06
07
08
09
10

NCQA
20 YEARS
Measuring quality.
Improving health care.

The State of Health Care Quality

Reform, The Quality Agenda and Resource Use

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Reform, The Quality Agenda and Resource Use

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PRESIDENT'S MESSAGE

Dear Colleague:

Never in the 14-year history of *The State of Health Care Quality Report* has this annual survey of America's health care system come at a more auspicious time; there is great promise in health care today.

The passage of health care reform was a historic watershed. The nation is engaged in the hard work of implementing the new law and defining in detail what reform will mean. During this time of transition, many Americans are wondering, "What should we do now?"

The quality agenda has made real advances in the past year. All of us who care about quality are pleased that the reform law contains provisions that support quality. Performance reporting, delivery system reform, market mechanisms that reward patient engagement, and wellness are built into reform in thoughtful, innovative ways.

The 2010 *The State of Health Care Quality Report* contains good news for quality, too. There has never been more transparency in the health care system: a record number of health plans reported HEDIS data, exceeding 1,000 for the first time. I am also heartened to see many improvements, including more monitoring of Medicare patients on long-term medications. This is an important facet of care in an aging society in which chronic illness is common.

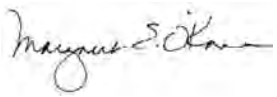
Gaps and challenges persist, though. Almost two-thirds of Americans remain in non-accountable plans, shut out of the quality gains that have helped so many since NCQA was founded 20 years ago. This year's report notes a slight drop in patients' satisfaction with their health plans and their physicians. Childhood vaccination has increased in Medicaid health plans but dropped in commercial plans. This disturbing development indicates parents in commercial plans are rejecting valuable, evidence-based treatment.

As to the question "What should we do now?," reform provides an opportunity to bring quality care to millions of people by encouraging them to enroll in high-performing plans through insurance exchanges. Now is also the time to go beyond just measuring performance to educating the public about how they can use measurement to obtain better care. Consumers cannot compare plans based on cost and quality if information about quality is not delivered to them in accessible, meaningful ways.

Above all, improving quality can help American health care achieve what is known as the Triple Aim: simultaneously improving the experience of care, improving population health, and reducing per-capita costs. HEDIS is a surveillance asset that can inform improvements to the nation's health. Relative Resource Use (RRU), a powerful tool analyzed in this report as never before, can help reduce costs by revealing the value and efficiency that health plans represent.

These are exciting times in health care and there is a lot to do. Thank you for your interest in these important issues.

Sincerely,



Margaret E. O'Kane
President

INTRODUCTION

NCQA produces the *The State of Health Care Quality Report* every year to call attention to the pressing quality issues we face as a nation and to drive improvement in the delivery of evidence-based medicine. This report documents performance trends over time, tracks variation in patterns of care and recommends future quality improvements.

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

We commend all plans that submitted data, 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.

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Thank you for your interest! We welcome your feedback. Please share your thoughts by e-mailing us at **communications@ncqa.org**.

EXECUTIVE SUMMARY

The release of the 14th edition of NCQA's *The State of Health Care Quality Report* comes at a turning point in American health care. Recently enacted health care reform will dramatically reduce the number of uninsured—addressing a major barrier to good care. The Affordable Health Care Act also calls for new initiatives that challenge health plans and providers to focus on quality improvement and value. We expect these initiatives to bear fruit in measurably better quality performance across health plans, physicians and delivery systems.

Successful health care reform will improve quality along the triple aims of population health, patient experience and total cost of care. With respect to total cost of care, purchasers and policymakers recognize that while health care costs will continue to grow, the nation cannot afford for costs to continue growing at their current rate. Reducing outright waste is critical, but it is also important to keep people healthy and develop new, more cost-effective approaches to meeting the burden of chronic illness. Holding health plans accountable through accreditation and performance measurement is an important step toward achieving these goals. In the following pages, we highlight key trends in HEDIS measurement and discuss how aspects of health reform align with NCQA's work.

Findings from 2010 HEDIS Measures

The number of health plans reporting quality improvement data in HEDIS Year 2010 (January 1–December 31, 2009) exceeded 1,000 for the first time, which means there has never been more transparency in health care.

Overall, clinical quality measures are improving, but changes for most measures are modest. However, gains for several measures are to be commended—for example, the improvement in colorectal cancer screening for commercial plans and beta-blocker treatment after a heart attack. There was progress in eye exams for diabetic patients in Medicare plans and improvement in Medicare and Medicaid plans with regard to monitoring patients taking medications long-term (at least six months). This pattern is consistent with that of the last few years: gains in quality appear to be flattening compared with earlier, more rapid gains in some measures. Multiple childhood immunization rates dropped in commercial plans—the first downward trend in what had been a pattern of steady gains. There were slight declines in patient-reported experience of care for health plan services and, for the first time, in specialist physician services. Rates of physicians recommending physical activity to older patients and physicians' attention to falls prevention in that population also declined.

TOP 10 AND BOTTOM 10 STATES	
STATUS	STATES
Top 10, based on mean of rates	CA, IA, MA, MN, ND, NH, OR, SD, VT, WI
Bottom 10, based on mean of rates	AK, AL, AR, DE, LA, MS, NC, OK, SC, TN
Middle range	AZ, CO, CT, DC, FL, GA, HI, ID, IL, IN, KS, KY, MD, ME, MI, MO, MT, NE, NJ, NM, NV, NY, OH, PA, RI, TX, UT, VA, WA, WV, WY

Four measures were used in ranking:
1. Comprehensive Diabetes Care (10 indicators)
2. Controlling High Blood Pressure (1 indicator)
3. Persistence of Beta-Blockers After a Heart Attack
4. Cholesterol Management for Patients With Cardiovascular Conditions (2 indicators).

Past editions of *The State of Health Care Quality Report* analyzed geographic quality differences using regions defined by the U.S. Census Bureau. Those analyses typically found quality highest in New England (CT, ME, MA, NH, RI, VT) and lowest in the South Central states (AL, AR, KY, LA, MI, OK, TN, TX).

This year, NCQA analyzed geographic quality variances by focusing on the top 10 and bottom 10 states, regardless of region. Three states from the Census Bureau's New England region and 3 from the South Central region are among the top 10 and bottom 10 cohorts, respectively. That 70 percent of states in the top 10 and bottom 10 are from other Census Bureau regions confirms that quality varies, even within the same region.

Overuse, waste and appropriateness of care

HEDIS includes clinical measures that address overuse, waste and appropriate care, such as avoiding ineffective use of antibiotic treatment in children with virus-caused sore throats and in adults with acute bronchitis, as well as overuse of imaging studies for acute low back pain. Continued gains in reducing unnecessary antibiotic use in children is encouraging, but offset by the continued trend of overuse in adults with acute viral bronchitis.

Also disappointing is the slow, minimal reduction in the use of imaging studies in acute low back pain—a costly (but profitable) practice shown to be of little or no benefit than can lead to unnecessary surgery. Recent advances in health information technology and clinical decision support tools related to imaging provide hope for improvement in this measure.

As reported in the July 1, 2010 edition of *The New England Journal of Medicine*, computed tomographic (CT) scans bring particular risks:

New Readmission Measure

Potentially preventable hospital readmissions are one of the most critical areas to monitor for quality improvement and possible cost savings. Readmissions resulting mainly from improper planning and poor care coordination are burdensome, costly and potentially dangerous. Starting in commercial and Medicare plans in 2011, the new Plan All-Cause Readmission measure will track hospital readmissions from a post-hospital care perspective. Our goal is to enable health plans, group practices and others to track and compare readmission rates and take steps to reduce unnecessary readmissions.

> Radiation doses from CT scans are 100 to 500 times those from conventional radiography, depending on what part of the body is imaged. [A brain-perfusion scan] delivers a dose 10 times that of a routine brain CT. Although such imaging techniques may have a role in diagnosis, there are few evidence-based guidelines regarding their use, and institutional us varies widely, reflecting physicians' preferences and manufacturers' promotion of these capabilities, rather than scientific evidence of improved clinical outcomes.

Resource use measures have the potential to be especially helpful in reaching the triple aim and in creating a health care system that maximizes value for the health care dollar. Resource use measures compare health plans' use of services—such as medications, outpatient visits, inpatient care, imaging and surgery—for patients with a given condition. Use of these services by all plans is averaged and risk-adjusted to create an "expected" resource use rate. NCQA then calculates an index showing the ratio of each plan's actual reported resource use to the risk-adjusted rate for the average plan. Plans that use more expensive services, such as inpatient hospital care, have higher actual-to-expected ratios than plans that use medications, outpatient care and other methods to manage conditions less expensively and more effectively. Evaluating resource use in tandem with quality measures for the same condition reveals that some plans deliver higher quality more efficiently than others, such as by avoiding hospital admissions and unneeded surgeries.

Wellness and prevention

Controlling weight and quitting smoking can have a profound influence on whether people will develop serious, life-threatening conditions like diabetes and heart disease. Timely screening can detect diseases in their early phase and prevent needless deaths. Yet, despite the well-known benefits of these interventions, findings from 2010 HEDIS measures suggest many opportunities for

improvement. For example, one measure tracks whether people had at least one outpatient visit in which a clinician documented their body mass index (BMI, the critical metric of obesity). We found that less than 42 percent of people had their BMI documented at an outpatient visit in 2009. With regard to quitting smoking, practitioners are more likely only to advise patients to quit instead of discussing treatments or interventions that would help patients act on that advice. About 80 percent of clinicians who see commercial patients and 74 percent of clinicians with Medicaid patients advised smokers to quit, but only about half offered treatment or smoking cessation programs.

The health care reform law requires coverage of preventive services, but coverage alone is not enough. There should be no barriers to screenings that substantially improve health and prevent deaths. Colorectal cancer screening rates have increased over the past few years, with a substantial (but still less than optimal) increase of nearly 2 percentage points in all types of plans except Medicare PPOs. We have to make more progress, as the highest rate for commercial HMOs is just over 60 percent. We also see continued gains in screening for chlamydia, a disease that is often a marker for other sexually transmitted diseases. Medicaid HMOs are to be commended for having the highest screening rates of all plans that collect this measure, reaching over 57 percent of their target population. That said, there is once again opportunity for substantial improvement across all plan types.

Low-income women need more outreach, improved access and better continuity for primary prenatal and postpartum care. For the commercial population, timeliness of prenatal care has improved from a level that was already high, but when comparing commercial rates to Medicaid rates, we see persistent disparities in care, particularly in postpartum care. Policies that allow women to retain Medicaid coverage after they give birth would help improve rates of postpartum care.

Chronic disease management

A sedentary lifestyle and poor diet can often lead to chronic conditions such as diabetes, heart disease and high blood pressure. Even though medications can be important for keeping people with chronic conditions out of the hospital and preventing serious complications, many people stop taking medications that control chronic conditions, even when their health plan covers most of the cost. More research is needed to develop strategies that will encourage people to follow their medication plan. Successful strategies might include ensuring that people understand how important their medication is, addressing medication side effects and using reminder systems.

Several HEDIS measures, such as the measure for controlling high blood pressure, focus on caring for people with chronic conditions and capture how well our health care system helps patients control chronic conditions. Although there has been gradual improvement in this measure across commercial, Medicare and Medicaid populations (and there was dramatic progress in the measure's early years), fewer than two-thirds of the sampled population had blood pressure levels in the desired range.

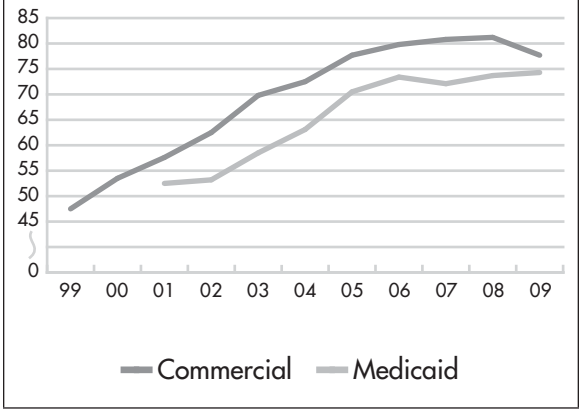
Another set of measures looks at aspects of diabetes care. Patients with well-managed diabetes can gain five or more years of life. That possibility—along with the potential of avoiding such complications as heart disease, blindness, kidney disease and stroke—makes investing in comprehensive diabetes care critically important. As with other measures, we see gradual, steady improvement in measures related to HbA1c testing, LDL-C screening and monitoring nephropathy.

Children

One of the most striking developments in this year's *The State of Health Care Quality Report* is the contrast in performance on childhood vaccinations rates between commercial and Medicaid populations. The vaccination rate declined by almost four percentage points among commercial enrollees while it actually improved by nearly three percentage points among Medicaid plan members. Information obtained by NCQA from medical societies and Federal research agencies indicates that their data show similar shifts.

CHILDHOOD IMMUNIZATION STATUS: COMBINATION 2

Commercial and Medicaid HMO Means



One plausible reason commercial and Medicaid vaccination rates have moved in opposite directions is parents in commercial plans refusing or delaying use of vaccines for their children based on the popular but discredited notion that vaccines cause autism spectrum disorders. Belief in such a link gained wide currency in the news media and on the Internet in recent years. Celebrity activists have been notably outspoken in fostering this opinion.

If this downward trend in vaccination rates in commercial plans persists, an unusual phenomenon may occur. The comparatively well educated or "high-information" members more typical of commercial plans may endanger their children's health—and the public's health—because of their greater access to and overvaluing of misinformation. Medicaid patients may become healthier.

Children on long-term medication plans—for example, children who take medications to treat ADD and ADHD—should receive appropriate monitoring from their physicians. The HEDIS ADHD measure tracks monitoring and follow-up. While initial and continued rates improved, they are still far below optimal. Two measures are related to appropriate use of antibiotics in children: one tracks the rate of antibiotic use in upper respiratory infections (which are caused by a virus and are not effectively treated with antibiotics), and one calls for testing for bacterial infection (strep throat) before prescribing antibiotics. Since antibiotic overuse is a major cause of antibiotic-resistant bacteria, it is a positive sign that both measures have improved steadily in the past few years.

The expansion of coverage to children through the CHIPRA legislation and the development of new quality measures should improve access to needed care while investing in more dimensions of care for children. NCQA supports using the same measures throughout the United States to allow benchmarking of performance over time and across states.

Older adults

As the population ages, it is more important than ever to make sure that older Americans receive high-quality care. The Centers for Medicare & Medicaid Services helped fund development of many of NCQA's measures for older adults. These include wellness and prevention measures such as recommended screenings (e.g., for glaucoma) and regular discussions with physicians about exercise and physical activity. Medication management is also an important aspect of care because many Medicare beneficiaries take multiple medications, putting them at risk for harmful medication interactions. Others are on beneficial medications that require careful monitoring.

Measures in this group also include good fall-prevention care and management of urinary incontinence—medical issues of particular importance to the frailest of the older adult population.

We see several commendable gains in measures for Medicare plans—beta-blocker treatment after a heart attack went up almost 3 percentage points, as did eye exams for diabetics. All of the medication monitoring measures went up—these are very important for tracking patient response to medications such as ACE inhibitors and diuretics.

However, there has been an unfortunate lack of improvement in several measures for the elderly. For example, less than one third of older patients who responded to the Health Outcomes Survey had a conversation about falls with their physician. Of those, less than two-thirds had an intervention, putting them at greater risk for hip fracture and other injuries.

The Medicare Advantage plan star rating system is an important initiative that will create a greater incentive for plans to work with providers to make gains in these measures. It will be especially important for the rating system to focus attention on areas where clinical gains can reduce deaths and suffering and improve quality of life in later years.

Consumer and patient engagement and experience

Consumer experience is a critical dimension of health plan performance. NCQA uses the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey tool to measure consumer and patient experience. Key dimensions of consumer experience are captured in ratings of health plan, health care and getting needed care (including access to specialists, tests and treatments). Measures have been rigorously tested to ensure they provide a valid barometer of consumer experience.

We have seen steady improvement in patient-reported experience of care in our HEDIS CAHPS survey measures. This year saw a small but significant decline in overall consumer satisfaction with health plans and, for the first time, with services provided by specialist physicians. There are some improvements in access and customer service, but patient-experience measures for Medicaid HMOs are all trending downward by about 2 percentage points, depending on plan type.

Medicaid and Medicare ratings have tended to be higher than commercial plan ratings in recent years, but in the last year Medicaid rankings worsened across all elements of patient experience,

including health care in general and physician care. Health plans will need to identify the causes of this ratings decline and implement solutions to improve patient experiences.

We do not know the reason for this downward trend, but it could be a reaction to the health care reform debate, which highlighted peoples' poor experiences with our current health care system and the gaps in quality. Declines may also reflect the population's general unhappiness because of the recession or may be due to more costly premiums and higher cost sharing.

How Health Plans and Performance Measurement Affect Quality

Physicians and other frontline providers are critical to health care quality, but evidence demonstrates that health plans also play a meaningful role. Most recently, a study by Laurence Baker and David Hopkins[1] found that health plans influence quality beyond what physician organizations achieve. The difference is apparent even in California, a state with highly organized physician groups.

As the main organization that accredits health plans and evaluates health care quality, NCQA has consistently raised the bar for health plans. Independent standards and measures drawn from current clinical evidence and consensus are the foundation of our programs. Nearly half of NCQA Accreditation scoring is contingent on measures of clinical outcomes and processes.

Many key quality measures have improved over time—improvements that come from measuring and reporting. Accredited plans consistently perform better than their nonaccredited counterparts. Comparative data on all measures are in Appendices 5, 7 and 9 of this report.

Even though this report focuses on health plan performance, NCQA strongly supports quality initiatives and other steps to improve the delivery of care at the practice level. For example, the NCQA Patient-Centered Medical Home Program focuses on engaging patients and coordinating their care. NCQA Physician Recognition Programs challenge practices to report quality measures and improve the organization and content of their practices with regard to specific conditions. NCQA will soon release elements of an accountable care organization program, which will distinguish provider organizations willing to be responsible for the cost and quality of their patients in a way that builds on primary care.

1. Baker, L., and D. Hopkins. 2010. The Contribution of Health Plans and Provider Organizations to Variations in Measured Plan Quality. *International Journal for Quality in Health Care* Volume 22, Number 3, pp. 210-18.

Reengineering Primary Care

In America's largest city, New York, the Primary Care Information Project (PCIP) has used NCQA's Physician Practice Connections® - Patient-Centered Medical Home™ Recognition program to help safety net practices create 72 medical homes. That number could double soon, as PCIP is energetically using the NCQA medical home model to modernize primary care in underserved areas.

PCIP is also showing that one of the most promising ways to improve the delivery of care is to build decision support into primary care and help practices incorporate technology into their daily routines. Information systems PCIP and installed in small practices across the city have sparked remarkable quality gains. Measures the PCIP system uses closely mirror HEDIS Effectiveness of Care measures, and are based on electronic medical records.

We are impressed and encouraged by what PCIP has accomplished. Results are reprinted with PCIP's permission on p.17.

Countless other initiatives call for new payment policies and experiments in the delivery system. Critical to their success will be the ability to track quality and patient experience, together with their effect on health care spending and providers.

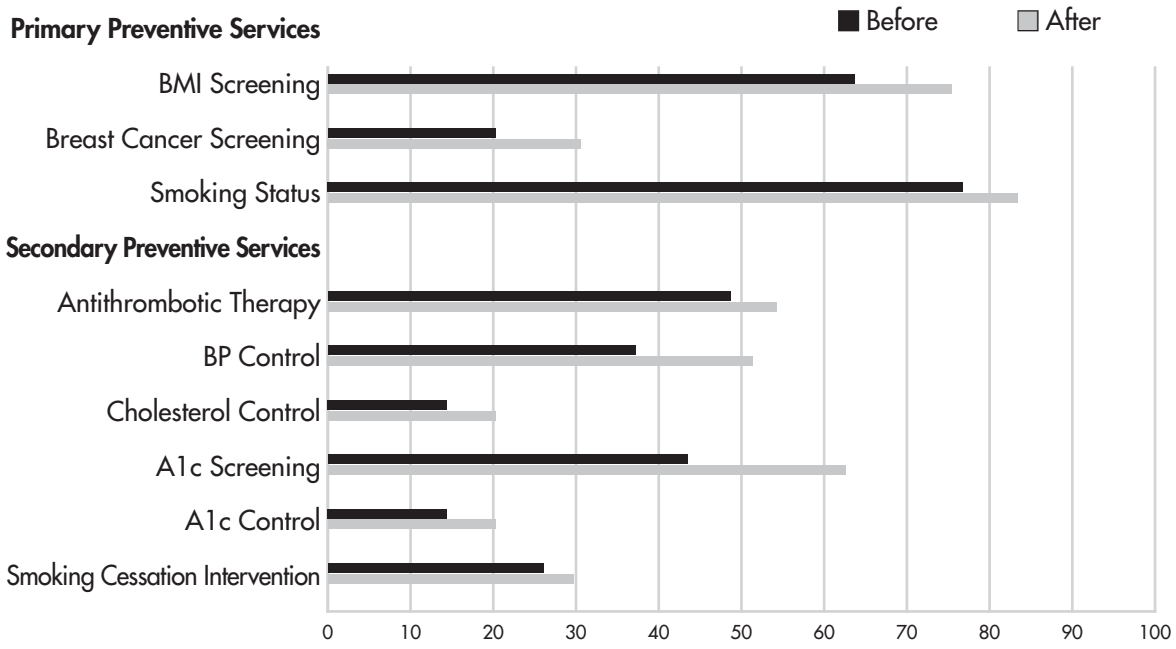
Health Care Reform's Promise of Coverage, Choice and Quality

Health care reform offers initiatives and investments to push the health care system to exceed current performance. It challenges plans to invest in quality and compete for members based on superior care, patient experience and premiums. Specifically:

Reform expands coverage and choice. Starting in 2014, Americans will have more options and support for finding and buying health insurance coverage. Medicaid coverage will expand to include all low-income people. States will develop health insurance exchanges that offer a choice of plans and financial support for purchasing coverage to many people who do not have coverage through their employers or public programs.

