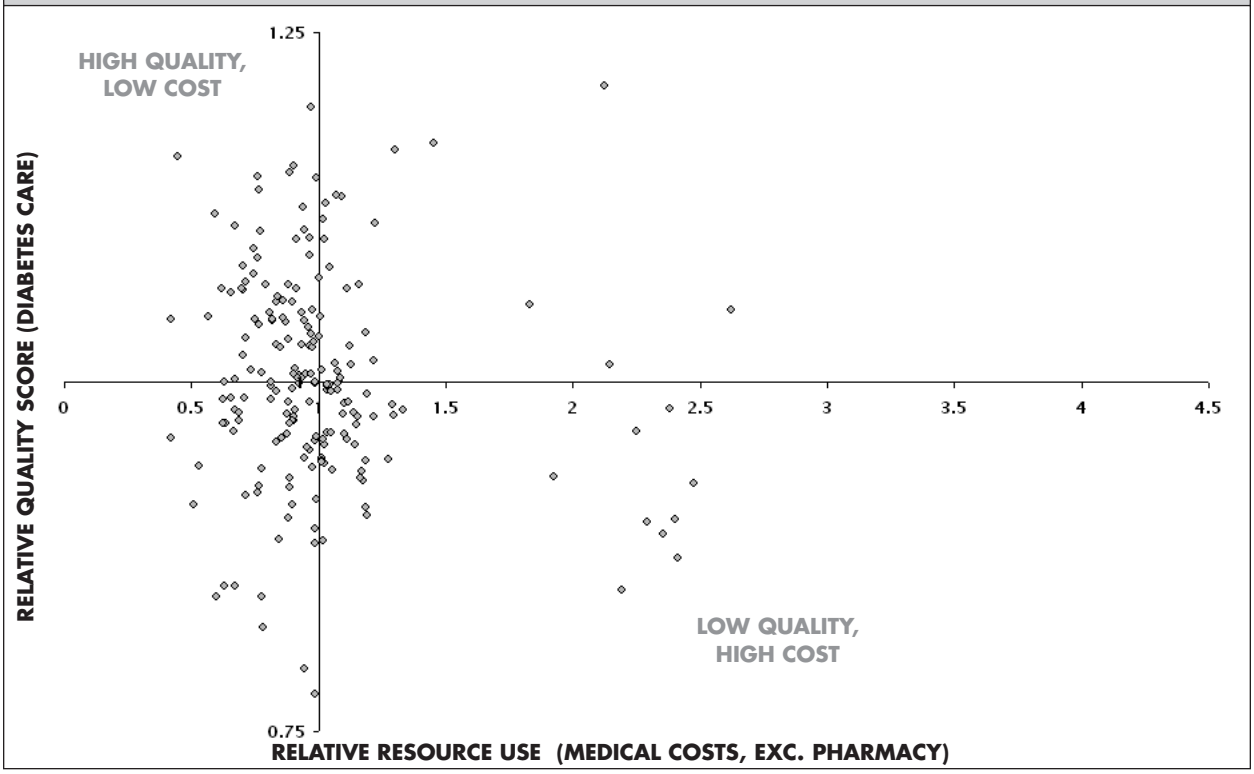
Because this is the first year that plans have reported RRUs to NCQA, we believe it is important to be careful about drawing any definitive conclusions. But some observations can be useful.

For diabetes, the data suggest that little to no meaningful relationship exists between the quality of care a plan delivers to diabetics and the resources it uses to deliver that care. In other words, some plans deliver high-quality care and use relatively few resources while other plans deliver low-quality care and use more resources than average.

These data point to inefficiency in the health care system. They demonstrate that getting the *most* care does not necessarily equate to getting the *best* care. By finding common factors among those plans that deliver high-quality care at low cost, it may be possible to reduce resource use without sacrificing quality--and provide better access and to those families who are currently priced out of the health insurance market.

RELATIVE RESOURCE USE (MEDICAL COSTS, EXC. PHARMACY) VS. RELATIVE QUALITY: DIABETES

COMMERCIAL PLANS, 2006 – VERTICAL SCALE EXPANDED TO ENHANCE DETAIL



RELATIVE RESOURCE USE: DIABETES

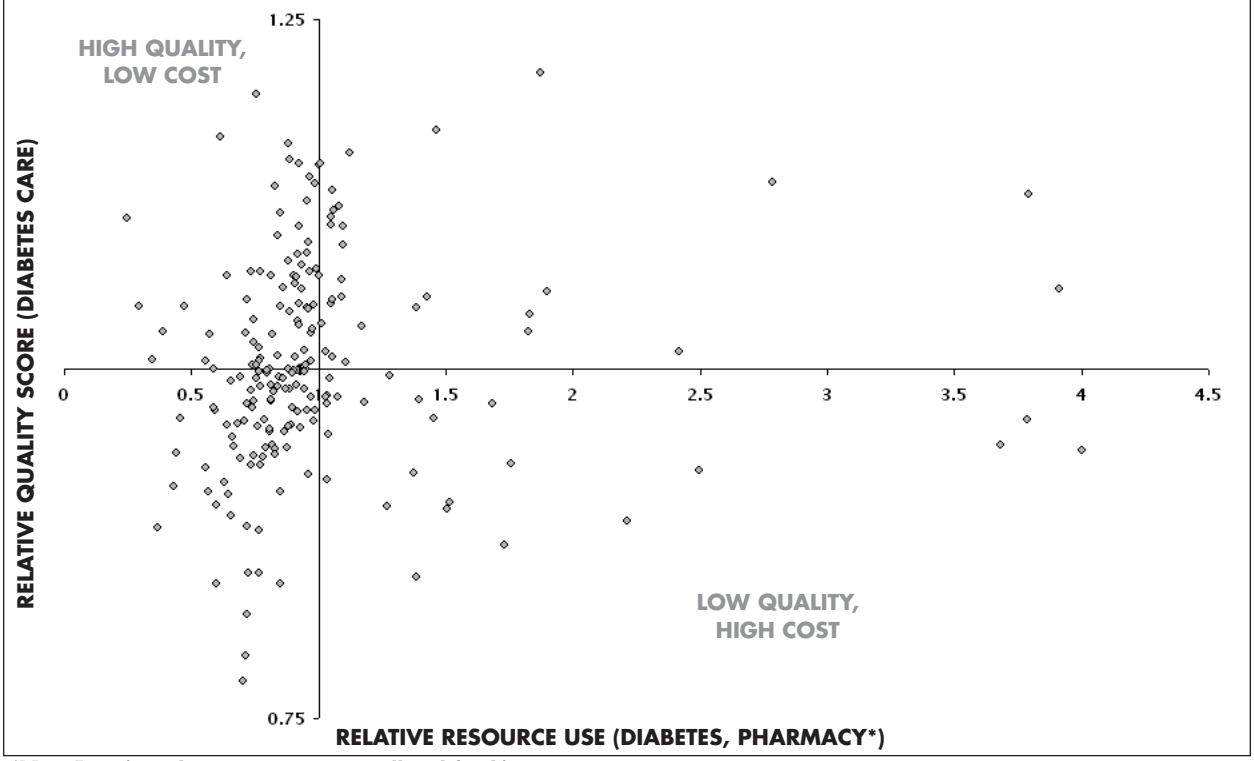
EIGHTFOLD VARIATION IN PHARMACY SPENDING OBSERVED