Health plans will have to meet high standards to be included in health insurance exchanges. Qualified plans must be accredited with respect to local performance on clinical quality measures such as HEDIS and CAHPS. Plans must also meet standards for consumer access; utilization management; quality assurance; provider credentialing; complaints and appeals; network adequacy and access; and patient information programs. Many of these requirements align with NCQA's current Accreditation Program. NCQA will incorporate new accreditation requirements into our programs as necessary.

PRIMARY CARE PRACTICES IN NEW YORK CITY, BEFORE AND AFTER USE OF PCIP CLINICAL DECISION SUPPORT SYSTEM



Public reporting on quality will help consumers choose among plans. This report provides overall data on health plans' quality of care. Consistent with NCQA's mission to hold health plans accountable, we also support publishing quality information for individual plans. NCQA is a leading developer of report cards that rank and publicly disclose information on plan performance.

NCQA released our most recent rankings of commercial health plans in September 2010; Consumers Union published these rankings online in early October and in the November print edition of Consumer Reports. NCQA will issue rankings of Medicare and Medicaid plans on October 21, and this information will be available on the *Consumer Reports* Web site on November 2.

Qualified health plans in health insurance exchanges will participate in a quality incentive program that calls for plans to improve health outcomes through:

- **Quality reporting, effective case management; care coordination; chronic disease management; and medication and care compliance initiatives, including the medical home model**
  Quality reporting is a hallmark of the NCQA Accreditation Program, and the initiatives listed above track areas where NCQA has standards for health plans.

- **Prevention of hospital readmissions through a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning and post-discharge reinforcement**
  Innovative health plans are already working with hospitals and physicians to reduce readmissions. As discussed earlier, NCQA's new Readmissions measure will be reported for commercial and Medicare plans in 2011.

- **Improvement of patient safety and reduction of medical errors through the appropriate use of best clinical practices, evidence-based medicine and health information technology**
  Health plans can collaborate with hospitals and physicians to improve care by steering patients to providers with top safety and quality records.

- **Wellness and health promotion activities**
  NCQA's wellness and health promotion activities track areas where it has standards for health plans. As discussed earlier, many HEDIS measures directly capture recommended clinical activities to reduce smoking and measure obesity.

  Many organizations find that offering employees health and wellness programs can help reduce their health care costs. By encouraging employees to adopt healthy habits, employers may also improve productivity.

  NCQA's Wellness & Health Promotion Accreditation Program assesses key areas of health promotion, including how wellness programs are implemented, how coaching and other services help participants learn to make healthy choices and how programs protect private health information. Accreditation helps health plans display the quality of their wellness initiatives, gives wellness vendors a way to demonstrate their value to employers and helps employers make informed choices among vendors.

- **Reduction of care disparities**
  Reducing disparities is one of health plans' greatest opportunities to enhance quality. The foundation of NCQA's work in this area is a 2004–2005 study, founded by The California

Endowment, in which NCQA analyzed how health plans can develop and implement culturally appropriate care, as well as monitor health care disparities, among managed care populations.

NCQA has highlighted some of the best-performing health plans through the Recognizing Innovation in Multicultural Health Care Award Program. From 2006 until 2009, these awards recognized health plans for exemplary efforts and effectiveness in fostering cultural competence and addressing the health care needs of diverse members. This awards series also shaped the standards and guidelines for Distinction in Multicultural Health Care, a voluntary NCQA Recognition Program for plans that sponsor initiatives to improve disparities.

Medicare Advantage plans with higher quality scores (based on a star rating system) will receive higher payments. Plans will also share the savings from providing more efficient care, in the form of lower cost sharing or additional benefits.

This change is an important correction to the market's longstanding failure to reward high-performing plans. A regime of differential payments based on health outcomes and care coordination is a step toward compensating plans for delivering quality care.

Advancing Quality and Resource Measurement

As plans and providers work toward better performance on existing measures, quality experts have called for new measures to fill gaps in care.

Health reform calls for funding new measure development and setting a national agenda for quality measurement. The National Priorities Partnership has identified six areas that need more emphasis: patient and family engagement; population health; safety; care coordination; palliative and end-of-life care; and overuse and waste. While all of these areas are important, one of the most critical is overuse and waste.

Clinical evidence is needed to support clear guidelines on appropriateness. HEDIS measures on use of imaging for low back pain and avoidance of antibiotics for certain conditions are key examples of overuse measures. As discussed earlier, NCQA has developed new resource measures that highlight patterns of service use among health plans. These measures help identify plans that provide high quality with less intensive use of hospitals and other costly care. Yet these measures only scratch the surface of what is needed in avoiding wasteful spending for services that do not improve patients' quality of life. In many cases, the research evidence needed to create relevant measures is still lacking.

ADDITIONAL LIVES AND COSTS THAT QUALITY CARE COULD SAVE

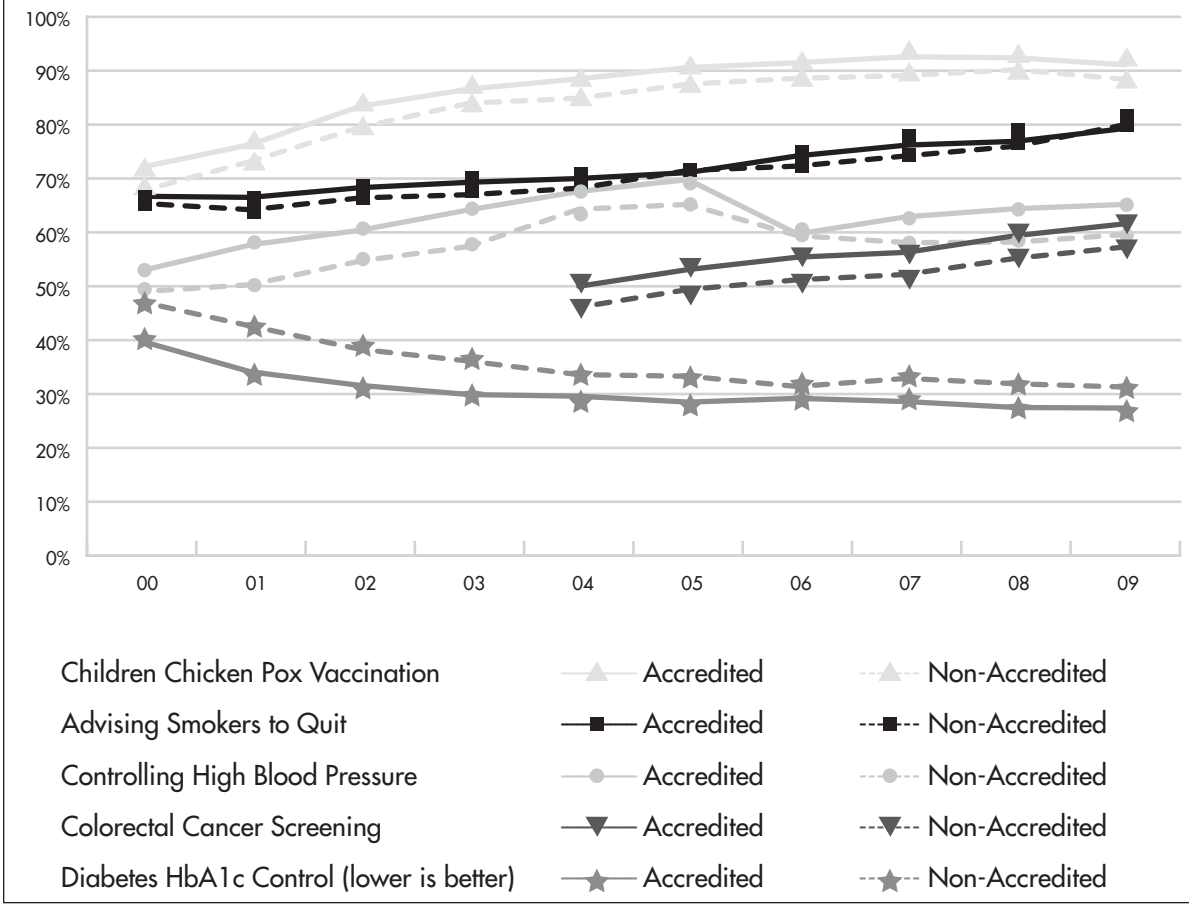
NCQA analyzed the additional lives and health care expense that the nation would save if all is clear that quality care could save tens of thousands of lives and billions of dollars.

CONDITION	MEASURE
Cardiovascular	Persistence of Beta-Blocker Treatment After a Heart Attack
	Persistence of Beta-Blocker Treatment After a Heart Attack
	Controlling High Blood Pressure
	Controlling High Blood Pressure
	Cholesterol Management for Patients With Cardiovascular Conditions
	Cholesterol Management for Patients With Cardiovascular Conditions
	Cholesterol Management for Patients With Cardiovascular Conditions
Prevention and Screening	Breast Cancer Screening
	Breast Cancer Screening
	Cervical Cancer Screening
	Colorectal Cancer Screening
	Colorectal Cancer Screening
	Smoking Cessation—No Medications
	Smoking Cessation—With Medications
	Smoking Cessation—No Medications
	Smoking Cessation—With Medications
	Prenatal Care
	Flu Shots for Older Adults
Diabetes	Diabetes Care—HbA1c Control
	Diabetes Care—HbA1c Control
Musculoskeletal	Osteoporosis Management in Women Who Had a Fracture

health plans that reported 2010 HEDIS data were as good as plans in the 90th percentile. It

OUTCOME	LOW ESTIMATE	HIGH ESTIMATE
Deaths Averted	478	1,355
Direct Costs Averted	$5,536,328	$29,524,959
Deaths Averted	5,217	61,490
Direct Costs Averted	$1,348,314,320	$2,502,468,396
Deaths Averted	11,438	46,014
Discharge Costs Averted	$934,549,231	$2,130,889,515
Reduced Morbidity Costs	$871,056,437	$882,803,658
Deaths Averted	1,032	10,319
Direct Costs Averted	$328,689,274	$332,113,121
Deaths Averted	684	1,327
Deaths Averted	1,083	1,841
Direct Costs Averted	$10,503,041	$17,865,998
Deaths Averted	1,681	2,521
Deaths Averted	7,284	10,870
Direct Costs Averted	$277,034,677	$300,092,291
Direct Costs Averted	$554,017,629	$600,128,554
Deaths Averted	5,649	5,820
Deaths Averted	12,965	17,001
Deaths Averted	3,146	27,955
Total Cost	$294,069,093	$613,551,565
Direct Costs Averted	$12,392,299	$32,148,599
Total Deaths Averted	**50,657**	**186,512**
Total Costs Averted	**$4,636,162,330**	**$7,441,586,656**

CHANGES IN SELECT HEDIS MEASURES: NATIONAL HMO MEANS, 2000–2009



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 by a growing number of PPO plans to measure performance on important dimensions of care and service. By providing objective, clinical performance data measures against a detailed set of measurement criteria, HEDIS helps purchasers and consumers compare health plans based on their performance.

HEDIS measures address a broad range of important health issues:

- Antibiotic use
- Asthma
- Breast, cervical and colorectal cancers
- Care for older adults
- Childhood immunizations
- Cholesterol management
- Diabetes
- High blood pressure
- Medication management
- Mental illness
- Smoking
- Prenatal and postpartum care.

The CAHPS 4.0 Survey is included in HEDIS. The survey measures members' experiences with their health care in areas such as claims processing and getting needed care quickly, and asks them to rate their health plan on a scale of 1–10.

HEDIS 2010 data collected for this report generally reflect services delivered during calendar year 2009. To ensure validity of HEDIS results, all data are rigorously audited by certified auditors, using a process designed by NCQA. See the appendices for more details about national averages and performance trends.

HOS Measures

Medicare Health Outcomes Survey (HOS) measures evaluate the physical and mental health of seniors enrolled in Medicare and are the first patient-based self-report of health status as a measure of quality of care in elderly populations. Including HOS in HEDIS measurement creates a broader scope of measures to evaluate the quality of care provided by health plans for the Medicare population. Included in this report are four HOS measures:

- Fall Risk Management
- Management of Urinary Incontinence in Older Adults

- Osteoporosis Testing in Older Adults
- Physical Activity in Older Adults.

Terms

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

Rate: The statistical mean for reported data. Each measure is described by an average rate for each applicable product line.

Regional Performance: This report illustrates regional performance on HEDIS measures of care, using regions defined by the United States Census Bureau.

East North Central:	Illinois, Indiana, Michigan, Ohio, Wisconsin
Middle Atlantic:	New Jersey, New York, Pennsylvania
Mountain:	Arizona, Colorado, Idaho, Montana, Nevada, New Mexico, Utah, Wyoming
New England:	Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont
Pacific:	Alaska, California, Hawaii, Oregon, Washington
South Atlantic:	Delaware, District of Columbia, Florida, Georgia, Maryland, North Carolina, South Carolina, Virginia, West Virginia
South Central:	Alabama, Arkansas, Kentucky, Louisiana, Mississippi, Oklahoma, Tennessee, Texas
West North Central:	Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota, South Dakota

A Note on Medicare Survey Data

Medicare CAHPS survey data of consumer experience and HEDIS measures collected through the survey (such as *Flu Shots for Adults* and *Medical Assistance With Smoking and Tobacco Use Cessation*) are not available at press time. NCQA will issue an updated version of this report that includes such data later in the year.

USE OF IMAGING STUDIES FOR LOW BACK PAIN

Approximately half of American adults will experience some low back pain in any given year, and about two-thirds will suffer from a prolonged episode at some point in their lifetime.[3] Most people have their first attack of low back pain between 30 and 40, and back pain becomes more common with age.[2] Acute low back pain occurs with a wide variety of minor injuries and conditions, is usually benign and self-limiting, and thus does not require imaging studies such as X-ray, MRI or CT scans for diagnosis. While most patients return to their usual activities in a month, a small percentage will need to be evaluated further to rule out more serious health problems.[3]

About Imaging Studies for Low Back Pain

- Less than 1 percent of radiographs identify a specific cause of low back pain.[4]
- Patients given conservative care (without imaging) experience no difference in health outcomes compared with those given lower back radiographs, other than a slight decrease in patient satisfaction.[5]
- Use of imaging in early, acute low back pain appears to lead to more use of surgery, and complications from unnecessary surgery can increase the duration of low back pain and lead to permanent disability.[6]

Measure Definition

This measure is the percentage of members with a primary diagnosis of low back pain who did not have an imaging study within 28 days of the diagnosis. Higher scores are better because they indicate fewer potentially inappropriate imaging studies.

The Case for Improvement

- Low back pain is the most costly ailment in the workplace, when both cost an average of $8,000 per claim and frequency are considered.[7] From 2000–2006, medical expenditures for imaging services such as CAT scans and MRIs rose from $3.6 billion to $7.6 billion.[8]
- Abnormalities found when imaging people without back pain are nearly as frequent as abnormalities found in patients with back pain, which indicates that imaging studies may have a very limited role in diagnosing the cause of most low back pain.[9]

- The duration of low back pain beyond the acute stage, more than the pain's severity, correlates with decreased quality of life and disability.[10]
- About 85 percent of persons with musculoskeletal diseases have at least one ambulatory care visit to a doctor's office, averaging around six visits each year.[11]

SCREENING RATE
HMO Means

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2009	73.9	N/A	76.1
2008	73.1	N/A	75.7
2007	74.6	N/A	77.3
2006	73.9	N/A	78.3
2005	75.4	N/A	79.0

AVOIDANCE OF ANTIBIOTIC TREATMENT IN ADULTS WITH ACUTE BRONCHITIS

Acute bronchitis, or chest cold, is the ninth most common illness among patients seen in office or outpatient settings.[1] The most common symptom of acute bronchitis is a cough. Approximately 5 percent of adults in the U.S. report an episode of bronchitis each year and 90 percent seek treatment.[1,3] Fewer than 1 case in 10 is caused by bacteria and will benefit from treatment with antibiotics—and the vast majority of those cases are in persons with serious underlying diseases.[4,5] Thus, antibiotic treatment is only infrequently appropriate for acute bronchitis unless there is underlying lung disease because antibiotics are not effective against viral illness.

About Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis

- About 80 percent of antibiotics prescribed for acute respiratory infections in adults are unnecessary.[6] In 2002, antibiotics were prescribed in 49 percent of U.S. adult acute bronchitis cases.[7]
- Elderly patients are especially likely to receive unnecessary antibiotic coverage, and more than 50 percent of prescriptions are for broad spectrum antibiotics.[2,8]

Measure Definition

The percentage of healthy adults 18–64 years of age with a diagnosis of acute bronchitis who *were not* dispensed an antibiotic prescription (a higher number is better).

The Case for Improvement

- The misuse and overuse of antibiotics contribute to antibiotic drug resistance (resistance makes a drug much less effective or ineffective for treating bacterial infections). Diminished efficacy of antibiotics against bacterial infections—particularly for use in patients with life-threatening bacterial infections[6,9,10]—is a significant public health concern.

- When resistance makes widely-used antibiotics ineffective, there is either no treatment at all or physicians must use more potent antibiotics, which are often more toxic and more expensive. This can result in longer hospital stays, more serious side effects and increased financial burden, including a financial burden for patients.[11]

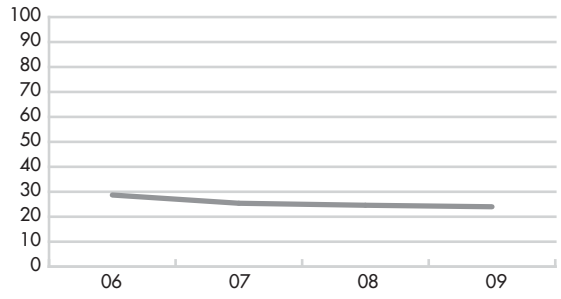
TREATMENT RATE

HMO Means

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2009	24.0	N/A	25.6
2008	24.6	N/A	25.8
2007	25.4	N/A	25.9
2006	28.7	N/A	28.0

AVOIDANCE OF ANTIBIOTIC TREATMENT IN ADULTS WITH ACUTE BRONCHITIS

Commercial HMO Means



RELATIVE RESOURCE USE (RRU)

For years, NCQA has issued quality reports that make it possible to compare health plans' effectiveness of care with market averages. RRU measures add another dimension to those comparisons, turning discussions about quality into broader conversations about value and efficiency—the intersection of quality and cost.

Relative resource use indicates how intensively health plans use health care resources (such as physician visits and hospital stays), compared with other plans in the same region, adjusted for the population of members they serve. When used in tandem with HEDIS quality measures, RRU measure results make it possible to talk about quality and cost issues in the same context.