While cost and quality were found to be independent of one another across all four service categories, variation in ambulatory pharmacy spending was observed to be widest. The plans with the greatest resource use spent roughly eight times more than those with the lowest. Yet this vast disparity in resource use did not correlate to better care.

The variation in resource use among plans shown here provides a stark reminder that getting the right care at the right time has more to do with assuring positive health outcomes than the volume of care delivered.

RELATIVE RESOURCE USE (PHARMACY*) VS. RELATIVE QUALITY: DIABETES, 2006

COMMERCIAL PLANS, 2006 – VERTICAL SCALE EXPANDED TO ENHANCE READABILITY



**Note: Inpatient pharmacy costs are not collected for this measure.*

RELATIVE RESOURCE USE: DIABETES

NEXT STEPS: WHAT WE CAN LEARN

The challenge before decisionmakers is to identify the factors prevalent among plans that deliver high-quality care while using relatively few resources and help other plans use those lessons to move toward that ideal. In time, such data could factor into employers' plan contracting decisions and, ultimately, into consumers' choice of plans. Key questions to consider include:

- Why do some plans deliver high-quality care while keeping relative resource use low, while others spend far more resources and perform at a lower level?
- What about plans that spend relatively more resources, yet deliver high-quality care?
- How much of this spending is going towards care that provides little, if any, benefit?
- What impact do geographic variations in care have on relative resource use?
- How can quality impact spending on different types of care? For example, does increased spending on pharmaceuticals and doctors' visits reduce spending on inpatient care?

Access to care is a prerequisite of health care quality. Without reliable access, checkups and well-care visits are skipped, chronic conditions go unmanaged, and necessary medications go unprescribed or unfilled.

In August, the Census Bureau that reported 47 million Americans are uninsured, a rise of 2 million from 2006. In September, the Kaiser Family Foundation reported that the rate of growth in health insurance premiums has slowed but still continues to outstrip increases in worker's earnings and overall inflation. Health care premiums have risen 98 percent since 2000, eating away at family income and corporate earnings, blunting the competitive edge of American businesses in the global economy, and shutting out an increasing number of people from the health insurance market.

We must all demand from our health care system the right care at the right time: no more, no less. It is our hope that the public reporting of these measures will spur more judicious use of our precious health care dollars. We owe nothing less to the 47 million Americans who live without health coverage today, to say nothing of one another.

APPENDIX 1: HEDIS EFFECTIVENESS OF CARE MEASURES: 2006 NATIONAL AVERAGES

HEDIS EFFECTIVENESS OF CARE MEASURES
NATIONAL AVERAGES - 2006

MEASURE	COMMERCIAL	MEDICARE	MEDICAID
Adolescent Immunization Status - Hepatitis B	74.6	N/A	71.1
Adolescent Immunization Status - MMR	78.8	N/A	75.4
Adolescent Immunization Status - VZV	63.1	N/A	57.4
Adolescent Immunization Status - Combo 2	57.7	N/A	51.2
Ann. Monitoring for Persistent Med. - ACE inhibitors/ARBs	74.8	79.5	79.9
Ann. Monitoring for Persistent Med. - Digoxin	77.3	81.7	83.0
Ann. Monitoring for Persistent Med. - Diuretics	74.4	79.1	79.1
Ann. Monitoring for Persistent Med. - Anticonvulsants	59.4	59.3	63.6
Ann. Monitoring for Persistent Med. - Combined	74.3	76.4	77.7
Antidepressant Medication Management - Contacts	20.0	11.4	21.3
Antidepressant Medication Management - Acute Phase	61.1	58.2	42.9
Antidepressant Medication Management - Continuation Phase	45.1	41.0	27.5
Appropriate Testing for Children with Pharyngitis	72.7	N/A	56.0
Appropriate Treatment for Children with a URI	82.8	N/A	83.4
Beta-Blocker Treatment After a Heart Attack	97.7	93.7	88.4
Beta-Blocker Persistence After a Heart Attack	72.5	69.6	68.1
Breast Cancer Screening	68.9	69.5	49.1
Cervical Cancer Screening	81.0	N/A	65.7
Childhood Immunization Status - Combo 2	79.8	N/A	73.4
Childhood Immunization Status - Combo 3	65.6	N/A	60.9
Childhood Immunization Status - DTaP/DT	87.2	N/A	79.3
Childhood Immunization Status - IPV/OPV	91.5	N/A	87.9
Childhood Immunization Status - MMR	93.6	N/A	91.1
Childhood Immunization Status - Hib	93.5	N/A	89.1
Childhood Immunization Status - Hepatitis B	91.1	N/A	88.4
Childhood Immunization Status - VZV	90.9	N/A	88.9
Childhood Immunization Status - Pneumococcal conjugate	72.6	N/A	68.3
Chlamydia Screening - 16-20 Years	36.2	N/A	38.0
Chlamydia Screening - 21-25 Years	38.0	N/A	55.0
Cholesterol Manage. for Cardiovascular Cond. - Screening	87.5	88.0	75.5
Cholesterol Manage. for Cardiovascular Cond. - Control	56.6	56.0	35.5
Colorectal Cancer Screening	54.5	53.3	N/A
Comprehensive Diabetes Care - HbA1c Testing	87.5	87.2	78.0
Comprehensive Diabetes Care - Poor HbA1c Control*	29.6	27.3	48.7

** Lower rates are better for this measure.*

APPENDIX 1: HEDIS EFFECTIVENESS OF CARE MEASURES: 2006 NATIONAL AVERAGES

HEDIS EFFECTIVENESS OF CARE MEASURES
NATIONAL AVERAGES - 2006

MEASURE	COMMERCIAL	MEDICARE	MEDICAID
Comprehensive Diabetes Care - Good HbA1c Control	41.8	45.9	30.2
Comprehensive Diabetes Care - Eye Exams	54.7	62.3	51.4
Comprehensive Diabetes Care - LDL-C Screening	83.4	84.8	71.1
Comprehensive Diabetes Care - LDL-C Control (<100	43.0	46.9	30.6
Comprehensive Diabetes Care - Monitoring Nephropathy	79.7	85.4	74.6
Comprehensive Diabetes Care - Blood Pressure (<130/80)	29.9	30.2	30.4
Comprehensive Diabetes Care - Blood Pressure (<140/90)	61.4	57.8	57.3
Controlling High Blood Pressure	59.7	56.8	53.1
DMARD Therapy in Rheumatoid Arthritis	84.8	68.2	67.6
Flu Shots for Adults	45.6	N/A	N/A
Follow-up After Hospitalization for Mental Illness - 7 Days	56.7	36.5	39.1
Follow-up After Hospitalization for Mental Illness - 30 Days	75.8	55.8	57.7
Follow-up for Children w/ADHD Medication - Initiation	33.0	N/A	31.8
Glaucoma Screening for Older Adults	N/A	62.2	N/A
Imaging Studies for Low Back Pain	73.9	N/A	78.3
Inappropriate Treatment for Adults with Acute Bronchitis	71.3	N/A	72.0
Init./Engage. Alcohol/Drug Dep. Treatment - Initiation	43.2	50.3	43.3
Init./Engage. Alcohol/Drug Dep. Treatment - Engagement	13.8	4.5	11.7
Medical Assistance w/ Smoking Cessation - Advising to Quit	73.8	N/A	68.2
Medical Assistance w/ Smoking Cessation - Discuss Meds	43.9	N/A	35.1
Medical Assistance w/ Smoking Cessation - Discuss Strategy	43.2	N/A	36.7
Osteoporosis Management in Women Who Had a Fracture	N/A	21.8	N/A
Potentially Harmful Drug-Disease Interactions in Elderly* Falls + Tricyclic Antidepressant, antipsychotics or sleep agents	N/A	14.6	N/A
Potentially Harmful Drug-Disease Interactions in Elderly* Dementia + Tricyclic Antidepressant, antipsychotics or sleep agents	N/A	24.6	N/A
Potentially Harmful Drug-Disease Interactions in Elderly* Chronic renal failure + NSAIDS	N/A	9.5	N/A
Potentially Harmful Drug-Disease Interactions in Elderly - Total*	N/A	19.4	N/A
Prenatal and Postpartum Care - Timeliness of Prenatal Care	90.6	N/A	81.2
Prenatal and Postpartum Care - Postpartum Care	79.9	N/A	59.1
Use of Appropriate Medications for Asthma - 5-9 Years	96.4	N/A	89.6
Use of Appropriate Medications for Asthma -10-17 Years	92.9	N/A	87.0
Use of Appropriate Medications for Asthma - 18-56 Years	90.3	N/A	84.7
Use of Appropriate Medications for Asthma - Combined	91.6	N/A	87.1
Use of High Risk Medications in the Elderly - One Drug*	N/A	23.1	N/A
Use of High Risk Medications in the Elderly - 2 or More Drugs*	N/A	5.9	N/A
Use of Spirometry in Assessment and Diagnosis of COPD	36.1	26.2	27.3

** Lower rates are better for this measure.*

APPENDIX 2: HEDIS EFFECTIVENESS OF CARE MEASURES:LIFE-OF-MEASURE TRENDS

ADOLESCENT IMMUNIZATION STATUS
HEPATITIS B VACCINATION: TRENDS, 1997 - 2006

YEAR	COMMERCIAL	MEDICAID
2006	**74.6**	**71.1**
2005	71.8	63.6
2004	66.8	61.1
2003	62.7	56.3
2002	54.6	46.8
2001	48.3	40.8
2000	41.1	33.0
1999	34.4	N/A
1998	25.5	N/A
1997	17.8	N/A

ADOLESCENT IMMUNIZATION STATUS
MMR VACCINATION: TRENDS, 1997 - 2006

YEAR	COMMERCIAL	MEDICAID
2006	**78.8**	**75.4**
2005	78.5	70.7
2004	76.8	71.5
2003	73.9	71.2
2002	67.9	64.2
2001	65.4	61.2
2000	62.3	54.2
1999	58.8	N/A
1998	52.3	N/A
1997	50.9	N/A

ADOLESCENT IMMUNIZATION STATUS
VZV (CHICKEN POX): TRENDS, 1997 - 2006

YEAR	COMMERCIAL	MEDICAID
2006	**63.1**	**57.4**
2005	60.2	48.3
2004	55.8	46.3
2003	50.9	44.1
2002	40.5	33.2
2001	34.1	27.8
2000	28.5	21.6
1999	24.1	N/A
1998	18.6	N/A
1997	16.9	N/A

CHILDHOOD IMMUNIZATION STATUS
DTP/DTaP VACCINATION: TRENDS, 1996 - 2006

YEAR	COMMERCIAL	MEDICAID
2006	**87.2**	**79.3**
2005	86.1	76.8
2004	85.9	75.6
2003	84.3	72.6
2002	80.1	69.4
2001	81.5	71.2
2000	80.4	70.1
1999	78.7	N/A
1998	75.6	N/A
1997	76.7	N/A
1996	76.8	N/A

APPENDIX 2: HEDIS EFFECTIVENESS OF CARE MEASURES:LIFE-OF-MEASURE TRENDS

CHILDHOOD IMMUNIZATION STATUS
HEPATITIS B VACCINATION: TRENDS, 1996 - 2006

YEAR	COMMERCIAL	MEDICAID
2006	**91.1**	**88.4**
2005	90.0	85.2
2004	87.2	81.9
2003	85.8	79.5
2002	81.9	76.7
2001	79.9	75.4
2000	77.9	73.3
1999	75.5	N/A
1998	71.9	N/A
1997	77.7	N/A
1996	78.2	N/A

CHILDHOOD IMMUNIZATION STATUS
HiB VACCINATION: TRENDS, 1996 - 2006

YEAR	COMMERCIAL	MEDICAID
2006	**93.5**	**89.1**
2005	92.9	86.7
2004	87.8	79.1
2003	86.1	77.7
2002	83.2	74.7
2001	83.4	74.9
2000	82.7	74.8
1999	80.7	N/A
1998	78.0	N/A
1997	78.9	N/A
1996	83.2	N/A