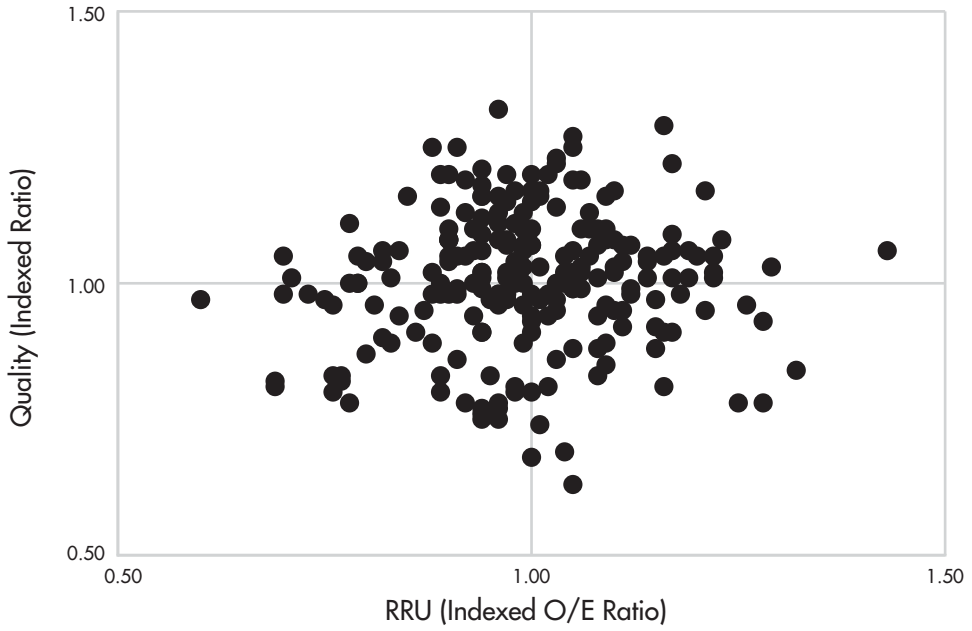
RRU measures should be reviewed in the context of related quality measures and not in isolation. The combination of resource use data and related quality indices, along with expenditures or plan premium, gives purchasers and plans a basis for a discussion of value that plans deliver for the health care dollar. As such, RRU measures enable a richer dialogue that goes beyond conventional conversations about premiums or quality in isolation and illuminates what stakeholders can expect from health plans in terms of their influence on resource use, unit prices and quality.

(For details on how NCQA calculates RRU, see Methodology Overview, p.101.)

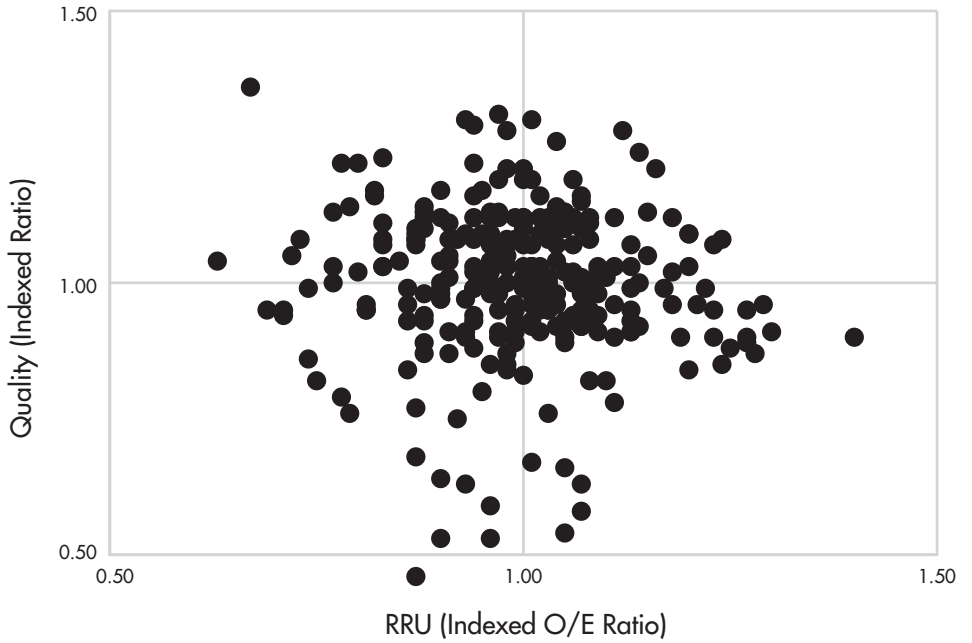
Generally, purchasers should be most interested in plans whose resource use and quality scores place them in the upper left quadrant of the scatter plots shown in this report (above-average quality, below-average resource use). Plans in the lower right quadrant are less desirable (below-average quality, above-average resource use).

A key insight from the simultaneous comparison of quality and RRU in the scatter plots is that utilization and quality are poorly correlated. More use of resources, such as inpatient bed days or procedures, can actually be associated with poorer quality; thus, it is important to consider both resource use *and* quality. Many people find this to be counterintuitive—in most fields, buyers can reasonably expect "you get what you pay for" to apply: buying more of a good or service, or paying a higher price, typically brings better results. That many plans fall in the upper right or lower right quadrant of the scatter plots suggests that the association between quality and cost does not follow the belief that more is better—at least, not in health care.

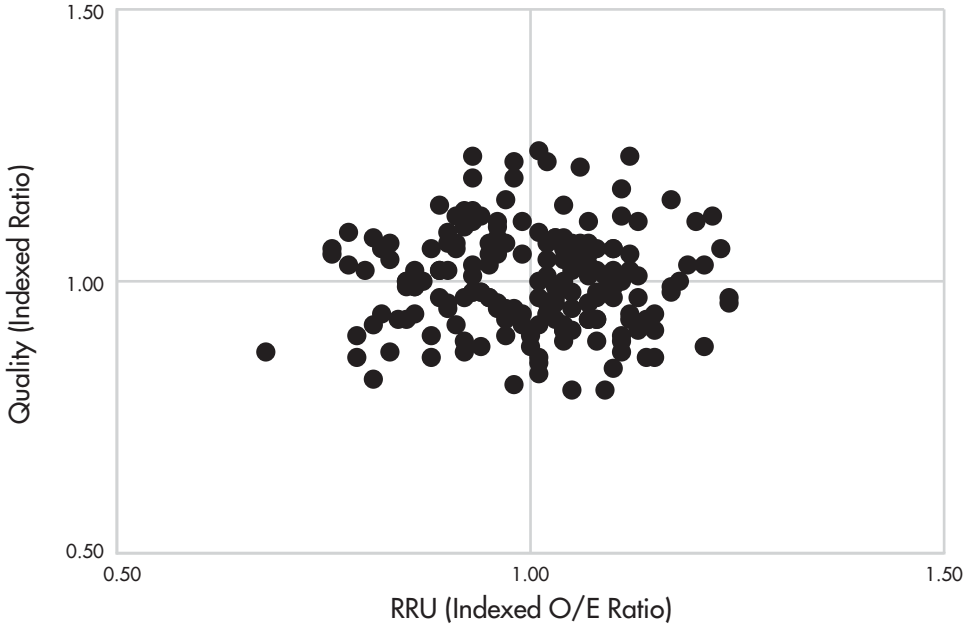
COST AND QUALITY (CARDIOVASCULAR CONDITIONS)



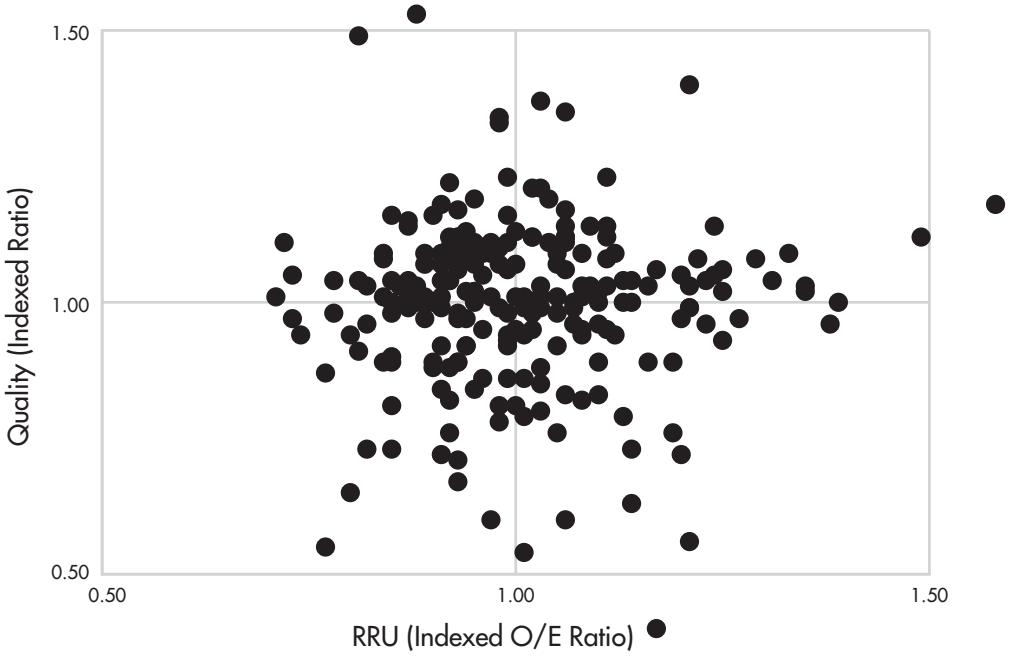
COST AND QUALITY (DIABETES)



COST AND QUALITY (COPD)



COST AND QUALITY (HYPERTENSION)



ADULT BODY MASS INDEX ASSESSMENT

Obesity, or being overweight, affects more than a third of the adult American population and is the second leading cause of preventable death in the United States, next to smoking.[1] It is a complex, chronic condition affecting every ethnic group, socioeconomic class and geographic region of the U.S. Excess weight and obesity are contributing causes to more than 50 percent of mortality among American adults. Approximately $99.2 billion is spent annually on obesity-related medical care and disability in the U.S.[2]

About Adult BMI Assessment

- Overweight and obesity ranges are determined by calculating the body mass index (BMI).[3] BMI is calculated from a person's weight and height and is the most effective, practical method for estimating body fat.[4,5]
- Guidelines from many organizations—including the Institute for Clinical Systems Improvement; the U.S. Preventive Services Task Force; the National Heart, Lung, and Blood Institute; and the Michigan Quality Improvement Consortium—indicate that the first step in weight management is calculating BMI.

Measure Definition

This measure estimates the percentage of members 18–74 years of age who had an outpatient office visit and had their BMI documented during the measurement year or in the year prior to the measurement year.

The Case for Improvement

- The increased risk of diseases associated with obesity, such as diabetes and cardiovascular disease, shortens life expectancy by approximately 13 years.[6]
- Obesity poses a long-term threat to public health. Childhood obesity rates continue to rise; today's children and young adults are carrying obesity-related risks for more of their life, compared with previous generations.[6]
- Despite the impact of overweight and obesity on the U.S. population, physicians often fail to diagnosis obesity or to counsel patients regarding weight, diet or exercise, and often do not assess BMI.[7]

ASSESSMENT RATE
HMO Means

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2009	41.3	38.8	34.6

MEDICAL ASSISTANCE WITH SMOKING AND TOBACCO USE CESSATION

Smoking is the second most common cause of death in the world and by far the most directly preventable cause of death and disability in the United States.[1-3] In 2006, an estimated 45.3 million Americans were smokers—nearly 20 percent. Of these, 36.3 million smoked every day.[2] Smoking adversely affects virtually every organ in the body and can lead to serious diseases in the lungs and heart. It is a major cause or contributing factor in cardiovascular diseases, periodontitis, cancer, pneumonia and sudden infant death syndrome.[1] But there is some positive news: in 2007, the percentage of American adults who smoked was reported at 19.2 percent, a historic low.[4]

About Medical Assistance With Smoking and Tobacco Use Cessation

- Although most smokers want to quit smoking entirely, less than 5 percent will have long-term success and will frequently relapse because of nicotine's addictive nature.[5]
- Studies show that female smokers who are older or have long-standing medical histories are more likely to be advised on how to quit smoking.[6] While advice to quit smoking is effective, especially when coupled with behavioral and pharmaceutical treatment, it is used far less than is desirable.
- Minority populations such as Hispanic or African-American receive advice on cessation less frequently than Caucasians.[6]

Measure Definition

This measure evaluates three facets of providing medical assistance with smoking and tobacco use cessation:

- *Advising Smokers and Tobacco Users to Quit.* A rolling average represents the percentage of members 18 years of age and older who are current smokers or tobacco users and who received advice to quit during the measurement year.
- *Discussing Cessation Medications.* A rolling average represents the percentage of members 18 years of age and older who are current smokers or tobacco users and who discussed or were recommended medications to quit during the measurement year.
- *Discussing Cessation Strategies.* A rolling average represents the percentage of members 18 years of age and older who are current smokers or tobacco users and who discussed or were provided cessation methods or strategies during the measurement year.

The Case for Improvement

- Smokers incur 18 percent higher health care charges over an 18-month period, compared with people who never smoked.[8]
- Smoking-attributable health care expenditures and productivity losses exceed $167 billion annually.[5,7]

- If screening and intervention for smoking were increased to 90 percent, a total of one million years of life could be saved.[8]
- In 2003, approximately 90 percent of health care plans covered tobacco dependence treatment.[9]

DISCUSSION OF SMOKING CESSATION STRATEGIES

HMO Means

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2009	50.0	N/A	38.8
2008	49.7	N/A	40.8
2007	48.0	N/A	39.2
2006	43.2	N/A	36.7
2005	38.9	N/A	33.9
2004	36.8	N/A	32.7
2003	36.0	N/A	32.3

DISCUSSION OF SMOKING CESSATION MEDICATIONS

HMO Means

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2009	53.3	N/A	43.4
2008	54.4	N/A	40.6
2007	50.9	N/A	38.7
2006	43.9	N/A	35.1
2005	39.4	N/A	31.8
2004	37.8	N/A	31.3
2003	37.6	N/A	31.5

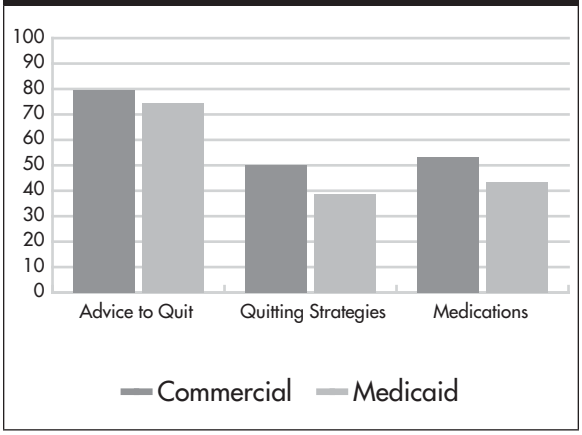
ADVISING SMOKERS TO QUIT

HMO Means

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2009	79.5	77.9	74.3
2008	76.7	76.9	69.3
2007	75.8	75.8	69.4
2006	73.8	76.1	68.2
2005	71.2	75.5	65.6
2004	69.6	64.7	66.7
2003	68.6	62.9	65.8
2002	67.7	61.6	63.6
2001	65.7	60.9	63.9
2000	66.3	N/A	N/A

SMOKING CESSATION: ADVICE AND INTERVENTION

Commercial and Medicaid HMO Means



FLU SHOTS FOR ADULTS

Every year, 5 percent–20 percent of Americans contract influenza (the flu).[1] The health impact of influenza on older adults is especially substantial: 63 percent of the more than 200,000 people hospitalized for flu-related complications each year are 65 or older.[1,2] Flu shots (influenza vaccines) are the most effective way to prevent severe illness or death resulting from influenza and its complications.[5]

About Flu Shots for Adults

- One third of all Americans 50–64 years of age have one or more chronic medical condition that puts them at increased risk for serious flu complications.[3]
- Among the elderly, influenza vaccines can prevent 50 percent–60 percent of hospitalizations and 68 percent of deaths from flu-related complications.[4]
- Flu vaccine effectiveness depends in part on the match between the viruses in the vaccine and the flu viruses circulating in the community. According to the Centers for Disease Control and Prevention, during well-matched years, clinical trials have shown vaccine effectiveness to be between 70 percent and 90 percent among healthy adults.[6]

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 50–64 years of age; reported results for Medicare represent adults 65 years of age and older. This measure *does not* address the H1N1 vaccine.

The Case for Improvement

- In 2005, less than half of the 50–64 high-risk group (e.g., people with asthma) had a flu shot, and about one quarter of the 18–49 high-risk group had one.[7]
- Total direct hospitalization costs of an influenza epidemic are estimated to be over $3 billion.[8]
- The cost of delivering the flu vaccine has been estimated to be around $15 per person vaccinated, including direct and indirect medical costs and costs associated with potential side effects.[9]

- Achieving 90 percent vaccination coverage would reduce deaths by over 15,000 annually in a year with an average flu season (i.e., not a major epidemic).[10]

VACCINATION RATE
HMO Means

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2009	51.3	64.5	N/A
2008	49.8	65.8	N/A
2007	48.6	68.6	N/A
2006	45.6	67.8	N/A
2005	36.2	70.3	N/A
2004	38.9	74.8	N/A
2003	47.9	74.4	N/A
2002	44.0	72.5	N/A
2001	30.3	71.2	N/A

PRENATAL AND POSTPARTUM CARE

Annually, there are over four million births in the U.S., making prenatal and postpartum care one of the most important services offered to young women and infants.[1] Early effective prenatal care can identify mothers at risk of delivering a preterm or otherwise high risk infant and if so, then provide an array of medical and educational interventions. 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

- Preterm babies constitute more than 12 percent of American live births; 8.2 percent of babies are born low birthweight.[1] Preterm infants are at increased risk for several health problems, including neurodevelopment handicaps, congenital anomalies and respiratory illness.[2]
- Death rates related to complications from pregnancy are four times higher among women who received no prenatal care compared to women who received prenatal care.[3]
- The postpartum visit is a chance for a physician to converse with the mother to detect early problems with parenting skills and perform pelvic, breast and postpartum depression screenings, among other tests. The postpartum visit also allows the physician to follow-up with any problems that occurred during pregnancy, such as maternal diabetes.[2]

Measure Definition

This measure has two indicators related to the percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year:

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

The Case for Improvement

- Preterm births cost the United States in excess of $26 billion in 2005.[2]
- Conditions such as high blood pressure and diabetes affect pregnancy outcomes and are important to find before pregnancy or as early as possible during pregnancy.[9,11]
- Compared to infants born after 33 weeks of gestation, infants born pre-term incur significantly higher hospitalization charges

at birth. Infants born at low-birthweight are also significantly more likely to incur higher hospitalization charges than infants born at normal birthweight.[6]

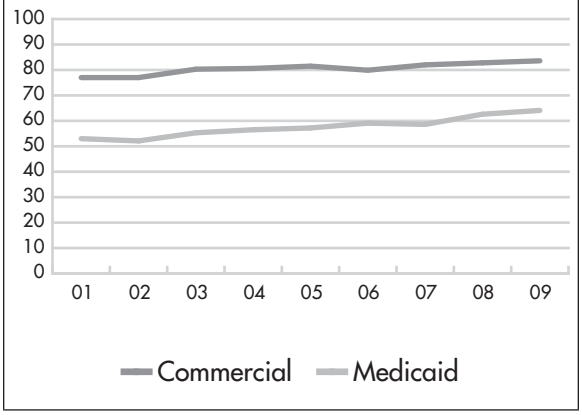
TIMELINESS OF PRENATAL CARE
HMO Means

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2009	93.1	N/A	83.4
2008	92.4	N/A	81.9
2007	91.9	N/A	81.5
2006	90.6	N/A	81.2
2005	91.8	N/A	79.6
2004	90.8	N/A	78.2
2003	89.4	N/A	76.5
2002	86.7	N/A	70.4
2001	85.1	N/A	72.9

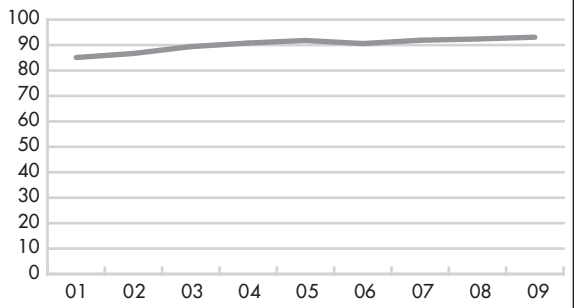
POSTPARTUM VISITS
HMO Means

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2009	83.6	N/A	64.1
2008	82.8	N/A	62.6
2007	82.0	N/A	58.6
2006	79.9	N/A	59.1
2005	81.5	N/A	57.2
2004	80.6	N/A	56.5
2003	80.3	N/A	55.3
2002	77.0	N/A	52.1
2001	77.0	N/A	53.0

POSTPARTUM VISIT BETWEEN 21 AND 56 DAYS AFTER DELIVERY
Commercial and Medicaid HMO Means



TIMELINESS OF PRENATAL CARE
Commercial HMO Means



BREAST CANCER SCREENING

Breast cancer is one of the most common types of cancer among American women, accounting for a quarter of all cancer diagnoses among women. In 2009, an estimated 192,370 new cases of invasive breast cancer were identified in women, and approximately 40,170 women died from the cancer.[1] The risk of breast cancer risk increases with age; between 2004 and 2007, 97 percent of breast cancer related deaths occurred in women older than 40.[1]

About Breast Cancer Screening

- Among the three main tests used to screen for breast cancer—breast self-exam, clinical breast exam and mammogram—only mammogram has been shown to reduce mortality from breast cancer. [2]
- Mammography screening for women ages 50 to 69 can reduce breast cancer mortality up to 35 percent.[3]
- A woman living in the U.S. has a one in eight lifetime risk of developing breast cancer.[2] Breast cancer mortality in women has declined in recent years, in part because of early detection using mammography.[4] The five-year survival rate is 89 percent, and the 10-year survival rate is 81 percent.[1]
- The annual cost for breast cancer treatment is approximately $7 billion.[1] Treating breast cancer detected in its earliest, pre-invasive stage costs significantly less than if the cancer is detected at more advanced stages.