CHILDHOOD IMMUNIZATION STATUS
IPV/OPV VACCINATION: TRENDS, 1996 - 2006

YEAR	COMMERCIAL	MEDICAID
2006	**91.5**	**87.9**
2005	90.3	84.5
2004	90.1	84.8
2003	88.7	83.1
2002	86.0	80.6
2001	85.4	79.1
2000	84.2	77.8
1999	82.6	N/A
1998	81.3	N/A
1997	82.6	N/A
1996	82.8	N/A

CHILDHOOD IMMUNIZATION STATUS
MMR VACCINATION: TRENDS, 1996 - 2006

YEAR	COMMERCIAL	MEDICAID
2006	**93.6**	**91.1**
2005	93.0	89.5
2004	92.3	88.1
2003	91.5	87.4
2002	90.1	84.6
2001	89.4	83.7
2000	88.4	82.1
1999	87.0	N/A
1998	85.6	N/A
1997	86.4	N/A
1996	86.5	N/A

APPENDIX 2: HEDIS EFFECTIVENESS OF CARE MEASURES:LIFE-OF-MEASURE TRENDS

CHILDHOOD IMMUNIZATION STATUS
VZV (CHICKEN POX) VACCINATION: TRENDS, 1997 - 2006

YEAR	COMMERCIAL	MEDICAID
2006	**90.9**	**88.9**
2005	89.9	86.4
2004	87.5	84.7
2003	85.7	81.8
2002	82.0	76.5
2001	75.3	73.6
2000	70.5	67.4
1999	63.8	N/A
1998	51.6	N/A
1997	39.5	N/A

MONITORING FOR PATIENTS ON PERSISTENT MEDICATIONS
DIURETICS: TRENDS, 2006

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2006	**74.4**	**79.1**	**79.1**

THIS IS A FIRST-YEAR MEASURE.

MONITORING FOR PATIENTS ON PERSISTENT MEDICATIONS
ACE INHIBITORS/ARBS: TRENDS, 2006

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2006	**74.8**	**79.5**	**79.9**

THIS IS A FIRST-YEAR MEASURE.

MONITORING FOR PATIENTS ON PERSISTENT MEDICATIONS
DIGOXIN: TRENDS, 2006

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2006	**77.3**	**81.7**	**83.0**

THIS IS A FIRST-YEAR MEASURE.

MONITORING FOR PATIENTS ON PERSISTENT MEDICATIONS
ANTICONVULSANTS: TRENDS, 2006

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2006	**59.4**	**59.3**	**63.6**

THIS IS A FIRST-YEAR MEASURE.

APPENDIX 3: CAHPS MEMBER SATISFACTION MEASURES: NATIONAL AVERAGES

CAHPS MEMBER SATISFACTION MEASURES
NATIONAL AVERAGES - 2006

MEASURE	COMMERCIAL	MEDICARE	MEDICAID
Rating of Health Plan (8,9 or 10)	63.0	N/A	70.1
Rating of Health Plan (9 or 10)	38.0	N/A	52.5
Claims Processing	86.0	N/A	N/A
Customer Service	N/A	N/A	N/A
Getting Care Quickly ("Usually" or "Always")	83.1	N/A	78.7
Getting Care Quickly ("Always" only)	56.8	N/A	53.4
Getting Needed Care	84.2	N/A	74.2
How Well Doctors Communicate ("Usually" or "Always")	92.8	N/A	86.3
How Well Doctors Communicate ("Always" only)	70.3	N/A	66.7
Rating of Health Care (8,9 or 10)	73.6	N/A	65.6
Rating of Health Care (9 or 10)	47.0	N/A	46.3
Rating of Personal Doctor or Nurse (8,9 or 10)	81.1	N/A	75.6
Rating of Specialist (8,9 or 10)	79.9	N/A	75.2
Rating of Specialist (9 or 10)	60.7	N/A	59.3

APPENDIX 4: HEDIS EFFECTIVENESS OF CARE MEASURES: ACCREDITED VS. NON-ACCREDITED PLANS - COMMERCIAL

HEDIS EFFECTIVENESS OF CARE MEASURES
ACCREDITED VS. NON-ACCREDITED PLANS: COMMERCIAL AVERAGES - 2006

MEASURE	ACCREDITED	UNACCREDITED	DIFFERENCE
Adolescent Immunization Status - Hepatitis B	76.1	69.0	7.1
Adolescent Immunization Status - MMR	79.7	75.5	4.3
Adolescent Immunization Status - VZV	65.6	53.9	11.7
Adolescent Immunization Status - Combo 2	60.2	47.4	12.8
Ann. Monitoring for Persistent Med. - ACE inhibitors/ARBs	74.4	76.5	(2.1)
Ann. Monitoring for Persistent Med. - Digoxin	77.1	78.7	(1.7)
Ann. Monitoring for Persistent Med. - Diuretics	74.0	75.8	(1.8)
Ann. Monitoring for Persistent Med. - Anticonvulsants	59.4	59.5	(0.1)
Ann. Monitoring for Persistent Med. - Combined	73.9	75.8	(1.9)
Antidepressant Medication Management - Contacts	20.5	17.8	2.7
Antidepressant Medication Management - Acute Phase	61.4	59.7	1.8
Antidepressant Medication Management - Continuation Phase	45.4	44.0	.4
Appropriate Testing for Children with Pharyngitis	73.0	71.4	1.6
Appropriate Treatment for Children with a URI	82.6	83.7	(1.1)
Beta-Blocker Treatment After a Heart Attack	98.2	94.4	3.8
Beta-Blocker Persistence After a Heart Attack	72.2	74.8	(2.5)
Breast Cancer Screening	69.3	67.3	2.0
Cervical Cancer Screening	81.8	78.0	3.9
Childhood Immunization Status - Combo 2	80.8	76.3	4.6
Childhood Immunization Status - Combo 3	66.7	62.0	4.73
Childhood Immunization Status - DTaP/DT	87.9	84.7	3.3
Childhood Immunization Status - IPV/OPV	92.1	89.3	2.7
Childhood Immunization Status - MMR	93.9	92.6	1.3
Childhood Immunization Status - Hib	94.0	91.4	2.6
Childhood Immunization Status - Hepatitis B	91.7	88.6	3.1
Childhood Immunization Status - VZV	91.5	88.6	3.0
Chlamydia Screening - 16-20 Years	37.0	33.1	4.0
Chlamydia Screening - 21-25 Years	38.7	35.2	3.5
Cholesterol Manage. for Cardiovascular Cond. - Screening	88.1	85.6	2.5
Cholesterol Manage. for Cardiovascular Cond. - Control	57.6	52.9	4.7
Colorectal Cancer Screening	55.4	51.2	4.2
Comprehensive Diabetes Care - HbA1c Testing	88.1	85.5	2.5
Comprehensive Diabetes Care - Poor HbA1c Control*	29.1	31.4	(2.3)

**Lower rates are better for this measure; the negative difference signifies higher performance among NCQA-Accredited plans for this measure.*

APPENDIX 4: HEDIS EFFECTIVENESS OF CARE MEASURES: ACCREDITED VS. NON-ACCREDITED PLANS - COMMERCIAL

HEDIS EFFECTIVENESS OF CARE MEASURES

ACCREDITED VS. NON-ACCREDITED PLANS: COMMERCIAL AVERAGES - 2006

MEASURE	ACCREDITED	UNACCREDITED	DIFFERENCE
Comprehensive Diabetes Care - Good HbA1c Control	41.9	41.1	0.8
Comprehensive Diabetes Care - Eye Exams	55.6	51.1	4.5
Comprehensive Diabetes Care - LDL-C Screening	84.0	80.9	3.1
Comprehensive Diabetes Care - LDL-C Control (<100)	43.3	41.5	1.9
Comprehensive Diabetes Care - Monitoring Nephropathy	80.1	78.1	2.0
Comprehensive Diabetes Care - Blood Pressure (<130/80)	29.9	30.0	0.1
Comprehensive Diabetes Care - Blood Pressure (<140/90)	61.9	59.5	2.4
Controlling High Blood Pressure	59.7	59.4	0.3
DMARD Therapy in Rheumatoid Arthritis	87.5	86.2	(1.6)
Flu Shots for Adults	45.6	45.5	0.1
Follow-up After Hospitalization for Mental Illness - 7 Days	58.1	49.4	8.8
Follow-up After Hospitalization for Mental Illness - 30 Days	77.0	69.5	7.6
Follow-up for Children w/ADHD Medication - Initiation	33.3	31.3	2.0
Imaging Studies for Low Back Pain	73.9	73.6	0.3
Inappropriate Treatment for Adults with Acute Bronchitis	71.4	70.7	0.7
Init./Engage. Alcohol/Drug Dep. Treatment - Initiation	43.4	42.2	1.2
Init./Engage. Alcohol/Drug Dep. Treatment - Engagement	14.1	12.7	1.3
Medical Assistance w/ Smoking Cessation - Advising to Quit	74.2	72.3	1.9
Medical Assistance w/ Smoking Cessation - Discuss Meds	44.2	42.9	1.28
Medical Assistance w/ Smoking Cessation - Discuss Strategy	43.2	43.4	(0.2)
Prenatal and Postpartum Care - Timeliness of Prenatal Care	92.2	83.5	8.7
Prenatal and Postpartum Care - Postpartum Care	81.8	71.6	10.2
Use of Appropriate Medications for Asthma - 5-9 Years	96.5	95.9	0.5
Use of Appropriate Medications for Asthma -10-17 Years	92.9	92.7	0.2
Use of Appropriate Medications for Asthma - 18-56 Years	90.3	90.4	0.1
Use of Appropriate Medications for Asthma - Combined	91.6	91.8	0.3
Use of Spirometry in Assessment and Diagnosis of COPD	36.6	33.8	2.7

APPENDIX 5: HEDIS EFFECTIVENESS OF CARE MEASURES: ACCREDITED VS. NON-ACCREDITED PLANS - MEDICAID

HEDIS EFFECTIVENESS OF CARE MEASURES

ACCREDITED VS. NON-ACCREDITED PLANS: MEDICAID AVERAGES - 2006

MEASURE	ACCREDITED	UNACCREDITED	DIFFERENCE
Adolescent Immunization Status - Hepatitis B	76.9	65.9	11.0
Adolescent Immunization Status - MMR	79.3	71.8	7.5
Adolescent Immunization Status - VZV	63.6	51.5	12.1
Adolescent Immunization Status - Combo 2	57.7	45.0	12.6
Ann. Monitoring for Persistent Med. - ACE inhibitors/ARBs	81.4	78.1	3.3
Ann. Monitoring for Persistent Med. - Digoxin	83.4	82.4	1.1
Ann. Monitoring for Persistent Med. - Diuretics	80.7	77.1	3.6
Ann. Monitoring for Persistent Med. - Anticonvulsants	65.3	60.8	4.5
Ann. Monitoring for Persistent Med. - Combined	79.1	76.1	3.0
Antidepressant Medication Management - Contacts	20.5	22.1	(1.5)
Antidepressant Medication Management - Acute Phase	42.3	43.6	(1.3)
Antidepressant Medication Management - Continuation Phase	27.7	27.2	0.5
Appropriate Testing for Children with Pharyngitis	55.4	57.0	(1.7)
Appropriate Treatment for Children with a URI	82.4	84.3	(2.0)
Beta-Blocker Treatment After a Heart Attack	91.9	82.7	9.2
Beta-Blocker Persistence After a Heart Attack	68.3	67.5	0.8
Breast Cancer Screening	49.4	48.8	0.6
Cervical Cancer Screening	68.6	63.5	5.1
Childhood Immunization Status - Combo 2	77.2	71.1	6.1
Childhood Immunization Status - Combo 3	63.4	59.2	4.2
Childhood Immunization Status - DTaP/DT	82.4	77.5	4.9
Childhood Immunization Status - IPV/OPV	90.5	86.4	4.1
Childhood Immunization Status - MMR	92.5	90.2	2.3
Childhood Immunization Status - Hib	91.1	87.8	3.3
Childhood Immunization Status - Hepatitis B	91.4	86.6	4.9
Childhood Immunization Status - VZV	91.0	87.4	3.5
Chlamydia Screening - 16-20 Years	51.2	49.7	1.6
Chlamydia Screening - 21-25 Years	55.0	54.6	0.4
Cholesterol Manage. for Cardiovascular Cond. - Screening	77.7	72.3	5.4
Cholesterol Manage. for Cardiovascular Cond. - Control	37.4	32.4	5.0
Comprehensive Diabetes Care - HbA1c Testing	79.7	76.7	3.0
Comprehensive Diabetes Care - Poor HbA1c Control*	45.3	51.3	(6.0)
Comprehensive Diabetes Care - Good HbA1c Control	32.7	28.2	4.5
Comprehensive Diabetes Care - Eye Exams	55.8	48.2	7.6

** Lower rates are better for this measure; the negative difference signifies higher performance among NCQA-Accredited plans for this measure.*