Measure Definition

This measure estimates the percentage of women 40 to 69 years of age who had at least one mammogram in the current or prior year.

The Case for Improvement

- Early detection is associated with better survival rates and more treatment options.

SCREENING RATE
HMO Means

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2009	71.3	69.3	52.4
2008	70.2	68.0	50.8
2007	69.1	67.3	49.8
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	56.0
2001	75.5	75.3	55.1
2000	74.5	N/A	N/A
1999	73.4	N/A	N/A

CERVICAL CANCER SCREENING

Unfortunately rates of cervical cancer in the U.S. have plateaued or even decreased in recent years, worldwide it is the second most common cancer and the tenth leading cause of cancer in females.[1,2] Cervical cancer incidence and mortality decrease in direct proportion with intensity of screening. Most importantly, when detected and treated early, cervical cancer is one of the most treatable cancers.[3] For women under 50 years old, cervical cancer is diagnosed in the early stage 62 percent of the time.[4]

About Cervical Cancer Screening

- A annual or biannual routine Papanicolaou (Pap) smear is recommended by the U.S. Preventive Services Task Force and the American Cancer Society for detecting cervical cancer at the pre-cancerous stage.[5,6]
- The 75 percent decrease in new incidences of cervical cancer and deaths due to cervical cancer over the last 50 years is thought to be mainly due to the increase in the Pap smear test.[7]

Measure Definition

The measure estimates the percentage of women 21 to 64 years of age who received a Pap test to screen for cervical cancer.

The Case for Improvement

- The one-year survival rate for cervical cancer is 88 percent; the five-year survival rate is 71 percent.[8] And earlier detection is associated with higher survival rates.
- Death from cervical cancer is rare among women who have regular screening, regardless of race or age.[9]
- The cost of treating cervical cancer is between $300 and $400 million annually and is concentrated in care of women detected at a late stage.[10]

SCREENING RATE
HMO Means

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2009	77.3	N/A	65.8
2008	80.7	N/A	66.0
2007	81.7	N/A	64.8
2006	81.0	N/A	65.7
2005	81.8	N/A	65.2
2004	80.9	N/A	64.7
2003	81.8	N/A	64.0
2002	80.5	N/A	62.2
2001	80.0	N/A	61.1
2000	78.1	N/A	N/A
1999	71.8	N/A	N/A

COLORECTAL CANCER SCREENING

Every year, approximately 57,000 Americans die from colorectal cancer.[1] In 2009, an estimated 146,970 men and women were diagnosed with the disease.[2] Symptoms are not common in colorectal cancer until the disease has progressed and chance of survival decreases once symptoms occur.[3] Most colorectal cancers occur in people without a family history of colorectal cancer.[4] However, treatment is extremely effective in the disease's earliest stages and the five-year survival rate exceeds 90 percent.[5]

About Colorectal Cancer Screening

- Fecal occult blood tests, colonoscopy and flexible sigmoidoscopy are shown to be effective screening methods.[6]
- Although colorectal cancer screening is very effective, screening rates for colorectal cancer lag behind other cancer screening rates.[7]

Measure Definition

This measure estimates the percentage of 50-to-75 year-olds who have had appropriate screening for colorectal cancer with any of the following tests:

- Fecal occult blood test during the measurement year.
- Flexible sigmoidoscopy during the measurement year or the four years prior to the measurement year.
- Colonoscopy during the measurement year or in any of the nine years prior to the measurement year.

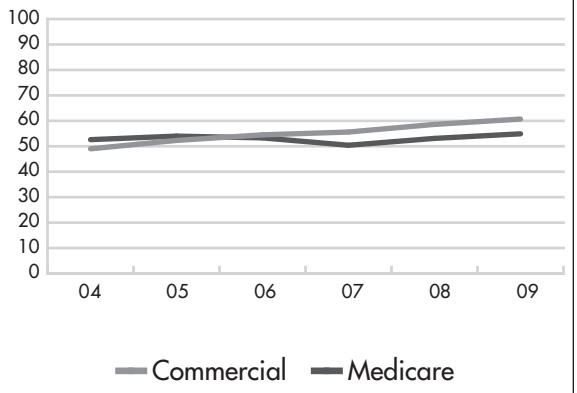
The Case for Improvement

- More than two in five American adults do not receive the necessary colorectal cancer screening.[8]
- Colorectal screening of asymptomatic individuals can identify polyps whose removal can prevent more than 90 percent of colorectal cancers.[9]
- In the last 15 years, deaths associated with colorectal cancer have decreased, primarily because screening has increased the likelihood of detecting and removing polyps.[10]

SCREENING RATE
HMO Means

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2009	60.7	54.9	N/A
2008	58.6	53.1	N/A
2007	55.6	50.4	N/A
2006	54.5	53.3	N/A
2005	52.3	54.0	N/A
2004	49.0	52.6	N/A

COLORECTAL CANCER SCREENING
Commercial and Medicare HMO Means



CHLAMYDIA SCREENING IN WOMEN

Chlamydia is often a "silent" sexually transmitted disease but one which can have serious consequence, and in addition is often associated with other, even more serious sexually transmitted conditions such as HIV or syphilis which can also be assymptomatic. Three-fourths of infected women and half of infected men do not realize they have the infection, as there are no symptoms until one to three weeks after infection.[1] Pregnant women who have a chlamydial infection may have adverse pregnancy outcomes, such as miscarriage, premature rupture of membranes, preterm labor, low birth weight and infant mortality.[2] Chlamydia can be passed from mother to infant during childbirth, and is a leading cause of conjunctivitis (pink eye) and pneumonia in newborns.[3] Chlamydia can also lead to reproductive health problems such as miscarriages, ectopic pregnancies and pelvic pain.

About Chlamydia Screening

- Since most chlamydia infections in women are asymptomatic; routine screening for sexually active women under 25 years old is essential.[4,5] However, fewer than half of sexually active women are screened. [6]
- In a study of pregnant women, 9 percent had asymptomatic chlamydia, highlighting the importance of chlamydia screening in women of childbearing age.[7]
- Routine screening of women younger than 25 years of age saves $45 annually for every woman screened.[8]
- Of the women 16 to 20 years of age routinely screened, approximately 5 to 14 percent are infected with chlamydia.[9] Approximately 3 to 12 percent of women 20 to 24 years of age who are routinely screened are infected.[10]

Measure Definition

This measure determines the percentage of sexually active (identified either by pharmacy use of contraceptives or diagnosis codes) females 15 to 24 years of age who had at least one test for chlamydia during the measurement year.

The Case for Improvement

- Chlamydia is easily treated and cured with antibiotics[1,11]
- Untreated chlamydia can damage a woman's reproductive organs, possibly causing permanent and irreversible damage to the fallopian tubes and uterus leading to infertility.[12]
- Untreated chlamydia can cost society over $3.1 billion annually.[13]

SCREENING RATE (16–20 YEARS)
HMO Means

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2009	41.0	N/A	54.4
2008	40.1	N/A	52.7
2007	36.4	N/A	48.6
2006	36.2	N/A	50.5
2005	34.4	N/A	49.2
2004	32.6	N/A	45.9
2003	30.4	N/A	44.3
2002	26.7	N/A	40.8
2001	24.5	N/A	39.6
2000	23.6	N/A	N/A
1999	18.5	N/A	N/A

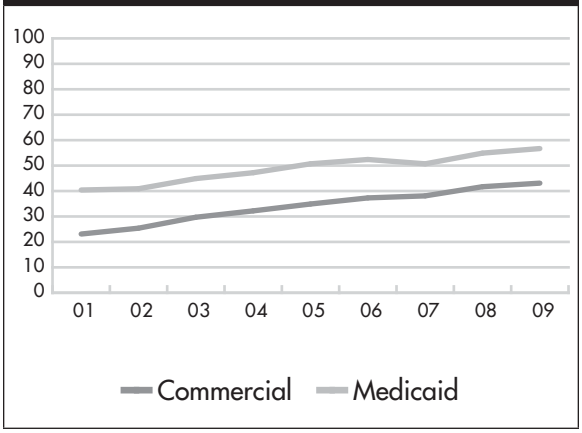
SCREENING RATE (21–24 YEARS)
HMO Means

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2009	45.4	N/A	61.6
2008	43.5	N/A	59.4
2007	39.2	N/A	54.0
2006	38.0	N/A	55.0
2005	35.2	N/A	52.5
2004	31.7	N/A	49.0
2003	29.1	N/A	46.0
2002	24.5	N/A	41.5
2001	22.1	N/A	41.1
2000	20.7	N/A	N/A
1999	16.0	N/A	N/A

SCREENING RATE (TOTAL RATE)
HMO Means

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2009	43.1	N/A	56.7
2008	41.7	N/A	54.9
2007	38.1	N/A	50.7
2006	37.3	N/A	52.4
2005	34.9	N/A	50.7
2004	32.2	N/A	47.2
2003	29.7	N/A	44.9
2002	25.4	N/A	40.9
2001	23.1	N/A	40.4

CHLAMYDIA SCREENING (TOTAL RATE)
Commercial and Medicaid HMO Means



PERSISTENCE OF BETA-BLOCKER TREATMENT AFTER A HEART ATTACK

An estimated 7.9 million Americans age 60 and older have a history of myocardial infarctions, or heart attacks.[1] Scientific evidence based guidelines from the American Heart Association and the American College of Cardiology strongly recommend treatment using beta-blockers following a heart attack to reduce mortality during acute and long-term management of patients who have had heart attacks.[2] The dramatic rise in rates of beta-blocker treatment in commercial health plans—more than 34 percent since 1996—illustrates that measuring beneficial treatments increases those treatments' use.[3] Ultimately, what gets measured gets improved.

About Beta-Blocker Treatment

- As many as 2,400 people die of cardiovascular or heart-related events every day, which equates to nearly one death every 37 seconds.[1] Almost half of cardiac-related deaths happen within one hour of symptom presentation.[4]
- Nearly 785,000 people in the U.S. experience a heart attack annually. Of those, more than half (470,000) have experienced at least one previous heart attack.[7]
- Beta-blockers are key to preventing future heart attacks by lowering an individual's blood pressure and the heart's workload.[10]

Measure Definition

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

The Case for Improvement

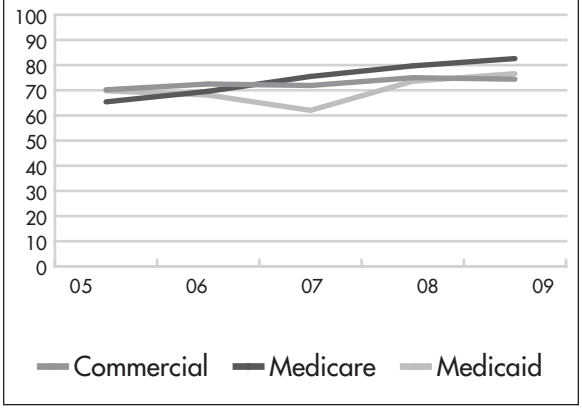
- Among adults who should be taking beta-blockers, 43.8 percent of nursing home residents and 61.4 percent of community-dwelling residents receive beta-blockers. For the nursing home patients who are taking their beta-blocker medication, mortality was significantly lower.[9]
- Measured at 360 days after discharge, only 45 percent of patients are taking beta-blockers. Adherence drops the most between 30 and 90 days.[8]

- If all first-time heart attack survivors took beta-blockers as prescribed for 20 years, an estimated 62,000 heart attacks would be prevented, 72,000 deaths from coronary heart disease avoided, 447,000 life-years gained and $18 million saved.[5]

TREATMENT RATE
HMO Means

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2009	74.4	82.6	76.6
2008	75.0	79.7	73.6
2007	71.9	75.5	62.0
2006	72.5	69.6	68.1
2005	70.2	65.4	69.8

BETA-BLOCKER TREATMENT
Commercial, Medicare and Medicaid HMO Means



COMPREHENSIVE DIABETES CARE

Diabetes is one of the leading causes of death and disability in the U.S.[1] Approximately 24 million Americans, or close to 8 percent of the population, have the disease and with the rise in the number persons overweight and obese in the US, the number of diabetics are on the rise most regrettably among younger age groups.[1] Much of the burden of illness and cost of diabetes is related to potentially preventable long-term complications that include heart disease, blindness, kidney disease and stroke.[2] Timely screening and careful treatment can significantly reduce and delay the onset of complications of diabetes.

About Diabetes

- Diabetes accounts for almost 45 percent of new cases of kidney failure.[3]
- People with diabetes are more susceptible to acute illness and have worse health outcomes than non-diabetics. For example, diabetics are more likely to die with pneumonia or influenza.[4]
- Every 10 millimeters of mercury reduction in systolic blood pressure in diabetics, results in a 12 percent reduction in diabetic complications.[1]

Measure Definition

This set of measures estimates the percentage of health plan members 18 to 75 years of age with diabetes (type 1 and type 2) who had received, or achieved the control levels specified for each of the following:

- Hemoglobin A1c (HbA1c) testing
- HbA1c poor control (>9.0%)
- HbA1c control (<8.0%)*
- HbA1c control (<7.0%)
- A retinal eye exam
- LDL-C screening
- LDL-C control (<100 mg/dL)
- Medical attention for kidney disease (nephropathy)
- Blood pressure control (<130/80 mm Hg)
- Blood pressure control (<140/90 mm Hg)

The Case for Improvement

- Patients with diabetes 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.[5]
- HbA1c control can result in quality-of-life improvements such as increased work productivity and lower health care use,

** Additional exclusion criteria are required for this indicator which is only reported for commercial and Medicaid health plans.*

while preventing the development of eye, kidney and nerve disease.[6]

- Diabetes was the sixth leading cause of death on U.S. death certificates in 2006.[7]
- Economic costs associated with diabetes totaled $174 billion in 2002.[1]
- A worker's decreased productivity due to diabetes can cost the worker between $3,700 and $8,700 in annual earnings.[6]

BLOOD PRESSURE CONTROL (<130/80 MM HG)
HMO Means

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2009	33.9	33.3	32.2
2008	33.4	31.8	30.7
2007	32.1	31.7	29.6

BLOOD PRESSURE CONTROL (<140/90 MM HG)
HMO Means

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2009	65.1	60.5	59.8
2008	65.6	59.5	56.9
2007	63.9	58.9	55.6

EYE EXAMS
HMO Means

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2009	56.5	63.5	52.7
2008	56.5	60.8	52.8
2007	55.0	62.7	49.8
2006	54.6	62.3	51.4
2005	54.8	66.5	48.6
2004	50.9	67.2	44.9
2003	48.8	64.9	45.0
2002	51.7	68.4	46.8
2001	52.1	66.0	46.4
2000	48.1	N/A	N/A
1999	45.3	N/A	N/A

HBA1C SCREENING
HMO Means

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2009	89.2	89.6	80.6
2008	89.0	88.3	80.5
2007	88.1	88.1	77.3
2006	87.5	87.2	78.0
2005	87.5	88.9	76.1
2004	86.5	89.1	75.9
2003	84.6	87.9	74.8
2002	82.6	85.0	73.0
2001	81.4	85.7	71.6
2000	78.4	N/A	N/A
1999	75.0	N/A	N/A

HBA1C CONTROL (<7.0%)

HMO Means

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2009	42.1	N/A	33.9
2008	43.3	43.4	32.9
2007	43.1	46.2	31.4

HBA1C CONTROL (<8.0%)

HMO Means

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2009	61.6	63.7	45.7

POOR HBA1C CONTROL (>9.0%)*

HMO Means

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2009	28.2	28.0	44.9
2008	28.4	29.4	44.8
2007	29.4	29.0	48.0
2006	29.6	27.3	48.7
2005	29.7	23.6	49.2
2004	30.7	22.3	48.6
2003	32.0	23.4	48.6
2002	33.9	24.5	48.9
2001	36.9	26.8	48.3
2000	42.5	N/A	N/A
1999	44.9	N/A	N/A

**Lower rates signify better performance.*

LDL CHOLESTEROL SCREENING

HMO Means

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2009	85.0	87.3	74.2
2008	84.8	86.3	74.1
2007	83.9	85.7	70.8
2006	83.3	84.8	71.1
2005	92.3	93.3	80.6
2004	91.0	93.5	79.6
2003	88.4	91.1	75.9
2002	85.1	87.9	70.8
2001	81.4	85.7	66.5
2000	76.5	N/A	N/A
1999	69.0	N/A	N/A

LDL CHOLESTEROL CONTROL (<100 MG/DL)

HMO Means

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2009	47.0	50.0	33.5
2008	45.5	48.7	33.8
2007	43.8	46.8	31.3
2006	43.0	46.9	30.6
2005	43.8	50.0	32.7
2004	40.2	47.6	30.6

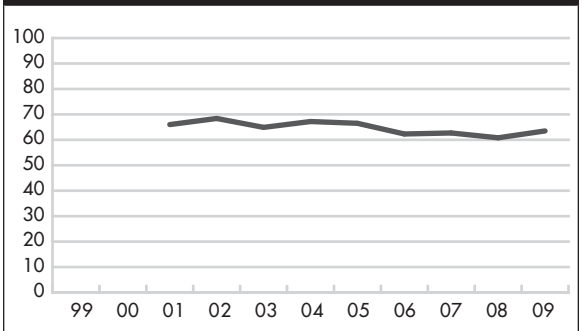
MONITORING NEPHROPATHY

HMO Means

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2009	82.9	88.6	76.9
2008	82.4	87.9	76.6
2007	80.6	85.7	74.3
2006	79.7	85.4	74.6
2005	55.1	60.3	48.9
2004	52.0	58.6	46.7
2003	48.2	53.6	43.7
2002	51.8	57.3	48.2
2001	46.3	51.9	42.3
2000	41.3	N/A	N/A
1999	36.0	N/A	N/A

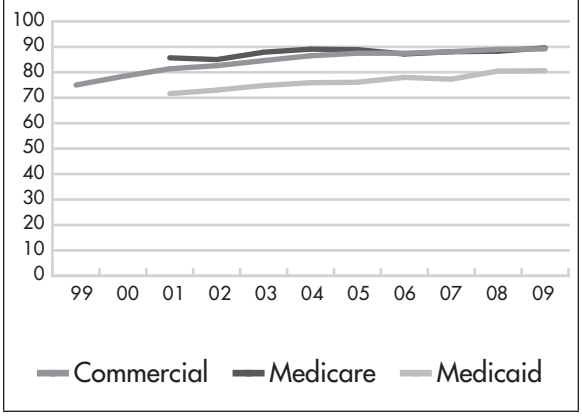
EYE EXAMS

Medicare HMO Means



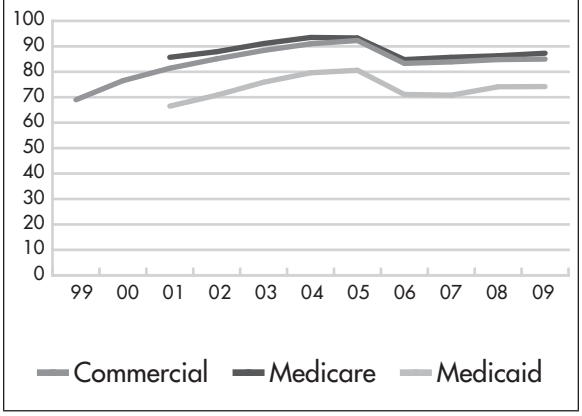
HBA1C SCREENING

Commercial, Medicare and Medicaid HMO Means



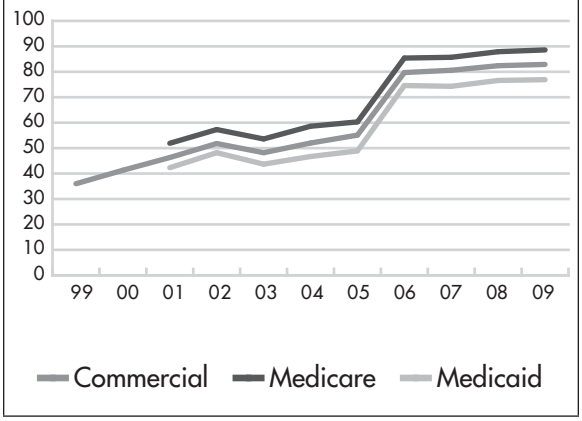
LDL-C SCREENING

Commercial, Medicare and Medicaid HMO Means



MONITORING NEPHROPATHY

Commercial, Medicare and Medicaid HMO Means



CONTROLLING HIGH BLOOD PRESSURE

One out of every three Americans has hypertension, or high blood pressure.[1] This condition will affect over 90 percent of middle-aged and elderly Americans.[2] The risk of developing hypertension increases with age, but with the epidemic in obesity, it is now seen more in younger persons, as well.[3] Hypertension is a major risk factor for heart attacks and strokes.[3] Even with the availability of effective treatment options, more than half of Americans with hypertension are untreated or do not have optimal levels of blood pressure while under treatment.[4]

About High Blood Pressure

- People with hypertension have twice the lifetime risk of stroke compared to those without hypertension.[5]
- In 2006, high blood pressure was a primary or contributing cause of death in approximately 326,000 deaths in the U.S.[4]
- Roughly 77 percent of people who have a stroke, 69 percent of people who have a heart attack and 74 percent of people with heart failure have high blood pressure.[4]

Measure Definition

This measure estimates the percentage of members 18–85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (using evidence-based guidelines, defined as <140/90 mm Hg) during the measurement year.