APPENDIX 5: HEDIS EFFECTIVENESS OF CARE MEASURES: ACCREDITED VS. NON-ACCREDITED PLANS - MEDICAID

HEDIS EFFECTIVENESS OF CARE MEASURES

ACCREDITED VS. NON-ACCREDITED PLANS: MEDICAID AVERAGES - 2006

MEASURE	ACCREDITED	UNACCREDITED	DIFFERENCE
Comprehensive Diabetes Care - LDL-C Screening	73.9	69.2	4.7
Comprehensive Diabetes Care - LDL-C Control (<100)	33.0	28.8	4.3
Comprehensive Diabetes Care - Monitoring Nephropathy	77.6	72.4	5.2
Comprehensive Diabetes Care - Blood Pressure (<130/80)	31.1	29.7	1.4
Comprehensive Diabetes Care - Blood Pressure (<140/90)	59.6	55.4	4.3
Controlling High Blood Pressure	54.1	51.4	2.7
DMARD Therapy in Rheumatoid Arthritis	66.7	69.2	(2.5)
Follow-up After Hospitalization for Mental Illness - 7 Days	45.9	35.3	10.6
Follow-up After Hospitalization for Mental Illness - 30 Days	63.1	55.5	7.6
Follow-up for Children w/ADHD Medication - Initiation	30.4	33.9	(3.6)
Imaging Studies for Low Back Pain	40.7	43.4	(2.6)
Inappropriate Treatment for Adults with Acute Bronchitis	72.9	70.8	2.2
Init./Engage. Alcohol/Drug Dep. Treatment - Initiation	43.9	42.4	1.5
Init./Engage. Alcohol/Drug Dep. Treatment - Engagement	15.0	10.3	4.7
Medical Assistance w/ Smoking Cessation - Advising to Quit	68.1	68.4	(0.3)
Medical Assistance w/ Smoking Cessation - Discuss Meds	35.8	34.5	1.3
Medical Assistance w/ Smoking Cessation - Discuss Strategy	37.0	36.4	0.5
Prenatal and Postpartum Care - Timeliness of Prenatal Care	83.5	79.8	3.8
Prenatal and Postpartum Care - Postpartum Care	60.5	58.2	2.3
Use of Appropriate Medications for Asthma - 5-9 Years	91.0	88.5	2.4
Use of Appropriate Medications for Asthma -10-17 Years	88.1	86.2	1.9
Use of Appropriate Medications for Asthma - 18-56 Years	85.7	84.0	1.7
Use of Appropriate Medications for Asthma - Combined	87.8	86.7	1.1
Use of Spirometry in Assessment and Diagnosis of COPD	29.6	23.1	6.5

APPENDIX 6: HEDIS EFFECTIVENESS OF CARE MEASURES: ACCREDITED VS. NON-ACCREDITED PLANS - MEDICARE

HEDIS EFFECTIVENESS OF CARE MEASURES

ACCREDITED VS. NON-ACCREDITED PLANS: MEDICARE AVERAGES - 2006

MEASURE	ACCREDITED	UNACCREDITED	DIFFERENCE
Ann. Monitoring for Persistent Med. - ACE inhibitors/ARBs	84.9	82.0	2.9
Ann. Monitoring for Persistent Med. - Digoxin	87.7	85.8	1.9
Ann. Monitoring for Persistent Med. - Diuretics	85.1	82.4	2.7
Ann. Monitoring for Persistent Med. - Anticonvulsants	68.0	61.4	6.6
Ann. Monitoring for Persistent Med. - Combined	84.8	80.9	3.9
Antidepressant Medication Management - Contacts	11.7	11.1	0.5
Antidepressant Medication Management - Acute Phase	60.2	56.6	3.6
Antidepressant Medication Management - Continuation Phase	46.4	44.0	2.4
Beta-Blocker Treatment After a Heart Attack	97.4	91.0	6.4
Beta-Blocker Persistence After a Heart Attack	73.2	66.1	7.1
Breast Cancer Screening	74.4	66.1	8.2
Cholesterol Manage. for Cardiovascular Cond. - Screening	90.4	86.3	4.0
Cholesterol Manage. for Cardiovascular Cond. - Control	60.8	52.4	8.4
Colorectal Cancer Screening	60.5	48.4	12.1
Comprehensive Diabetes Care - HbA1c Testing	91.2	85.2	6.0
Comprehensive Diabetes Care - Poor HbA1c Control*	18.7	31.8	(13.0)
Comprehensive Diabetes Care - Good HbA1c Control	51.8	42.8	9.0
Comprehensive Diabetes Care - Eye Exams	71.4	57.7	13.7
Comprehensive Diabetes Care - LDL-C Screening	89.2	82.7	6.5
Comprehensive Diabetes Care - LDL-C Control (<100)	53.2	43.7	9.4
Comprehensive Diabetes Care - Monitoring Nephropathy	87.3	84.4	2.9
Comprehensive Diabetes Care - Blood Pressure (<130/80)	31.5	29.5	1.9
Comprehensive Diabetes Care - Blood Pressure (<140/90)	60.1	56.5	3.6
Controlling High Blood Pressure	59.9	55.2	4.7
DMARD Therapy in Rheumatoid Arthritis	74.0	64.2	9.7
Flu Shots for Adults	N/A	N/A	N/A
Follow-up After Hospitalization for Mental Illness - 7 Days	44.7	30.2	14.5
Follow-up After Hospitalization for Mental Illness - 30 Days	64.1	49.3	14.8
Glaucoma Screening in Older Adults	66.0	59.8	6.2
Init./Engage. Alcohol/Drug Dep. Treatment - Initiation	50.3	50.2	0.1
Init./Engage. Alcohol/Drug Dep. Treatment - Engagement	5.1	4.2	0.8
Medical Assistance w/ Smoking Cessation - Advising to Quit	N/A	N/A	N/A

** Lower rates are better for this measure; the negative difference signifies higher performance among NCQA-Accredited plans for this measure.*

APPENDIX 6: HEDIS EFFECTIVENESS OF CARE MEASURES: ACCREDITED VS. NON-ACCREDITED PLANS - MEDICARE

HEDIS EFFECTIVENESS OF CARE MEASURES

ACCREDITED VS. NON-ACCREDITED PLANS: MEDICARE AVERAGES - 2006

MEASURE	ACCREDITED	UNACCREDITED	DIFFERENCE
Osteoporosis Management in Women Who Had a Fracture	24.3	19.8	4.5
Potentially Harmful Drug-Disease Interactions in Elderly* Falls + Tricyclic Antidepressant, antipsychotics or sleep agents	14.5	14.8	(0.4)
Potentially Harmful Drug-Disease Interactions in Elderly* Dementia + Tricyclic Antidepressant, antipsychotics or sleep agents	23.7	25.3	(1.6)
Potentially Harmful Drug-Disease Interactions in Elderly* Chronic renal failure + NSAIDS	7.8	10.9	(3.1)
Potentially Harmful Drug-Disease Interactions in Elderly-Combo*	18.5	20.2	(1.8)
Use of High Risk Medications in the Elderly - One Drug*	21.4	24.0	(2.6)
Use of High Risk Medications in the Elderly - 2 or More Drugs*	5.0	6.4	(2.6)
Use of Spirometry in Assessment and Diagnosis of COPD	27.7	25.0	2.7

** Lower rates are better for this measure; the negative difference signifies higher performance among NCQA-Accredited plans for this measure.*

APPENDIX 6: HEDIS EFFECTIVENESS OF CARE MEASURES: PUBLICLY REPORTING VS. NON-PUBLICLY REPORTING PLANS - COMMERCIAL

HEDIS EFFECTIVENESS OF CARE MEASURES

PUBLICLY REPORTING VS. NON-PUBLICLY REPORTING PLANS: COMMERCIAL AVERAGES - 2006

MEASURE	PUBLIC	NON-PUBLIC	DIFFERENCE
Adolescent Immunization Status - Hepatitis B	75.7	62.9	12.8
Adolescent Immunization Status - MMR	79.7	70.0	9.7
Adolescent Immunization Status - VZV	64.5	49.1	15.4
Adolescent Immunization Status - Combo 2	58.9	42.9	16.0
Ann. Monitoring for Persistent Med. - ACE inhibitors/ARBs	74.8	74.4	0.5
Ann. Monitoring for Persistent Med. - Digoxin	77.1	81.6	(4.5)
Ann. Monitoring for Persistent Med. - Diuretics	74.4	74.4	0.0
Ann. Monitoring for Persistent Med. - Anticonvulsants	59.9	53.6	6.3
Ann. Monitoring for Persistent Med. - Combined	74.3	74.1	0.2
Antidepressant Medication Management - Contacts	20.0	19.6	0.4
Antidepressant Medication Management - Acute Phase	61.3	58.5	2.8
Antidepressant Medication Management - Continuation Phase	45.4	41.5	3.9
Appropriate Testing for Children with Pharyngitis	73.0	69.7	3.3
Appropriate Treatment for Children with a URI	82.7	84.0	(1.3)
Beta-Blocker Treatment After a Heart Attack	97.9	93.4	4.5
Beta-Blocker Persistence After a Heart Attack	72.5	72.3	0.2
Breast Cancer Screening	69.1	66.9	2.2
Cervical Cancer Screening	81.4	77.6	3.8
Childhood Immunization Status - Combo 2	80.7	71.3	9.4
Childhood Immunization Status - Combo 3	66.5	56.3	10.2
Childhood Immunization Status - DTaP/DT	87.9	80.7	7.2
Childhood Immunization Status - IPV/OPV	92.0	85.7	6.3
Childhood Immunization Status - MMR	93.9	90.8	3.0
Childhood Immunization Status - Hib	93.9	88.9	5.0
Childhood Immunization Status - Hepatitis B	91.8	83.9	7.8
Childhood Immunization Status - VZV	91.3	86.6	4.7
Chlamydia Screening - 16-20 Years	36.4	34.6	4.8
Chlamydia Screening - 21-25 Years	38.1	36.5	1.6
Cholesterol Manage. for Cardiovascular Cond. - Screening	87.7	85.7	2.0
Cholesterol Manage. for Cardiovascular Cond. - Control	57.0	51.8	5.3
Colorectal Cancer Screening	55.2	47.4	7.8
Comprehensive Diabetes Care - HbA1c Testing	87.8	84.9	2.9
Comprehensive Diabetes Care - Poor HbA1c Control*	29.4	31.9	(2.5)

** Lower rates are better for this measure; the negative difference signifies higher performance among publicly-reporting plans for this measure.*

APPENDIX 6: HEDIS EFFECTIVENESS OF CARE MEASURES: PUBLICLY REPORTING VS. NON-PUBLICLY REPORTING PLANS - COMMERCIAL

HEDIS EFFECTIVENESS OF CARE MEASURES

PUBLICLY REPORTING VS. NON-PUBLICLY REPORTING PLANS: COMMERCIAL AVERAGES - 2006

MEASURE	PUBLIC	NON-PUBLIC	DIFFERENCE
Comprehensive Diabetes Care - Good HbA1c Control	42.0	39.5	2.5
Comprehensive Diabetes Care - Eye Exams	55.5	46.0	9.5
Comprehensive Diabetes Care - LDL-C Screening	83.6	81.1	2.5
Comprehensive Diabetes Care - LDL-C Control (<100)	43.4	38.4	5.0
Comprehensive Diabetes Care - Monitoring Nephropathy	79.8	78.3	1.5
Comprehensive Diabetes Care - Blood Pressure (<130/80)	30.1	28.1	2.0
Comprehensive Diabetes Care - Blood Pressure (<140/90)	61.8	57.1	4.7
Controlling High Blood Pressure	59.8	57.1	2.8
DMARD Therapy in Rheumatoid Arthritis	84.9	83.7	1.2
Flu Shots for Adults	46.1	39.6	6.5
Follow-up After Hospitalization for Mental Illness - 7 Days	57.4	47.3	10.1
Follow-up After Hospitalization for Mental Illness - 30 Days	76.5	66.2	10.3
Follow-up for Children w/ADHD Medication - Initiation	33.2	29.9	3.2
Imaging Studies for Low Back Pain	74.1	71.0	3.1
Inappropriate Treatment for Adults with Acute Bronchitis	71.4	69.6	1.8
Init./Engage. Alcohol/Drug Dep. Treatment - Initiation	43.1	45.2	2.1
Init./Engage. Alcohol/Drug Dep. Treatment - Engagement	13.8	14.7	0.9
Medical Assistance w/ Smoking Cessation - Advising to Quit	74.1	70.0	4.1
Medical Assistance w/ Smoking Cessation - Discuss Meds	44.4	37.3	7.2
Medical Assistance w/ Smoking Cessation - Discuss Strategy	43.6	38.5	5.1
Prenatal and Postpartum Care - Timeliness of Prenatal Care	91.5	79.6	11.9
Prenatal and Postpartum Care - Postpartum Care	80.8	69.2	11.5
Use of Appropriate Medications for Asthma - 5-9 Years	96.5	95.6	0.9
Use of Appropriate Medications for Asthma -10-17 Years	92.8	94.0	(1.2)
Use of Appropriate Medications for Asthma - 18-56 Years	90.4	89.4	1.0
Use of Appropriate Medications for Asthma - Combined	91.7	91.2	0.5
Use of Spirometry in Assessment and Diagnosis of COPD	36.3	33.6	2.7