The Case for Improvement

- Projected 2010 direct and indirect costs associated with high blood pressure in the U.S. are $76.6 billion.[4]
- One study estimated that an intervention that reduced blood pressure by 5 mm Hg, decreased death from stroke by 14 percent, death from coronary heart disease by 9 percent and death from all causes by 7 percent.[6]
- Among 50-year-olds, life expectancies of men and women with hypertension are 5.1 years shorter and 4.9 years shorter, respectively, than for men and women with normal blood pressure.[7]

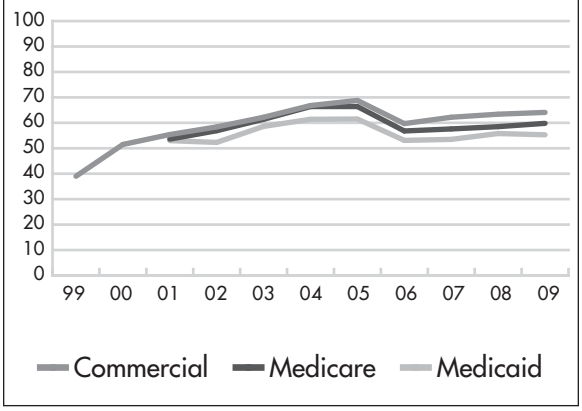
CONTROL RATE

HMO Means

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2009	64.1	59.8	55.3
2008	63.4	58.5	55.8
2007	62.2	57.6	53.5
2006	59.7	56.8	53.1
2005	68.8	66.4	61.5
2004	66.8	64.6	61.4
2003	62.2	61.4	58.6
2002	58.4	56.9	52.3
2001	55.4	53.6	53.0
2000	51.5	N/A	N/A
1999	39.0	N/A	N/A

CONTROLLING HIGH BLOOD PRESSURE

Commercial, Medicare and Medicaid HMO Means



CHOLESTEROL MANAGEMENT FOR PATIENTS WITH CARDIOVASCULAR CONDITIONS

For over 85 years, heart disease has ranked as the top cause of death in the United States.[1] Every day, as many as 2,400 people die of cardiovascular or heart-related events. [2] Nearly 1 in 3 American adults has some form of cardiovascular disease, including coronary heart disease, congenital heart defects, high blood pressure, heart failure and stroke.[2] High cholesterol is a major risk factor for cardiovascular disease, particularly coronary heart disease.[3] Screening and managing cholesterol in patients with cardiovascular conditions is extremely important and prevents coronary heart disease and other cardiovascular disease.

About Cholesterol Management for Patients With Cardiovascular Conditions

- Reductions in LDL-C (or "bad" cholesterol) levels have been shown to lower the occurrence of cardiovascular events.[4]
- Therapy to lower LDL cholesterol levels in patients with coronary heart disease—ranging from low-fat diet plans to drug therapy—significantly reduces the risk that those patients will have further heart events or suffer a stroke.[5]

Measure Definition

These measures assess the percentage of patients 18–75 years of age who were discharged for acute myocardial infarction (heart attack), coronary artery bypass surgery or percutaneous transluminal coronary angioplasty, or who had a diagnosis of ischemic vascular disease. One measure numerator is patients who received an LDL-C screening; the other numerator is patients whose LDL-C level was controlled to <100 mg/dL.

The Case for Improvement

- In 2009, the estimated total cost of cardiovascular disease was 475.3 billion.[2] Heart disease is projected to cost more than $316.4 billion in 2010, including health care services, medications and lost productivity.[6]
- When combined with lifestyle changes, aggressive cholesterol-lowering statin therapies can lower total cholesterol levels after a cardiac event and decrease the chance of future events.[7]
- A high cholesterol level, like high blood pressure, is usually asymptomatic. Before being told by a physician that they have one or more risk factors, most adults think they meet the criteria for ideal heart health.[9]

SCREENING RATE HMO Means			
YEAR	COMMERCIAL	MEDICARE	MEDICAID
2009	88.4	88.4	80.7
2008	88.9	88.6	79.6
2007	88.2	87.9	76.3
2006	87.5	88.0	75.5

CONTROL RATE HMO Means			
YEAR	COMMERCIAL	MEDICARE	MEDICAID
2009	59.2	55.7	41.2
2008	59.7	56.7	40.1
2007	58.7	55.9	38.3
2006	56.6	56.0	35.5

DISEASE MODIFYING ANTI-RHEUMATIC THERAPY IN RHEUMATOID ARTHRITIS

Rheumatoid arthritis (RA) is a chronic autoimmune disorder often characterized by progressive joint destruction and damage to muscles, kidneys or other organs.[1] RA affects 1.3 million American adults, and affects more than twice as many women as men.[2,3] Persistent RA is often associated with chronic pain, inflammation, joint and bone damage, weakening of surrounding muscles and tissues and a higher risk of disability and premature mortality.[2-4]

About Disease Modifying Anti-Rheumatic Therapy

- While there is no cure for RA, there are effective treatments that slow disease progression, prevent or delay joint destruction, relieve pain and maintain functional capacity.[2]
- Disease-modifying anti-rheumatic drugs (DMARD) protect joints and delay the disease course, minimizing inflammation and pain and slowing the progression of bone erosion.[3,5]

Measure Definition

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

The Case for Improvement

- According to the Centers for Disease Control and Prevention, nearly 75 percent of people diagnosed with RA experience some remission after treatment.[6]
- In 2003, arthritis and other rheumatic conditions cost the U.S. $80.8 billion in direct costs and $47 billion in indirect costs.[7]
- Costs related to disability and work loss from RA are estimated to be three times higher than direct costs associated with the disease.[8]

TREATMENT RATE
HMO Means

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2009	86.4	72.3	70.5
2008	85.7	70.4	69.4
2007	85.3	68.7	68.1
2006	84.8	68.2	67.6

USE OF APPROPRIATE MEDICATIONS FOR PEOPLE WITH ASTHMA

Asthma is one of the nation's most costly and high-impact diseases. It has become increasingly common over the past two decades. Approximately 34.1 million Americans have been diagnosed with asthma[1] and each year nearly 5,000 Americans die of it. Many asthma-related deaths, hospitalizations, emergency room visits and missed work and school days could be avoided if patients had appropriate medications and medical management.[2,3] Medications help reduce underlying airway inflammation and relieve or prevent airway narrowing.

About Appropriate Medications for People With Asthma

- In 2006, 1.7 million emergency department visits were attributed to asthma.[2]
- The number of people with asthma in the U.S. is predicted to be more than 100 million by 2025.[4]
- A 45 percent reduction in the risk of repeat emergency department visits has been shown in patients using inhaled corticosteroid treatment.[3]

Measure Definition

This measure estimates the percentage of members 5–50 years of age during the measurement year who were identified as having persistent asthma and who were prescribed recommended medication during the measurement year.

The Case for Improvement

- The annual economic cost of asthma is $20.7 billion. Direct costs, including prescriptions, make up $15.6 billion of that total, and indirect costs such as lost productivity add another $5.1 billion.[2]
- Among children 5–17 years of age, asthma is a leading cause of school absences, accounting for an annual loss of more than 14 million school days.[3]
- Asthma is the cause of an estimated 14.2 million lost workdays for adults.[3]

TREATMENT RATE (5–11 YEARS)
HMO Means

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2009	96.6	N/A	91.8

TREATMENT RATE (12–50 YEARS)
HMO Means

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2009	91.4	N/A	86.0

TREATMENT RATE (OVERALL)
HMO Means

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2009	92.7	N/A	88.6
2008	92.4	N/A	88.7
2007	92.3	N/A	86.9
2006	91.6	N/A	87.1
2005	89.9	N/A	85.7
2004	72.9	N/A	64.5
2003	71.4	N/A	64.1
2002	67.9	N/A	62.5
2001	65.6	N/A	60.1
2000	62.6	N/A	N/A
1999	57.7	N/A	N/A

USE OF SPIROMETRY TESTING IN THE ASSESSMENT AND DIAGNOSIS OF COPD

Chronic obstructive pulmonary disease (COPD) is a group of diseases that includes chronic bronchitis and emphysema. It develops gradually and obstructs airway passages in the lungs.[1] Smoking and environmental pollution and toxins are the most common causes of COPD, although there is a hereditary component, as well. After heart disease, cancer and stroke, COPD is the fourth leading cause of death and disability in the United States and is projected to be the third largest disease burden in the world by 2020.[2,3] More than 12 million people in the U.S have been diagnosed with COPD—another 12 million are not aware they have the disease.[2]

About Spirometry in the Assessment and Diagnosis of COPD

- Spirometry is a test that measures the amount and speed at which a person can exhale after a deep breath.[4] Symptomatic and asymptomatic patients suspected of having COPD should have spirometry performed to determine airway limitation and disease severity.[5]
- Spirometry is the gold standard for diagnosing COPD because it is the most standardized and reproducible measurement of airflow limitation.[6]
- Only one in three patients newly diagnosed with COPD receives a spirometry-based screening.[7]

Measure Definition

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

The Case for Improvement

- In 2000, COPD was responsible for 726,000 hospitalizations, nearly 2 million emergency department encounters and 119,000 deaths. In addition, about 8 million hospital or general physician outpatient treatments were linked to COPD.[8]
- Annual health care costs for COPD are nearly $6,000 per patient.[9]
- Spirometry is a relatively simple and inexpensive procedure that can usually be performed in a doctor's office.[10]

- Early detection of COPD can improve health outcomes by establishing effective treatment and disease management, such as prioritizing administration of flu and pneumonia vaccines.[11]

SPIROMETRY TESTING RATE

HMO Means

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2009	38.8	28.5	28.6
2008	37.6	27.7	29.3
2007	35.7	27.2	28.4
2006	36.1	26.2	27.3

PHARMACOTHERAPY MANAGEMENT OF COPD: BRONCHODILATORS

HMO Means

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2009	78.0	76.2	80.7
2008	76.1	74.1	78.2

PHARMACOTHERAPY MANAGEMENT OF COPD: SYSTEMIC CORTICOSTEROIDS

HMO Means

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2009	66.1	60.9	61.8
2008	67.0	60.0	61.7

ANNUAL MONITORING FOR PATIENTS ON PERSISTENT MEDICATIONS

Over 700,000 Americans visit an emergency room each year due to adverse drug events, or incidents relating to use of a drug. Annually 120,000 patients need to be hospitalized for further treatment after an emergency visit for an adverse drug event.[1] More than a quarter of adverse drug events are preventable. [2]

About Persistent Medications Monitoring

- Approximately 90 percent of people over age 65 take at least one prescription weekly and 40 percent take five or more prescriptions weekly. Over 700,000 Americans visit an emergency room each year due to adverse drug events, or incidents relating to use of a drug. Annually 120,000 patients need to be hospitalized for further treatment after an emergency visit for an adverse drug event.[1] More than a quarter of adverse drug events are preventable.[2] The number of adverse drug reactions increases in direct proportion to the number of medications taken. Safe use of many medications requires careful monitoring of drug toxicity levels or other parameters, yet up to half of patients on persistent medications that require drug monitoring for safe use receive no annual drug monitoring.[3,4]
- Among Americans age 65 and older, 87 percent of hospitalizations from unintentional drug overdose are due to drugs that commonly require outpatient monitoring.[5]

Measure Definition

This measure assesses the percentage of members 18 years and older on persistent medications (at least 180 treatment days ambulatory medication therapy) who received annual monitoring related to the following drugs:

- Angiotensin-converting enzyme (ACE) inhibitors and angiotensin II receptor blockers (ARB)
- Digoxin
- Diuretics
- Anticonvulsants

A combined rate is also reported.

Data for all indicators can be found in Appendix 1.

The Case for Improvement

- An estimated 1.5 million preventable adverse drug events occur within the healthcare system each year. The costs associated with these events total more than $4 billion.[6]
- Medication-related problems cause an estimated 106,000 deaths annually.[7]

ACE INHIBITORS OR ARBS
HMO Means

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2009	80.8	89.6	85.9
2008	79.4	86.7	84.8
2007	77.2	84.8	82.5
2006	74.8	82.7	79.9

ANTICONVULSANTS
HMO Means

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2009	62.0	69.7	68.7
2008	61.7	67.5	68.7
2007	59.6	65.1	65.9
2006	59.4	63.6	63.6

DIGOXIN
HMO Means

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2009	83.6	92.0	88.9
2008	81.9	90.4	88.5
2007	79.7	87.9	84.9
2006	77.3	86.2	83.0

DIURETICS
HMO Means

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2009	80.4	89.8	85.4
2008	79.1	87.1	84.2
2007	76.8	84.8	81.3
2006	74.4	83.0	79.1

COMBINED
HMO Means

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2009	80.3	89.2	83.2
2008	78.9	86.3	82.6
2007	76.6	84.3	80.1
2006	74.3	82.2	77.7

ANTIDEPRESSANT MEDICATION MANAGEMENT

Depression affects nearly 15 million adults in the United States[1] and is estimated to affect nearly a quarter of men and women in their lifetime.[2] Symptoms of depression include appetite and sleep disturbances, anxiety, irritability and decreased concentration.[3] Evidence-based guidelines, including those of the American Psychiatric Association, recommend use of antidepressant medication and behavioral therapies, such as psychotherapy, to treat depression.[4]

About Antidepressant Management

- For the past 50 years, antidepressant medication has proven to be effective—especially for patients with more severe symptoms.[5]
- Among patients who initiate antidepressant treatment, one in three discontinues treatment within one month, before the effect of medication can be assessed, and nearly one in two discontinues treatment within three months.[6]
- Medication maintenance helps ensure that evaluation and improvement continue. More than 50 percent of patients discontinue antidepressant medications during the maintenance phase (i.e., after one month but before six months). Premature discontinuation of treatment is associated with higher rates of depression relapse and major depressive episodes.[7]

Measure Definition

This measure assesses the percentage of members 18 years of age and older who were diagnosed with a new episode of major (more serious) depression, were treated with antidepressant medication and remained on medication for a specified period of time. Two rates are reported.

- *Effective Acute Phase Treatment*: The percentage of newly diagnosed and treated members who remained on an antidepressant medication for at least 84 days (12 weeks).
- *Effective Continuation Phase Treatment*: The percentage of newly diagnosed and treated members who remained on an antidepressant medication for at least 180 days (6 months).

The Case for Improvement

- Depression, emotional disorders and anxiety rank among the top five most costly diseases. The average cost per case is $1,646.[8]
- One study showed that patients who discontinue antidepressant treatment within six months accumulate $432 in higher medical costs per year than adherent patients. In the simplest framework, patients who don't take medications prescribed for depression cannot benefit from those medications.[9]
- Major depression accounts for 48 percent of lost productive time, translating to over $30 billion lost per year.[10]

ACUTE PHASE
HMO Means

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2009	62.9	63.7	49.6
2008	63.1	62.5	48.2
2007	62.9	61.2	42.8
2006	61.1	58.2	42.9
2005	61.3	55.0	45.1
2004	60.9	56.4	46.4
2003	60.7	53.3	46.2
2002	59.8	52.1	47.5
2001	56.9	51.2	45.5
2000	N/A	N/A	N/A
1999	58.8	N/A	N/A

CONTINUATION PHASE
HMO Means

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2009	46.2	50.6	33.0
2008	46.3	49.3	31.8
2007	46.1	48.7	27.4
2006	45.1	45.1	27.5
2005	45.0	41.1	29.7
2004	44.3	42.4	30.4
2003	44.1	39.2	29.3
2002	42.8	37.7	32.4
2001	40.1	36.8	30.0
2000	N/A	N/A	N/A
1999	42.1	N/A	N/A

FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS: 7 DAYS AND 30 DAYS

The burden of mental illness on health and productivity in the United States and throughout the world has long been underestimated and underappreciated.[1] Approximately one quarter of adults suffer from a diagnosable mental disorder in a given year and a substantial proportion suffer from more than one mental disorder at a given time.[1] In the United States, mental illnesses such as depression, bipolar disorder and schizophrenia are significant causes of disability and in some cases death. Appropriate treatment and follow-up can reduce the duration of disability from mental illness and the likelihood of recurrence most especially in the small but severely ill portion of those with mental illness who require hospitalization.[2]

About Mental Illness And Hospitalizations

- Mortality rates, primarily from suicide, are estimated to be 4.2 percent for major clinical depression.[3]
- Appropriate follow-up care helps reduce the risk of repeat hospitalization and identifies patients in need of additional interventions before they reach a crisis point which might require re-hospitalization.[2]
- Half of first-time psychiatric patients were readmitted within two years of hospital discharge.[4]
- The number of days between hospital discharge and follow-up appointment is a significant predictor of non-adherence, independent of mental illness and severity.[5]

Measure Definition

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

The Case for Improvement

- The economic burden of serious mental illness is estimated at $317 billion which includes the cost of health services, loss of earnings and disability benefits.[7]
- In 2008, 30 million adults received treatment for mental health problems.[8]
- Mental illnesses account for more than 15 percent of the overall disease burden in the U.S.[9]

WITHIN 7 DAYS POST-DISCHARGE HMO Means			
YEAR	COMMERCIAL	MEDICARE	MEDICAID
2009	58.7	37.3	42.9
2008	57.2	38.1	42.6
2007	55.6	37.0	42.5
2006	56.7	36.9	39.1
2005	55.8	39.2	39.2
2004	55.9	40.1	38.0
2003	54.4	38.8	37.7
2002	52.7	38.7	37.2
2001	51.3	37.2	33.2
2000	48.2	N/A	N/A
1999	47.4	N/A	N/A

WITHIN 30 DAYS POST-DISCHARGE HMO Means			
YEAR	COMMERCIAL	MEDICARE	MEDICAID
2009	76.8	54.8	60.2
2008	76.1	56.5	61.7
2007	74.0	54.4	61.0
2006	75.8	56.3	57.7
2005	75.9	59.4	56.8
2004	75.9	60.7	54.9
2003	74.4	60.3	56.4
2002	73.6	60.6	56.7
2001	73.2	60.6	52.2
2000	71.2	N/A	N/A
1999	70.1	N/A	N/A

INITIATION AND ENGAGEMENT OF ALCOHOL AND OTHER DRUG DEPENDENCE TREATMENT

Approximately 22.3 million Americans 12 years of age or older are classified as dependent on or abusing alcohol or illicit drugs, or both.[1] The serious consequences of alcohol and drug abuse include increased risk of sudden death, liver cancer, accidents, heart failure and depression, as well as social costs such as increased crime and family and employment issues.[9] Engaging in ongoing treatment—rather than only stabilizing or ceasing substance use—is important for preventing relapse. Individuals who complete treatment or receive more days of treatment typically show more improvement than those who leave care prematurely.[2]

About Alcohol and Other Drug Dependence Treatment

- Among Americans diagnosed with substance dependence or abuse, 70 percent abuse alcohol only, an additional 17 percent abuse illicit drugs only and 14 percent abuse both alcohol and illicit drugs.[1]
- Alcohol abuse accounts for 85,000 deaths annually and is one of the largest preventable causes of death in the United States.[5]
- Frequency and intensity of engagement is important in treatment outcomes and reducing drug-related illnesses.[6]

Measure Definition

This measure assesses care given to adolescent and adult members who were diagnosed with a new episode of alcohol or drug (AOD) dependence, and determines if they received the following care.