APPENDIX 7: HEDIS EFFECTIVENESS OF CARE MEASURES: PUBLICLY REPORTING VS. NON-PUBLICLY REPORTING PLANS - MEDICAID

HEDIS EFFECTIVENESS OF CARE MEASURES

PUBLICLY REPORTING VS. NON-PUBLICLY REPORTING PLANS: MEDICAID AVERAGES - 2006

MEASURE	PUBLIC	NON-PUBLIC	DIFFERENCE
Adolescent Immunization Status - Hepatitis B	73.3	65.1	8.2
Adolescent Immunization Status - MMR	77.8	68.9	8.9
Adolescent Immunization Status - VZV	60.0	50.2	9.8
Adolescent Immunization Status - Combo 2	53.7	44.2	9.5
Ann. Monitoring for Persistent Med. - ACE inhibitors/ARBs	81.4	75.9	5.5
Ann. Monitoring for Persistent Med. - Digoxin	83.7	80.2	3.6
Ann. Monitoring for Persistent Med. - Diuretics	80.7	74.8	5.9
Ann. Monitoring for Persistent Med. - Anticonvulsants	66.3	54.0	12.3
Ann. Monitoring for Persistent Med. - Combined	79.1	73.9	5.2
Antidepressant Medication Management - Contacts	21.6	20.3	1.3
Antidepressant Medication Management - Acute Phase	43.5	40.8	2.7
Antidepressant Medication Management - Continuation Phase	28.5	24.4	4.1
Appropriate Testing for Children with Pharyngitis	57.1	52.5	4.5
Appropriate Treatment for Children with a URI	83.5	83.1	0.4
Beta-Blocker Treatment After a Heart Attack	90.5	80.1	10.4
Beta-Blocker Persistence After a Heart Attack	69.2	63.6	5.6
Breast Cancer Screening	49.3	48.3	1.0
Cervical Cancer Screening	67.5	61.6	5.9
Childhood Immunization Status - Combo 2	75.2	69.3	5.9
Childhood Immunization Status - Combo 3	63.1	55.9	7.2
Childhood Immunization Status - DTaP/DT	80.9	75.9	5.0
Childhood Immunization Status - IPV/OPV	89.3	84.7	4.6
Childhood Immunization Status - MMR	91.9	89.4	2.5
Childhood Immunization Status - Hib	90.4	86.3	4.1
Childhood Immunization Status - Hepatitis B	90.0	84.7	5.3
Childhood Immunization Status - VZV	89.7	87.0	2.7
Chlamydia Screening - 16-20 Years	51.5	48.4	3.1
Chlamydia Screening - 21-25 Years	55.6	53.6	2.0
Cholesterol Manage. for Cardiovascular Cond. - Screening	76.3	72.0	4.4
Cholesterol Manage. for Cardiovascular Cond. - Control	36.8	29.7	7.2
Comprehensive Diabetes Care - HbA1c Testing	79.5	74.0	5.4
Comprehensive Diabetes Care - Poor HbA1c Control*	46.3	55.1	(8.8)
Comprehensive Diabetes Care - Good HbA1c Control	31.7	26.3	5.4
Comprehensive Diabetes Care - Eye Exams	53.1	46.8	6.3

APPENDIX 7: HEDIS EFFECTIVENESS OF CARE MEASURES: PUBLICLY REPORTING VS. NON-PUBLICLY REPORTING PLANS - MEDICAID

HEDIS EFFECTIVENESS OF CARE MEASURES

PUBLICLY REPORTING VS. NON-PUBLICLY REPORTING PLANS: MEDICAID AVERAGES - 2006

MEASURE	PUBLIC	NON-PUBLIC	DIFFERENCE
Comprehensive Diabetes Care - LDL-C Screening	72.7	67.0	5.7
Comprehensive Diabetes Care - LDL-C Control (<100)	32.1	26.8	5.2
Comprehensive Diabetes Care - Monitoring Nephropathy	75.9	71.1	4.8
Comprehensive Diabetes Care - Blood Pressure (<130/80)	31.3	27.6	3.7
Comprehensive Diabetes Care - Blood Pressure (<140/90)	58.6	53.6	5.0
Controlling High Blood Pressure	54.8	46.2	8.6
DMARD Therapy in Rheumatoid Arthritis	68.3	63.6	4.7
Follow-up After Hospitalization for Mental Illness - 7 Days	42.8	34.0	8.9
Follow-up After Hospitalization for Mental Illness - 30 Days	61.4	52.5	8.9
Follow-up for Children w/ADHD Medication - Initiation	32.8	28.2	4.5
Imaging Studies for Low Back Pain	77.3	81.5	(4.2)
Inappropriate Treatment for Adults with Acute Bronchitis	72.4	70.7	1.6
Init./Engage. Alcohol/Drug Dep. Treatment - Initiation	42.6	44.6	(2.0)
Init./Engage. Alcohol/Drug Dep. Treatment - Engagement	13.4	8.6	4.8
Medical Assistance w/ Smoking Cessation - Advising to Quit	68.1	68.9	(0.7)
Medical Assistance w/ Smoking Cessation - Discuss Meds	34.9	36.0	1.1
Medical Assistance w/ Smoking Cessation - Discuss Strategy	36.3	38.7	(2.4)
Prenatal and Postpartum Care - Timeliness of Prenatal Care	82.1	79.4	2.7
Prenatal and Postpartum Care - Postpartum Care	60.5	56.0	4.4
Use of Appropriate Medications for Asthma - 5-9 Years	91.6	84.4	7.2
Use of Appropriate Medications for Asthma -10-17 Years	88.1	84.0	4.1
Use of Appropriate Medications for Asthma - 18-56 Years	85.2	83.6	1.6
Use of Appropriate Medications for Asthma - Combined	87.9	85.3	2.6
Use of Spirometry in Assessment and Diagnosis of COPD	28.4	22.4	6.0

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ACKNOWLEDGEMENTS

HEALTH PLANS

The *State of Health Care Quality* report is made possible through the willingness of hundreds of commercial, Medicare and Medicaid HMO and point-of-service plans to publicly share their performance data. Nearly three-fourths of the nation's HMO and POS plans—covering almost 90% of all Americans enrolled in such a plan—shared their performance data in this year's report. More than 140 PPO plans have done so as well. All these plans are to be commended for their ongoing commitment to accountability and continuous quality improvement.

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