Initiation of AOD Treatment: The percentage of people who begin treatment within 14 days of a diagnosis that resulted from an AOD inpatient admission, outpatient visit, intensive outpatient encounter or partial hospitalization.

Engagement of AOD Treatment: The percentage of people who began treatment after an AOD diagnosis and had two or more additional services within 30 days of the initial visit.

The Case for Improvement

- Drug abuse contributes to $500 billion in health care, criminal justice and lost productivity costs.[8]
- For every dollar spent on addiction treatment programs, there is an estimated $4–$7 reduction in the cost of drug-related crimes.[8]
- Nine in 10 people who need treatment for an AOD problem do not receive it in a treatment center.[1]
- Serious drinking often starts in adolescence: approximately 40 percent of alcoholics develop their first symptoms between 15 and 19 years of age.[4]

ENGAGEMENT
HMO Means

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2009	16.1	4.6	12.3
2008	16.2	4.3	12.4
2007	15.2	4.5	14.4
2006	13.8	4.5	11.7
2005	14.1	4.7	9.7
2004	15.5	7.1	11.9

INITIATION
HMO Means

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2009	42.7	46.2	44.3
2008	42.4	45.9	44.5
2007	44.5	50.4	45.6
2006	43.2	50.3	43.3
2005	44.5	50.9	40.7
2004	45.9	52.6	45.7

APPROPRIATE TESTING FOR CHILDREN WITH PHARYNGITIS

Pharyngitis, or sore throat, is common in children and adolescents and can be caused by a virus or bacterial infection.[1,2] Before antibiotics are prescribed, a simple diagnostic test can identify the infection's cause as viral or bacterial in origin. Contrary to popular belief, the severity of the sore throat or presence of fever, are not reliable signs of bacterial versus viral infecton.[3] While antibiotics are effective in treating bacterial pharyngitis (sometimes called "strep throat"), they are not recommended because they are ineffective in treating viral pharyngitis. Reducing inappropriate use of antibiotic prescriptions to treat viral infections has been made a high priority by the American Academy of Pediatrics and the Centers for Disease Control and Prevention.[2,3,4] due to the emergence through overuse of these agents, of bacteria that are resistant to antibiotics.

About Pharyngitis Testing

- Out of the 7.3 million outpatient visits linked to sore throat that occur among children in the United States annually, group A streptococcus (GAS) is directly accountable for 15 percent–36 percent of cases.[7]
- Several surveys examining clinical practices related to pharyngitis have shown that up to 80 percent of physicians follow inappropriate strategies in short and long-term management of pharyngitis.[8] When treating children with pharyngitis, one in three patients do not receive a simple and rapidly useful diagnostic test prior to prescribing antibiotics.[5]

Measure Definition

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

The Case for Improvement

- The emergence of bacteria that are resistant to most (or all) antibiotics have greatly complicated and increased the cost of treating serious bacterial infections in both children and in adults. Resistance to antibiotics emerges much more rapidly with widespread use of antibiotics, Thus use of antibiotics where they are not effective, such in viral pharyngitis not only does no good, but both exposes the child to serious and sometime fatal reactions to antibiotics, but also promotes the more rapid

appearance of "super bugs"—bacteria that are resistant to multiple antibiotics.

- A study conducted in 2005 found that guidelines for clinical evaluation were not followed for 25 percent of children who were diagnosed with pharyngitis and consequently prescribed antibiotics.[5]
- GAS rapid diagnostic tests which are widely available to practitioners could result in a two-thirds reduction of antibiotics consumption for pharyngitis in children.[9]

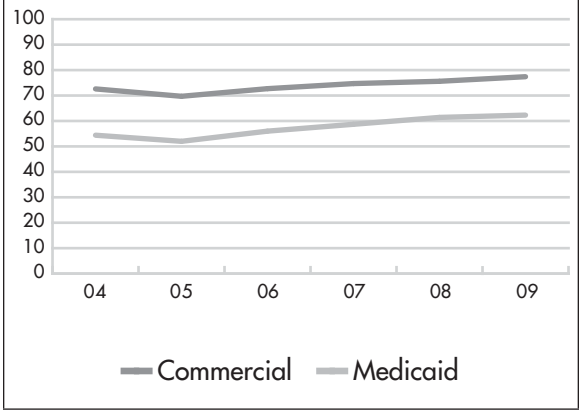
TESTING RATE

HMO Means

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2009	77.4	N/A	62.3
2008	75.6	N/A	61.4
2007	74.7	N/A	58.7
2006	72.7	N/A	56.0
2005	69.7	N/A	52.0
2004	72.6	N/A	54.4

APPROPRIATE TESTING FOR CHILDREN WITH PHARYNGITIS

Commercial and Medicaid HMO Means



APPROPRIATE TREATMENT FOR CHILDREN WITH UPPER RESPIRATORY INFECTION

Every year, Americans suffer an average of 3 upper respiratory infections (URI), or common colds.[1] Colds are especially prevalent among children, whose relative lack of exposure to prior infections and high contact with other children result in an estimated 6–10 colds a year each.[1] The cause of the common cold is nearly always viral, which means that antibiotics are usually ineffective, although they are frequently prescribed.[2]

About Appropriate Treatment for Children With Upper Respiratory Infection

- Studies have found that as many as 22 percent of office visits for the common cold for children under 15 years of age result in an antibiotic prescription.[4]
- While overall levels are still well above optimal, recent data indicate that there is a trend toward fewer prescriptions for broad-spectrum antibiotics (which are critical for use in serious infections in both children and adults).[3]

Measure Definition

This measure estimates the percentage of children 3 months–18 years of age who were diagnosed with a URI and who *did not* receive an antibiotic prescription (higher numbers are better).

The Case for Improvement

- Appropriate treatment for URI decreases the number of individuals at risk for complications arising from the side effects of antibiotics, including fevers, rashes, drug allergies, prolonged hospital stays and death.[5]
- Overuse of antibiotics for viral infections (the most frequent cause of colds and acute bronchitis) causes a more rapid emergence of antibiotic resistance—which results in antibiotics being either less useful in serious, life-threatening infections or of no use at all.
- An estimated $227 million is spent each year on 7.4 million patients for inappropriate treatment of URI.[5]
- The $40 billion annual economic impact of URI exceeds that of other common conditions such as hypertension, COPD, congestive heart failure and asthma.[6]

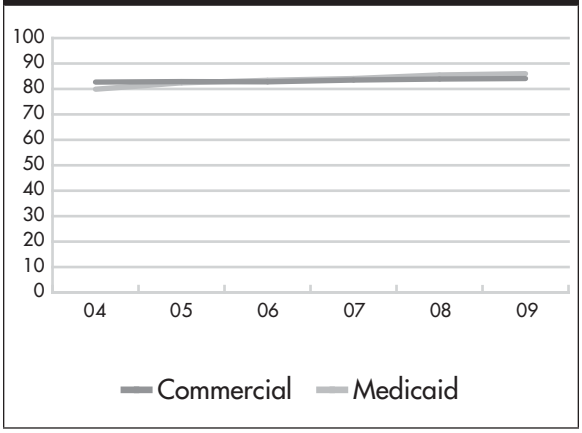
TESTING RATE

HMO Means

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2009	84.1	N/A	86.0
2008	83.9	N/A	85.5
2007	83.5	N/A	84.1
2006	82.8	N/A	83.4
2005	82.9	N/A	82.4
2004	82.7	N/A	79.9

APPROPRIATE TREATMENT FOR CHILDREN WITH UPPER RESPIRATORY INFECTION

Commercial and Medicaid HMO Means



CHILDHOOD IMMUNIZATION STATUS

Immunizations are among the most safe and effective way to protect children from potentially serious diseases. Childhood immunizations reduce the prevalence of many infectious diseases that were once common in the U.S., including polio, measles, diphtheria, pertussis (whooping cough), rubella (German measles), mumps, tetanus and haemophilus influenzae type b (Hib—the leading cause of meningitis).[1] In spite of established guidelines and the well-known benefits of vaccination, in 2007 nearly 25 percent of children 19–35 months of age had not received the recommended immunizations.[2]

About Childhood Immunization

- Approximately 85 percent–95 percent of a population must be immunized for the entire population to be protected from sporadic outbreaks (a phenomena called "herd immunity").[3]
- Vaccine-preventable diseases are costly and can result in doctor's visits, hospitalizations and even premature death. Frequently, there is also the issue of parents' lost time from work when a child is sick.[1]
- Before vaccination became routine, hepatitis B infected 24,000 infants and children each year. It is still all too common.[4]
- Measles is one of the most infectious diseases in the world: more than 90 percent of people who are not immune will get the virus if they are exposed to it.[5]
- The incidence of Hib has declined by 98 percent since the conjugate Hib vaccine was introduced in 1987.[5]
- Unless a disease can be declared as totally eradicated throughout the world—like smallpox—failure to vaccinate could result in outbreaks of diseases like polio or diphtheria.

Measure Definition

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

The Case for Improvement

- Childhood immunizations against DTaP, Hib, IPV, MMR, hepatitis B and chickenpox vaccines have an annual direct cost savings of $9.9 billion and a societal cost savings (including indirect costs, such as time away from work) of $43.3 billion.[6]
- With the introduction of the chickenpox vaccine, the total estimated direct medical expenditures for chickenpox hospitalizations and ambulatory visits declined by 74 percent from 1994–2002, from an average of $84.9 million to $22.1 million.[6]
- Pediatric vaccines are responsible for preventing 10.5 million diseases per birth cohort in the U.S. and are a cost-effective preventive measure. For every dollar spent on immunizations, as much as $29 can be saved in direct and indirect costs.[7]

DTAP/DT
HMO Means

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2009	85.4	N/A	79.6
2008	87.2	N/A	78.6
2007	86.9	N/A	77.8
2006	87.2	N/A	79.3
2005	86.1	N/A	76.9
2004	85.9	N/A	75.6
2003	84.3	N/A	72.6
2002	80.1	N/A	69.4
2001	81.5	N/A	71.2
2000	80.4	N/A	N/A
1999	78.7	N/A	N/A

HEPATITIS B
HMO Means

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2009	90.1	N/A	89.1
2008	91.8	N/A	88.3
2007	91.3	N/A	87.2
2006	91.0	N/A	88.4
2005	90.0	N/A	85.4
2004	87.2	N/A	81.9
2003	85.8	N/A	79.5
2002	81.9	N/A	76.2
2001	79.9	N/A	75.4
2000	77.9	N/A	N/A
1999	75.5	N/A	N/A

HIB
HMO Means

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2009	94.8	N/A	93.7
2008	94.8	N/A	93.4
2007	93.1	N/A	87.7
2006	93.4	N/A	89.1
2005	92.9	N/A	86.8
2004	87.7	N/A	79.1
2003	86.1	N/A	77.7
2002	83.2	N/A	73.8
2001	83.4	N/A	74.9
2000	82.7	N/A	N/A
1999	80.7	N/A	N/A

MMR
HMO Means

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2009	90.6	N/A	91.2
2008	93.5	N/A	90.9
2007	93.5	N/A	90.4
2006	93.6	N/A	91.1
2005	93.0	N/A	89.6
2004	92.3	N/A	88.1
2003	91.5	N/A	87.4
2002	90.1	N/A	84.4
2001	89.4	N/A	83.7
2000	88.4	N/A	N/A
1999	87.0	N/A	N/A

IPV
HMO Means

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2009	91.1	N/A	89.0
2008	92.1	N/A	87.9
2007	91.5	N/A	87.3
2006	91.4	N/A	87.9
2005	90.3	N/A	84.7
2004	90.1	N/A	84.8
2003	88.7	N/A	83.1
2002	86.0	N/A	80.3
2001	85.4	N/A	79.1
2000	84.2	N/A	N/A
1999	82.6	N/A	N/A

PNEUMOCOCCAL CONJUGATE (PCV)
HMO Means

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2009	84.6	N/A	77.6
2008	84.8	N/A	75.6
2007	83.6	N/A	73.8
2006	72.8	N/A	68.3

VZV
HMO Means

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2009	90.6	N/A	90.6
2008	92.0	N/A	89.7
2007	91.9	N/A	88.7
2006	90.9	N/A	88.9
2005	89.9	N/A	86.6
2004	87.5	N/A	84.7
2003	85.7	N/A	81.8
2002	82.0	N/A	76.4
2001	75.3	N/A	73.6
2000	70.5	N/A	N/A
1999	63.8	N/A	N/A

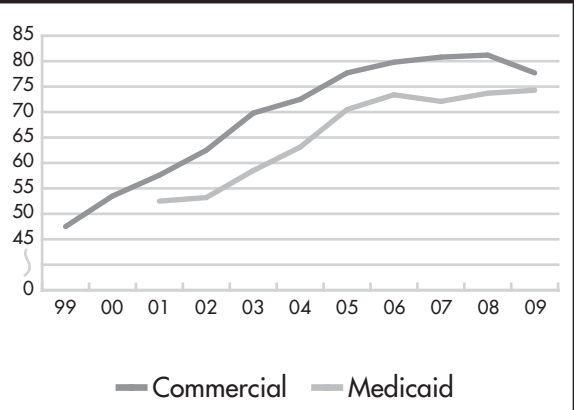
COMBINATION 2
HMO Means

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2009	77.7	N/A	74.3
2008	81.2	N/A	73.7
2007	80.8	N/A	72.1
2006	79.8	N/A	73.4
2005	77.7	N/A	70.5
2004	72.5	N/A	63.1
2003	69.8	N/A	58.5
2002	62.5	N/A	53.2
2001	57.6	N/A	52.5
2000	53.5	N/A	N/A
1999	47.5	N/A	N/A

COMBINATION 3
HMO Means

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2009	73.4	N/A	69.4
2008	76.6	N/A	67.6
2007	75.5	N/A	65.4
2006	65.7	N/A	60.9

COMBINATION 2
Commercial and Medicaid HMO Means



FOLLOW-UP CARE FOR CHILDREN PRESCRIBED ADHD MEDICATION

Attention deficit/hyperactivity disorder (ADHD) is the most commonly treated childhood neurobehavioral disorder.[1] It has been diagnosed in approximately 3 to 7 percent of school-aged children; male children are twice as likely to have ADHD as female children. There has been concern about the over-diagnosis of ADHD and subsequent overuse of medications with possibly harmful side effects; since 2006, the diagnosis of ADHD has annually increased by 3 percent. However, researchers believe that much of the increased use of stimulants reflects better diagnosis and more effective treatment as well.[2] Given the high prevalence of ADHD among school-aged children, primary care clinicians will encounter children with ADHD in their practices regularly and should have strategies for diagnosing and managing this condition. There is also very strong support for careful monitoring and follow-up of children who are placed on medications for ADHD, since as noted, most of these medications can cause serious side effects.[3]

About Follow-Up Care for Children Prescribed ADHD Medication

- In 2005, approximately 4.4 percent of American children used ADHD medication.[4,5]
- The main treatments for a child diagnosed with ADHD include medications along with strategies that affect the child's behavior, such as parenting techniques and interventions in the child's educational setting.[6]
- A good treatment plan will require close follow-up and monitoring, particularly for children prescribed stimulants. Doctors may make adjustments to ensure that children receive individualized care.

Measure Definition

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

- *Initiation Phase*: The percentage of children 6 to 12 years of age diagnosed with ADHD who had one follow-up visit with a practitioner within a month of the first prescription of ADHD medication.
- *Continuation and Maintenance 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 nine months subsequent to the Initiation Phase.

The Case for Improvement

- The total estimated cost for treating children with ADHD in the U.S. ranges from $2 to 11 billion.[7]

- Between 70 percent and 90 percent of children respond to at least one ADHD drug treatment.[8]
- It is very important that children prescribed medications in response to ADHD be followed up routinely to assess the impact of the medication.[9]
- Close monitoring is needed to watch for side effects from prescription drugs, such as a decrease in appetite, weight loss, insomnia, headaches and (more uncommonly) tics and emotional irritability.[10]
- Children with ADHD may experience significant functional problems, such as school difficulties, academic underachievement, troublesome relationships with family members and peers and behavioral problems.[11] Among children with ADHD, those with more follow-up for medication treatment have significantly lower frequency and costs of emergency department visits.[12]
- Children with ADHD use significantly more health services before and after their diagnosis than children without ADHD. Children with ADHD on average cost $488 more in the two years before their ADHD diagnosis, $678 more one year before their diagnosis, $1,328 more the year after their diagnosis and $1,040 more in the second year after their diagnosis.[13]

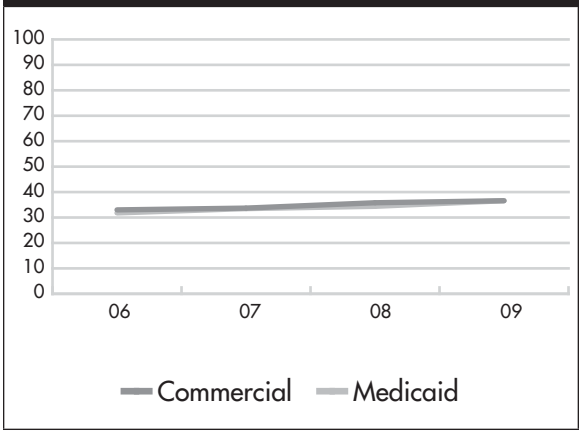
INITIATION
HMO Means

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2009	36.6	N/A	36.6
2008	35.8	N/A	34.4
2007	33.7	N/A	33.5
2006	33.0	N/A	31.8

CONTINUATION
HMO Means

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2009	41.7	N/A	41.7
2008	40.2	N/A	39.5
2007	38.7	N/A	38.9
2006	38.1	N/A	34.0

INITIATION
Commercial and Medicaid HMO Means



LEAD SCREENING IN CHILDREN

Lead poisoning is a chronic, insidious disease that can lead to cognitive impairments and behavioral disorders.[1] Although lead-based paints were banned for use in housing units in 1978, there are approximately 24 million houses with deteriorating leaded paint and elevated levels of lead-contaminated house dust. More than 4 million of these are homes to young children.[2] Approximately 250,000 U.S. children 1–5 years of age have elevated blood lead levels (>10 micrograms of lead per deciliter of blood).[3] Children with elevated blood lead levels have increased all-cause mortality compared with children with lower levels.[4]

About Lead Screening In Children

- The two most common methods of screening children for lead poisoning are venous blood sampling (inserting a needle into a vein) and capillary blood sampling (finger or heel stick). The venous method is more accurate, but capillary screening is often the easiest way to screen young children.[5]
- The capillary screening test can be performed in the physician's office and costs about $6. Lab analysis is less than $20.[6]

Measure Definition

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

The Case for Improvement

- Very high lead exposure can result in serious, long-term neurological conditions or even death.[7] Before the advent of chelation therapy, 28 percent–45 percent of lead-poisoned children who presented with signs or symptoms of lead poisoning died.[7]
- Based on the reduction in lead exposure since the 1970s, the estimated increase in earnings for the cohort of children 2 years of age in 2000 would be between $110 billion and $319 billion over their lifetime.[6]
- Children's blood lead levels have been on the decline, though disparities persist: mean levels continue to be higher for low-income children, non-Hispanic black children and children living in housing built before 1950.[8]

- Both public health (lead abatement) and individual treatments for lead toxicity can be effective in reducing the long-term consequences of lead poisoning.
- Total annual costs of environmental pollutants are estimated to be $54.9 billion. Of this, $43.4 billion is attributable to lead poisoning.[9]

SCREENING RATE
HMO Means

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2009	N/A	N/A	66.4
2008	N/A	N/A	66.7

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

In addition to the risk of diabetes, high blood pressure, and the social stigma of childhood obesity, overweight and obese children and adolescents are far more likely those other children to remain obese, or become obese again later in life.[1,2] National Health and Nutrition Examination Survey data from 1976 to 2009 document an alarming increase in the prevalence of obesity in all age, ethnic and gender groups, but most notably in children.[11] Physical consequences of childhood or adolescent obesity include glucose intolerance and insulin resistance, type 2 diabetes, hypertension, sleep apnea, impaired balance and orthopedic problems.[3] Emotional and social health consequences can include low self-esteem, negative body image, depression and discrimination.[4]

About Weight Assessment and Counseling

- Screening for overweight or obesity begins in the primary care office with the calculation of body mass index (BMI), which is weight in kilograms divided by height in meters squared.
- Interventions to curb unhealthy habits leading to obesity in children can improve long-term health.[5]
- In addition to dietary modification, experts recommend at least 30 minutes of moderate-intensity physical activity and reducing sedentary activities to promote health, psychological well-being, a healthy body weight and to reduce the risk of the early onset of chronic diseases like diabetes and high blood pressure.[6]

Measure Definition

This measure assesses the percentage of children two to 17 years old who had an outpatient visit with a primary care physician or OB/GYN and who had documentation of the BMI percentile, counseling for nutrition and counseling for physical activity during the measurement year. Because BMI norms for youth vary with age and gender, this measure evaluates whether BMI percentile is assessed, rather than absolute BMI value.

The Case for Improvement

- Routine recording of BMI is not regularly documented in children's medical records and few children received a formal diagnosis or any documented treatment.[7]

- About two-thirds of young people in grades 9–12 do not achieve recommended levels of physical activity. Daily participation in physical education classes dropped from 42 percent–33 percent in 1991.[8]

BMI PERCENTILE (OVERALL)
HMO Means

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2009	35.4	N/A	30.3

COUNSELING FOR NUTRITION (OVERALL)
HMO Means

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2009	41.0	N/A	41.9

COUNSELING FOR PHYSICAL ACTIVITY (OVERALL)
HMO Means

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2009	36.5	N/A	32.5

FALL RISK MANAGEMENT

Falling is a serious concern for older persons because of their highly likelihood of falls and their greater susceptibility to injury and death from these falls. Indeed, among persons over 80, falling is the most common cause of nonfatal injuries and hospitalization.[1] More than one-third of adults 65 years of age and older have at least one fall in a given year,[2,3] with the rate of falls increasing with age.[1]

About Fall Risk Management

- Fractures are the most common and most expensive non-fatal fall-related injuries.[4] Approximately 95 percent of hip fractures result from falls.[5] Older persons with conditions that affect balance (impaired hearing and vision, arthritis, neurological conditions etc) have a higher incidence of falls, and those with osteoporosis (bone weakening) have a higher incidence of injury with falls.
- Widely accepted evidenced based guidelines recommend that all older persons who are under the care of a health professional should be asked at least once a year about falls and if falls have occurred, that they receive assessment and advice on how to avoid falls. Older persons who seek medical attention directly for a fall, report multiple falls per year, or demonstrate irregularities of gait and/or balance should receive a fall evaluation. A fall evaluation identifies risk factors related to vision, muscle strength and reflexes—important information for developing a treatment plan.[6]

Measure Definition

The following components of this measure assess different facets of fall risk management:

- *Discussing Fall Risk:* The percentage of Medicare members 75 years of age and older or 65 to 74 years of age with balance or walking problems or a fall in the past 12 months, who were seen by a practitioner in the past 12 months and who discussed falls or problems with balance or walking with their current practitioner.
- *Managing Fall Risk:* The percentage of Medicare members 65 years of age and older who had a fall or had problems with balance or walking in the past 12 months, who were seen by a practitioner in the past 12 months and who received fall risk intervention from their current practitioner.

The Case for Improvement

- Unintentional injuries, such as injuries not resulting from crime, are the fifth leading cause of death in older adults; falls are responsible for two-thirds of deaths resulting from unintentional injuries.[6]

- The average cost of a fall injury for adults 65 years and older was $17,483 in 2004; the average length of a hospital stay for such injuries was seven days.[7] In 2000, the estimated direct medical costs for injuries resulting from falls totaled $19.2 billion.[8] By 2020, the costs is estimated to rise to $54.9 billion.[11]
- 20 percent–30 percent of older adults who fall suffer moderate to severe injuries that may reduce mobility and independence and increase risk of premature death.[9] Falls are a significant factor in 40 percent of admissions to long-term care facilities.[10]

DISCUSSION

HMO Means

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2009	N/A	31.1	N/A
2008	N/A	31.3	N/A
2007	N/A	29.4	N/A
2006	N/A	27.5	N/A

MANAGEMENT

HMO Means

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2009	N/A	57.7	N/A
2008	N/A	57.8	N/A
2007	N/A	55.8	N/A
2006	N/A	56.0	N/A

MEDICATION IN THE ELDERLY

Spending for prescription drugs is concentrated among Americans 65 and older,[1] who are twice as likely as people younger than 65 to experience adverse drug events and almost seven times as likely to be hospitalized from adverse drug events.[2] Even with broad medical consensus that certain drugs increase the risk of harm to the elderly and should be avoided,[3-5] those drugs are often prescribed for this population. More than one in four elderly patients has filled at least one potentially inappropriate prescription, and one in six has filled at least two.[6,7]

Common medication side effects can pose extra risks to elderly people with certain pre-existing conditions and can cause harm that outweighs the benefits of medication. Reducing the use of potentially harmful medications could have a substantial impact on both quality of care and on spending for health care that is actually harmful. Clinical research and guidelines have identified drugs that are inappropriate for elderly populations with specific diagnoses or conditions, and inappropriate for the elderly in general.[3,5]

About Medication Management in the Elderly

- Over 40 percent of serious, life-threatening or fatal adverse drug events in the elderly are seen by experts as potentially preventable.[8]
- About 5 percent of prescriptions filled by the elderly are for drugs classified as "always avoid"; 13 percent are for drugs that would rarely be considered appropriate.[7]
- The elderly are 13 percent of the population but account for 33 percent of all prescription drug expenditures in the U.S.[1] Inappropriate prescription of drugs in older persons has a substantial health and cost impact.
- Inappropriate prescribing is linked to increased risk of harmful side effects; hospitalization; increased length of illness; nursing home placement; and falls and fractures that can cause further physical, functional and social decline.[1,9-11]

Measure Definitions

This measure assesses two different dimensions of medication management in the elderly.

- *Use of High-Risk Medications in the Elderly* assesses the percentage of Medicare members 65 and older who received at least one high-risk medication, and the percentage of Medicare members who received at least two different high-risk medications.

- *Potentially Harmful Drug-Disease Interactions* assesses the percentage of Medicare members 65 and older with evidence of an underlying disease, condition or health concern, who were dispensed an ambulatory prescription for a medication that has been designated as inappropriate or contraindicated for most persons with their specific diagnosis.

A combined rate is also reported. Lower rates represent better performance.

The Case for Improvement

- Studies estimate that between 30 percent and 80 percent of adverse drug events in the elderly are preventable.[12]
- Reducing inappropriate prescriptions can improve patient safety and reduce costs. The extra cost of potentially inappropriate medications prescribed to the elderly averages $7.2 billion annually.[9]
- One study found that 32 percent of patients 65 or older who visit an emergency department were taking at least one potentially inappropriate medication. Among patients discharged with a new prescription, 13 percent were given potentially inappropriate medications.[13]

Potentially Harmful Drug-Disease Interactions in the Elderly

CHRONIC RENAL FAILURE AND NSAIDS OR COX-2 SELECTIVE NSAIDS*

HMO Means

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2009	N/A	11.5	N/A
2008	N/A	11.7	N/A
2007	N/A	10.5	N/A

**Lower rates signify better performance.*

DEMENTIA AND TRICYCLIC ANTIDEPRESSANTS OR ANTICHOLINERGIC AGENTS*

HMO Means

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2009	N/A	28.6	N/A
2008	N/A	28.2	N/A
2007	N/A	27.3	N/A

**Lower rates signify better performance.*

FALLS AND TRICYCLIC ANTIDEPRESSANTS, ANTIPSYCHOTICS, AND SLEEP AGENTS* HMO Means			
YEAR	COMMERCIAL	MEDICARE	MEDICAID
2009	N/A	16.7	N/A
2008	N/A	16.2	N/A
2007	N/A	16.2	N/A

**Lower rates signify better performance.*

OVERALL RATE* HMO Means			
YEAR	COMMERCIAL	MEDICARE	MEDICAID
2009	N/A	23.2	N/A
2008	N/A	23.0	N/A
2007	N/A	21.8	N/A

**Lower rates signify better performance.*

Use of High Risk Medications in the Elderly

AT LEAST ONE MEDICATION* HMO Means			
YEAR	COMMERCIAL	MEDICARE	MEDICAID
2009	N/A	23.0	N/A
2008	N/A	23.4	N/A
2007	N/A	23.2	N/A
2006	N/A	23.1	N/A

**Lower rates signify better performance.*

AT LEAST TWO MEDICATIONS* HMO Means			
YEAR	COMMERCIAL	MEDICARE	MEDICAID
2009	N/A	5.7	N/A
2008	N/A	6.0	N/A
2007	N/A	6.0	N/A
2006	N/A	5.9	N/A

**Lower rates signify better performance.*

MANAGEMENT OF URINARY INCONTINENCE IN OLDER ADULTS

Approximately 5 percent of adult Americans suffer from involuntary leakage of urine, known as urinary incontinence (UI). Although UI is a common, correctable or controllable problem in older persons, it is too often assumed to be an inevitable part of aging.[1,2] UI can be caused or exacerbated by a wide range of conditions in the elderly, including delayed complications of prior pregnancies, irritable bowel syndrome, inflammatory bowel disease, neurologic conditions, impaired mobility, depression and constipation.[4]

About Urinary Incontinence

- Current estimates show that over 20 million women have UI.[4]
- UI is common among women across the adult life span, and its onset and severity increases with age.[5]
- More than a quarter of women 80 years of age and older experience UI, compared with one in five men 65 and older.

Measure Definition

This is a patient survey measure that assesses the diagnosis and management of UI in older adults.

- *Discussing UI:* The percentage of Medicare members 65 years of age and older who report having a urine leakage problem in the past six months and who discussed it with their current doctor or other health care practitioner.
- *Receiving UI Treatment:* The percentage of Medicare members 65 years of age and older who reported having a urine leakage problem in the past six months and who received treatment for their current urine leakage problem.

The Case for Improvement

- The incidence of UI is likely to increase with an aging American population, where comorbid conditions are more prevalent and are associated with incontinence.[4]
- Among elderly women, UI is related to poorer health status, social isolation, depression, decreased physical activity, falls, fractures and nursing home admission.[5,6]

DISCUSSION HMO Means			
YEAR	COMMERCIAL	MEDICARE	MEDICAID
2009	N/A	57.1	N/A
2008	N/A	57.3	N/A
2007	N/A	57.8	N/A
2006	N/A	56.8	N/A
2005	N/A	56.0	N/A

TREATMENT HMO Means			
YEAR	COMMERCIAL	MEDICARE	MEDICAID
2009	N/A	35.5	N/A
2008	N/A	35.4	N/A
2007	N/A	35.4	N/A
2006	N/A	35.3	N/A
2005	N/A	33.3	N/A

PHYSICAL ACTIVITY IN OLDER ADULTS

Older adults can reap great benefits from engaging in physical activity, which can have a major positive effect on their ability to live independently and substantially reduce their risk of falling and fracturing bones.[1] Since most older adults are predominantly sedentary, they generally suffer from at least one chronic condition, for which there is a clinical guideline recommending regular exercise.

About Physical Activity in Older Adults

- Regular physical activity can increase an overall sense of well-being and alleviate the risk of cardiovascular disease, thromboembolic stroke, hypertension, type 2 diabetes, osteoporosis, obesity, colon cancer, breast cancer, anxiety and depression.[2]
- 28 percent–34 percent of adults 65–74 years of age and 35 percent–44 percent of adults 75 or older are inactive, engaging in little or no physical activity. The vast majority of inactivity is not due to health restrictions.[3]
- Only half of the older adults who attended a routine check-up during the previous year reported being asked about physical activity by their health care provider.[4]

Measure Definition

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

- Spoke with a doctor or other health provider about their level of exercise or physical activity
- Received advice to start, increase or maintain their level of exercise or physical activity.

The Case for Improvement

- Physical inactivity is directly associated with both short-term and long-term mortality in the elderly population. Health plans may want to consider investing resources in programs designed to encourage physically active lifestyles in older adults.[5]
- Higher levels of long-term, regular physical activity in the elderly are strongly associated with higher levels of cognitive function and less cognitive decline. The apparent cognitive benefits of greater physical activity are similar to being about

three years younger and are associated with a 20 percent lower risk of cognitive impairment.[6]

- People who are aware of the health benefits of exercise are more likely to become regular exercisers,[7] and research has shown that the mobility and functioning of frail and very old adults can be improved by regular physical activity.[3]

ADVICE

HMO Means

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2009	N/A	46.9	N/A
2008	N/A	47.0	N/A
2007	N/A	46.1	N/A
2006	N/A	45.2	N/A
2005	N/A	43.7	N/A

DISCUSSION

HMO Means

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2009	N/A	51.3	N/A
2008	N/A	51.5	N/A
2007	N/A	51.1	N/A
2006	N/A	50.3	N/A
2005	N/A	50.6	N/A

OSTEOPOROSIS TESTING AND MANAGEMENT

Approximately 10 million Americans have osteoporosis. Another 34 million are estimated to have low bone mass, which places them at increased risk for osteoporosis. 80 percent of Americans with osteoporosis are women. A woman over 50 has a 50 percent chance of having an osteoporosis-related fracture in her lifetime. In 2005, osteoporosis contributed to more than 2 million fractures, including over 500,000 vertebral (neck and back) fractures. Once a woman has one fracture, she is at four times greater risk for another fracture. A bone mineral density test is the most effective method for determining bone health and can identify osteoporosis, determine risk for fractures and assess response to osteoporosis treatment.[1]

About Osteoporosis

- Women lose bone density with age. 44 percent of women 80 and older have detectable bone loss.[2]
- The United States Preventive Services Task Force recommends that osteoporosis screening begin for women at 65, and at 60 for women at increased risk for osteoporotic fractures.[3]
- One in two women and one in four men will have an osteoporosis-related fracture in their lifetime.[4]

Measure Definitions

- *Osteoporosis Testing in Older Women:* This measure assesses the number of Medicare women 65 years of age and older who report ever having received a bone density test to check for osteoporosis.
- *Osteoporosis Management in Women Who Had a Fracture:* 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 a prescription for a drug to treat or prevent osteoporosis in the six months after the fracture. The measure uses the presence of a fracture as a trigger to look for underlying osteoporosis.

The Case for Improvement

- Fractures resulting from low bone mass or osteoporosis cost the health care system more than $10 billion each year.[5]
- Higher rates of bone density testing for women 60–80 years of age correlates to lower fracture rates.[6]
- Although hip fracture rates and subsequent mortality among older adults are declining, comorbidities among patients who suffer from hip fractures are on the rise, indicating that prevention and treatment continue to be vital to osteoporosis management.[7]
- Less than one-third of patients who experience fragility fractures receive acceptable evaluation and treatment for osteoporosis (e.g., bone mineral density testing and advice on vitamin D and calcium intake).[8]
- Therapy that targets osteoporosis has the potential to reduce the risk of fracture by nearly 50 percent.[9]

OSTEOPOROSIS TESTING IN OLDER WOMEN: TESTING RATE

HMO Means

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2009	N/A	68.0	N/A
2008	N/A	66.7	N/A
2007	N/A	65.7	N/A
2006	N/A	64.4	N/A

OSTEOPOROSIS MANAGEMENT IN WOMEN WHO HAD A FRACTURE: TREATMENT RATE

HMO Means

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2009	N/A	20.7	N/A
2008	N/A	20.7	N/A
2007	N/A	20.4	N/A

GLAUCOMA SCREENING IN OLDER ADULTS

Glaucoma is a group of eye diseases resulting in irreversible damage to the nerve that carries information from the eye to the brain (optic nerve).[1] Untreated glaucoma can lead to vision loss and blindness. Because vision loss is gradual and usually painless in the early stages, as many as half of the people with glaucoma don't know they have it.[2] Screening for glaucoma is clinically important because glaucoma-related blindness is largely preventable with early detection and appropriate treatment regimens.[3] In fact, most people with glaucoma are diagnosed through routine eye exams.[3]

Measure Definition

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

The Case for Improvement

- An estimated 6.7 million Americans suffer from blindness due to glaucoma. Glaucoma is the second most common cause of legal blindness in the United States, and is the leading cause of blindness in African Americans.
- Even mild glaucoma hampers driving, mobility and social interactions in the elderly, and visual loss may lead to other problems.[4] For example, states where vision testing is not required for people over 65 have higher ratios of fatal car crashes among the elderly.[5]
- Treating early-stage glaucoma is much less expensive than treating late-stage glaucoma—one study estimates the difference at nearly $2,000 per patient, per year.[6]
- 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.[7]

SCREENING RATE
HMO Means

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2009	N/A	62.3	N/A
2008	N/A	59.8	N/A
2007	N/A	59.5	N/A
2006	N/A	62.2	N/A
2005	N/A	61.5	N/A

CAHPS MEASURES OF CONSUMER EXPERIENCE

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

Rating of Health Plan

Respondents were asked to give their health plan an overall rating, with 0 equaling "worst health plan possible" and 10 equaling "best health plan possible." The tables below represent the percentage of respondents who rated their health plans either 8 or higher, or 9 or higher.

In 2009 the percentage of members who rated their health plan 8, 9 or 10 decreased by 1.6 percentage points for commercial plans and by 2 percentage points for Medicaid plans.

The percentage of members who rated their plan 9 or 10 decreased by 0.8 percentage points for commercial plans and by 3 percentage points for Medicaid plans.

RATING OF 9 OR 10
HMO Means

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2009	38.3	59.0	52.5
2008	39.1	60.7	55.3
2007	37.1	61.1	53.3

Rating of Health Care

In 2009 the percentage of members who rated their health care 8, 9 or 10 decreased by 0.3 percentage points for commercial plans and by 0.9 percentage points for Medicaid plans.

The percentage of members who rated their health care 9 or higher stayed the same for commercial plans and decreased by 1.1 percentage points for Medicaid plans.

RATING OF 9 OR 10 HMO Means			
YEAR	COMMERCIAL	MEDICARE	MEDICAID
2009	48.7	56.2	47.0
2008	48.7	56.2	48.1
2007	47.2	55.9	46.8

Getting Needed Care

The Getting Needed Care composite measures the experience members had in the last 12 months when attempting to get care from doctors and specialists. Members were asked if they were able to:

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

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

ALWAYS HMO Means			
YEAR	COMMERCIAL	MEDICARE	MEDICAID
2009	52.9	63.6	48.5
2008	52.6	62.4	49.4
2007	50.4	62.0	48.7
2006	50.1	62.6	46.7
2005	80.1	95.9	73.4
2004	79.3	95.7	73.8
2003	78.4	94.9	72.1
2002	76.9	94.8	72.3
2001	76.7	94.9	75.4
2000	75.4	N/A	N/A

In 2009 the national average increased by 0.1 percentage points for commercial plans and decreased by 0.7 percentage points for Medicaid plans.

GETTING CARE QUICKLY: ALWAYS
HMO Means

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2009	57.8	64.0	54.7
2008	57.6	63.7	55.7
2007	56.0	63.5	55.6
2006	56.8	65.4	53.4
2005	46.5	58.7	44.5
2004	45.5	58.5	44.2
2003	45.0	57.2	42.6
2002	43.9	55.8	44.1
2001	44.8	60.0	46.5
2000	45.8	N/A	N/A

HOW WELL DOCTORS COMMUNICATE: ALWAYS
HMO Means

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2009	72.0	74.7	67.5
2008	71.1	75.3	68.0
2007	70.2	74.6	67.7
2006	70.3	75.0	66.7
2005	61.3	69.5	61.5
2004	60.2	69.0	60.8
2003	59.4	68.6	59.1
2002	57.7	68.0	59.9
2001	57.1	68.5	60.4
2000	58.4	N/A	N/A

RATING OF PERSONAL DOCTOR: RATING OF 9 OR 10

HMO Means

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2009	63.2	73.3	60.1
2008	63.3	73.6	61.1
2007	62.1	73.6	60.4
2006	62.3	73.8	60.3
2005	52.8	67.8	59.2
2004	51.7	67.5	58.4
2003	51.9	66.4	58.9
2002	49.7	65.2	58.0
2001	50.5	65.8	76.5
2000	48.3	N/A	N/A
1999	47.0	N/A	N/A

RATING OF SPECIALIST: RATING OF 9 OR 10

HMO Means

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2009	61.8	69.3	60.5
2008	62.3	68.9	60.7
2007	61.7	69.2	60.8
2006	60.7	70.7	59.3
2005	57.2	67.7	60.2
2004	56.2	67.5	59.2
2003	55.8	67.7	58.3
2002	54.4	67.7	57.8
2001	54.6	68.5	75.3
2000	53.7	N/A	N/A
1999	51.8	N/A	N/A

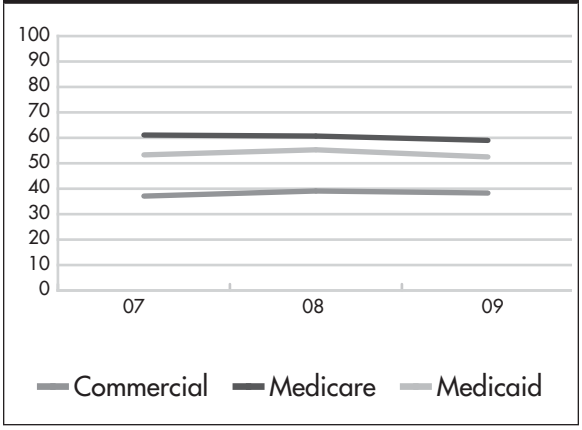
CUSTOMER SERVICE: ALWAYS

HMO Means

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2009	57.9	66.4	57.9
2008	57.2	66.6	59.0
2007	55.4	66.5	57.3
2006	54.2	N/A	49.7
2005	71.2	91.5	68.6
2004	71.0	94.8	69.8
2003	70.8	94.5	69.7
2002	70.4	94.3	67.4
2001	67.2	94.8	67.5
2000	66.6	N/A	N/A
1999	51.8	N/A	N/A

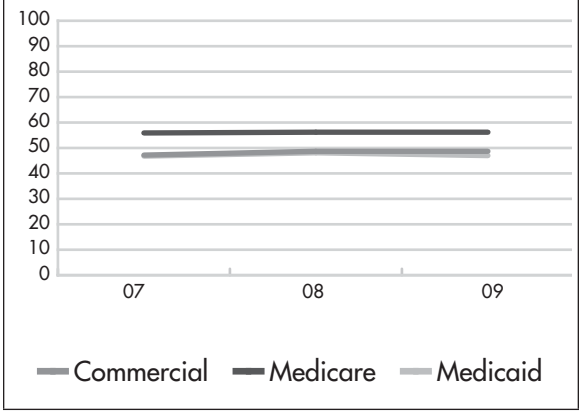
RATING OF HEALTH PLAN: RATING OF 9 OR 10

Commercial, Medicaid and Medicare HMO Means



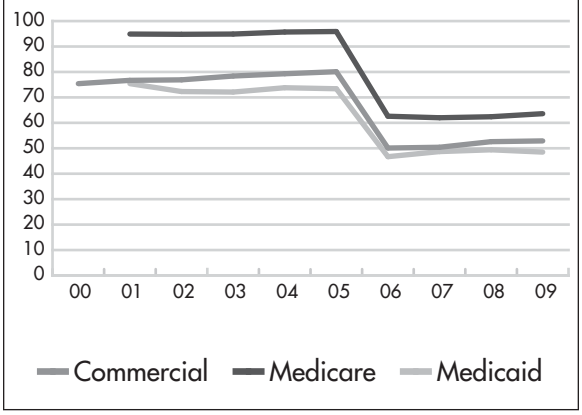
RATING OF HEALTH CARE: RATING OF 9 OR 10

Commercial, Medicaid and Medicare HMO Means



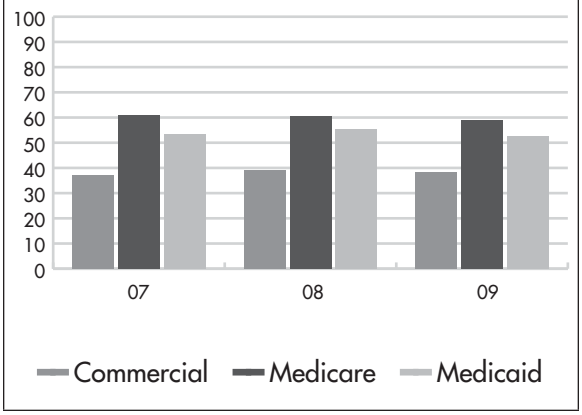
GETTING NEED CARE: ALWAYS

Commercial, Medicaid and Medicare HMO Means



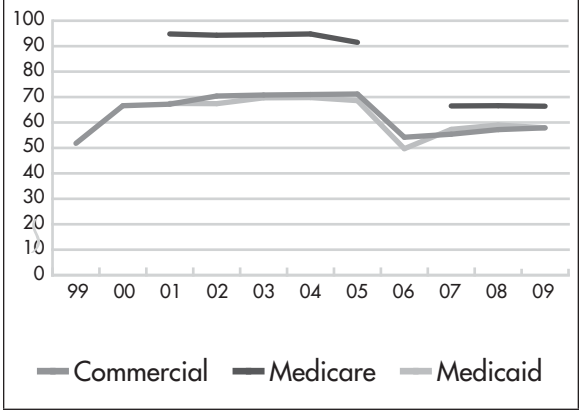
OVERALL EXPERIENCE WITH HEALTH PLAN

Commercial, Medicaid and Medicare HMO Means



CUSTOMER SERVICE: ALWAYS

Commercial, Medicaid and Medicare HMO Means



METHODOLOGY OVERVIEW

General Methods

Data in this report are from HEDIS year 2010, which is measure year 2009 (January 1–December 31, 2009). Unless otherwise noted, all references to "years" in charts and tables are to measure years, not HEDIS years.

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

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

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

Best States

Identification of high-performing state cohorts is based on the state means of five measures: Diabetes (10 indicators), Hypertension (1 indicator), Persistence of Beta-Blockers After a Heart Attack (1 indicator) and Cholesterol Management for Patients With Cardiovascular Conditions (2 indicators).

For each state, the unweighted average of all indicators across all plans in a state is calculated. No distinction is made among plans with respect to product line or reporting type. The composite means are ranked in descending order. The top 10 states compose the "Best" cohort.

In the Diabetes quality composite, the Poor Glycemic Control Indicator is inverted before calculation of the composite so that higher performance is indicated by a higher rate.

Composite Measure Means by Region

This analysis provides mean rates for several composite measures by U.S. Census region. The Childhood Immunizations composite rate comprises the rates for the DTaP/DT, hepatitis B, HIB, IPV, MMR, pneumococcal conjugate and chicken pox vaccines and combinations.

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

All rating summaries reflect ratings of 9 or 10 and all composites correspond to responses of "Always." The Diabetes composite summarizes the mean for the following indicators: Blood Pressure Control (<130/80 mm Hg and <140/90 mm Hg), Eye Exams, HbA1c Screening, Poor Glycemic Control (>9%), LDL Cholesterol Screening, LDL Cholesterol Control (<100 mg/dL) and Medical Attention for Nephropathy.

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

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

Relative Resource Use

Health plans report case mix-adjusted measures of resource use related to five chronic illnesses: asthma, cardiovascular conditions, COPD, diabetes and hypertension. These measures incorporate cost and service frequency for each eligible member during the measurement year. All services administered to members identified with one of these conditions are attributed to the RRU measure for that condition.

Each of the five RRU measures summarizes a health plan's utilization of several service categories:

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

NCQA calculates two observed-to-expected (O/E) ratios for each health plan, one for quality and one for resource use. An O/E ratio is a plan's actual quality level or resource use (the "observed"), divided by an estimate of the quality level or resource use the plan would have if its population was the same as the average population of all other plans submitting data to NCQA (the "expected").

To enable comparison within plan types (HMO or PPO), NCQA indexes O/E ratios by dividing each plan's ratio by the national average O/E for all HMOs or PPOs.

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

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

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

APPENDIX 1: HEDIS EFFECTIVENESS OF CARE MEASURES—2009 NATIONAL HMO MEANS

HEDIS EFFECTIVENESS OF CARE MEASURES NATIONAL HMO MEANS—2009			
MEASURE	COMMERCIAL	MEDICARE	MEDICAID
Safety and Potential Waste			
Imaging Studies for Low Back Pain	73.9	N/A	76.1
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	24.0	N/A	25.6
Wellness and Prevention			
Adult Body Mass Index Assessment	41.3	38.8	34.6
Medical Assistance With Smoking Cessation—Advising Smokers to Quit	79.5	77.9	74.3
Medical Assistance With Smoking Cessation—Discussion of Smoking Cessation Strategies	50.0	N/A	38.8
Medical Assistance With Smoking Cessation—Discussion of Smoking Cessation Medications	53.3	N/A	43.4
Flu Shots for Adults	51.3	64.5	N/A
Prenatal and Postpartum Care—Timeliness of Prenatal Care	93.1	N/A	83.4
Prenatal and Postpartum Care—Postpartum Visit Between 21 and 56 Days After Delivery	83.6	N/A	64.1
Breast Cancer Screening	71.3	69.3	52.4
Cervical Cancer Screening	77.3	N/A	65.8
Colorectal Cancer Screening	60.7	54.9	N/A
Chlamydia Screening—16–20 Years	41.0	N/A	54.4
Chlamydia Screening—21–24 Years	45.4	N/A	61.6
Chlamydia Screening—Total Rate	43.1	N/A	56.7
Chronic Disease Management			
Persistence of Beta-Blocker Treatment After a Heart Attack	74.4	82.6	76.6
Comprehensive Diabetes Care—Blood Pressure Control (<130/80 mm Hg)	33.9	33.3	32.2
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	65.1	60.5	59.8
Comprehensive Diabetes Care—Eye Exams	56.5	63.5	52.7
Comprehensive Diabetes Care—HbA1c Screening	89.2	89.6	80.6
Comprehensive Diabetes Care—Good Glycemic Control (HbA1c <7% for a Selected Population)	42.1	N/A	33.9
Comprehensive Diabetes Care—Good Glycemic Control (HbA1c <8%)	61.6	63.7	45.7
Comprehensive Diabetes Care—Poor Glycemic Control (HbA1c >9%)*	28.2	28.0	44.9
Comprehensive Diabetes Care—LDL Cholesterol Screening	85.0	87.3	74.2
Comprehensive Diabetes Care—LDL Cholesterol Control (<100 mg/dL)	47.0	50.0	33.5
Comprehensive Diabetes Care—Medical Attention for Nephropathy	82.9	88.6	76.9
Controlling High Blood Pressure	64.1	59.8	55.3
Cholesterol Management for Patients With Cardiovascular Conditions—LDL Cholesterol Screening	88.4	88.4	80.7
Cholesterol Management for Patients With Cardiovascular Conditions—LDL Control (<100 mg/dL)	59.2	55.7	41.2
Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis	86.4	72.3	70.5

HEDIS EFFECTIVENESS OF CARE MEASURES
NATIONAL HMO MEANS—2009

MEASURE	COMMERCIAL	MEDICARE	MEDICAID
Use of Appropriate Medications for People With Asthma—5–11 Years	96.6	N/A	91.8
Use of Appropriate Medications for People With Asthma—12–50 Years	91.4	N/A	86.0
Use of Appropriate Medications for People With Asthma—Overall Rate	92.7	N/A	88.6
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	38.8	28.5	28.6
Pharmacotherapy Management of COPD—Bronchodilators	78.0	76.2	80.7
Pharmacotherapy Management of COPD—Systemic Corticosteroids	66.1	60.9	61.8
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	80.8	89.6	85.9
Annual Monitoring for Patients on Persistent Medications—Anticonvulsants	62.0	69.7	68.7
Annual Monitoring for Patients on Persistent Medications—Digoxin	83.6	92.0	88.9
Annual Monitoring for Patients on Persistent Medications—Diuretics	80.4	89.8	85.4
Annual Monitoring for Patients on Persistent Medications—Combined	80.3	89.2	83.2
Antidepressant Medication Management—Acute Phase	62.9	63.7	49.6
Antidepressant Medication Management—Continuation Phase	46.2	50.6	33.0
Follow-Up After Hospitalization for Mental Illness—Within 7 Days Post-Discharge	58.7	37.3	42.9
Follow-Up After Hospitalization for Mental Illness—Within 30 Days Post-Discharge	76.8	54.8	60.2
Alcohol and Other Drug Dependence Treatment—Engagement	16.1	4.6	12.3
Alcohol and Other Drug Dependence Treatment—Initiation	42.7	46.2	44.3
Measures Targeted Toward Children			
Appropriate Testing for Children With Pharyngitis	77.4	N/A	62.3
Appropriate Testing for Children With Upper Respiratory Infection	84.1	N/A	86.0
Childhood Immunization Status—DTaP/DT	85.4	N/A	79.6
Childhood Immunization Status—Hepatitis B	90.1	N/A	89.1
Childhood Immunization Status—HiB	94.8	N/A	93.7
Childhood Immunization Status—IPV	91.1	N/A	89.0
Childhood Immunization Status—MMR	90.6	N/A	91.2
Childhood Immunization Status—Pneumococcal Conjugate (PCV)	84.6	N/A	77.6
Childhood Immunization Status—VZV	90.6	N/A	90.6
Childhood Immunization Status—Combination 2 (DTaP, IPV, MMR, HiB, Hepatitis B and VZV)	77.7	N/A	74.3
Childhood Immunization Status—Combination 3 (DTaP, IPV, MMR, HiB, Hepatitis B, VZV and PCV)	73.4	N/A	69.4
Follow-Up Care for Children Prescribed ADHD Medication—Initiation	36.6	N/A	36.6
Follow-Up Care for Children Prescribed ADHD Medication—Continuation	41.7	N/A	41.7
Lead Screening in Children	N/A	N/A	66.4

HEDIS EFFECTIVENESS OF CARE MEASURES
NATIONAL HMO MEANS—2009

MEASURE	COMMERCIAL	MEDICARE	MEDICAID
Weight Assessment and Counseling for Nutrition and Physical Activity in Children and Adolescents—BMI Percentile (Overall)	35.4	N/A	30.3
Weight Assessment and Counseling for Nutrition and Physical Activity in Children and Adolescents—Counseling for Nutrition (Overall)	41.0	N/A	41.9
Weight Assessment and Counseling for Nutrition and Physical Activity in Children and Adolescents—Counseling for Physical Activity (Overall)	36.5	N/A	32.5
Measures Targeted Toward Older Adults			
Fall Risk Management—Discussion	N/A	31.1	N/A
Fall Risk Management—Management	N/A	57.7	N/A
Potentially Harmful Drug-Disease Interactions in the Elderly—Chronic Renal Failure and NSAIDS or Cox-2 Selective NSAIDS*	N/A	11.5	N/A
Potentially Harmful Drug-Disease Interactions in the Elderly—Dementia and Tricyclic Antidepressants or Anticholinergic Agents*	N/A	28.6	N/A
Potentially Harmful Drug-Disease Interactions in the Elderly—Falls and Tricyclic Antidepressants, Antipsychotics and Sleep Agents*	N/A	16.7	N/A
Potentially Harmful Drug-Disease Interactions in the Elderly—Overall Rate*	N/A	23.2	N/A
Use of High-Risk Medications in the Elderly—At Least One Medication*	N/A	23.0	N/A
Use of High-Risk Medications in the Elderly—At Least Two Medications*	N/A	5.7	N/A
Management of Urinary Incontinence—Discussion	N/A	57.1	N/A
Management of Urinary Incontinence—Treatment	N/A	35.5	N/A
Physical Activity in Older Adults—Advice	N/A	46.9	N/A
Physical Activity in Older Adults—Discussion	N/A	51.3	N/A
Osteoporosis Testing in Older Women	N/A	68.0	N/A
Osteoporosis Management in Women Who Had a Fracture	N/A	20.7	N/A
Glaucoma Screening in Older Adults	N/A	62.3	N/A

**Lower rates signify better performance.*

APPENDIX 2: HEDIS EFFECTIVENESS OF CARE MEASURES—2009 NATIONAL PPO MEANS

HEDIS EFFECTIVENESS OF CARE MEASURES NATIONAL PPO MEANS—2009		
MEASURE	COMMERCIAL	MEDICARE
Safety and Potential Waste		
Imaging Studies for Low Back Pain	72.7	N/A
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	22.6	N/A
Wellness and Prevention		
Adult Body Mass Index Assessment	15.7	24.1
Medical Assistance With Smoking Cessation—Advising Smokers to Quit	72.9	75.2
Medical Assistance With Smoking Cessation—Discussion of Smoking Cessation Strategies	41.1	N/A
Medical Assistance With Smoking Cessation—Discussion of Smoking Cessation Medications	47.3	N/A
Flu Shots for Adults	50.5	65.1
Prenatal and Postpartum Care—Timeliness of Prenatal Care	61.9	N/A
Prenatal and Postpartum Care—Postpartum Visit Between 21 and 56 Days After Delivery	54.1	N/A
Breast Cancer Screening	67.1	65.5
Cervical Cancer Screening	74.6	N/A
Colorectal Cancer Screening	47.0	40.1
Chlamydia Screening—16–20 Years	37.7	N/A
Chlamydia Screening—21–24 Years	41.4	N/A
Chlamydia Screening—Total Rate	39.5	N/A
Chronic Disease Management		
Persistence of Beta-Blocker Treatment After a Heart Attack	69.6	78.9
Comprehensive Diabetes Care—Blood Pressure Control (<130/80 mm Hg)	23.6	26.7
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	46.3	49.0
Comprehensive Diabetes Care—Eye Exams	42.6	59.4
Comprehensive Diabetes Care—HbA1c Screening	83.3	89.3
Comprehensive Diabetes Care—Good Glycemic Control (HbA1c <7% for a Selected Population)	30.3	N/A
Comprehensive Diabetes Care—Good Glycemic Control (HbA1c <8%)	48.0	51.8
Comprehensive Diabetes Care—Poor Glycemic Control (HbA1c >9%)*	44.6	41.3
Comprehensive Diabetes Care—LDL Cholesterol Screening	78.6	85.5
Comprehensive Diabetes Care—LDL Cholesterol Control (<100 mg/dL)	36.8	40.5
Comprehensive Diabetes Care—Medical Attention for Nephropathy	69.9	85.2
Controlling High Blood Pressure	48.3	54.8
Cholesterol Management for Patients With Cardiovascular Conditions—LDL Cholesterol Screening	80.2	86.7
Cholesterol Management for Patients With Cardiovascular Conditions—LDL Control (<100 mg/dL)	42.3	47.2
Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis	86.6	76.4
Use of Appropriate Medications for People With Asthma—5–11 Years	97.0	N/A
Use of Appropriate Medications for People With Asthma—12–50 Years	91.6	N/A

HEDIS EFFECTIVENESS OF CARE MEASURES
NATIONAL PPO MEANS—2009

MEASURE	COMMERCIAL	MEDICARE
Use of Appropriate Medications for People With Asthma—Overall Rate	92.8	N/A
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	36.7	28.8
Pharmacotherapy Management of COPD—Bronchodilators	75.0	74.9
Pharmacotherapy Management of COPD—Systemic Corticosteroids	64.1	64.2
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	77.6	89.8
Annual Monitoring for Patients on Persistent Medications—Anticonvulsants	59.2	68.5
Annual Monitoring for Patients on Persistent Medications—Digoxin	77.9	92.2
Annual Monitoring for Patients on Persistent Medications—Diuretics	77.2	90.3
Annual Monitoring for Patients on Persistent Medications—Combined	77.0	89.7
Antidepressant Medication Management—Acute Phase	63.2	63.4
Antidepressant Medication Management—Continuation Phase	46.4	51.0
Follow-Up After Hospitalization for Mental Illness—Within 7 Days Post-Discharge	52.6	40.6
Follow-Up After Hospitalization for Mental Illness—Within 30 Days Post-Discharge	72.1	60.5
Alcohol and Other Drug Dependence Treatment—Engagement	15.7	4.2
Alcohol and Other Drug Dependence Treatment—Initiation	41.8	57.4
Measures Targeted Toward Children		
Appropriate Testing for Children With Pharyngitis	75.5	N/A
Appropriate Testing for Children With Upper Respiratory Infection	82.5	N/A
Childhood Immunization Status—DTaP/DT	59.9	N/A
Childhood Immunization Status—Hepatitis B	53.7	N/A
Childhood Immunization Status—HiB	74.8	N/A
Childhood Immunization Status—IPV	65.3	N/A
Childhood Immunization Status—MMR	80.5	N/A
Childhood Immunization Status—Pneumococcal Conjugate (PCV)	60.1	N/A
Childhood Immunization Status—VZV	79.7	N/A
Childhood Immunization Status—Combination 2 (DTaP, IPV, MMR, HiB, Hepatitis B and VZV)	43.1	N/A
Childhood Immunization Status—Combination 3 (DTaP, IPV, MMR, HiB, Hepatitis B, VZV and PCV)	40.4	N/A
Follow-Up Care for Children Prescribed ADHD Medication—Initiation	35.4	N/A
Follow-Up Care for Children Prescribed ADHD Medication—Continuation	39.0	N/A
Weight Assessment and Counseling for Nutrition and Physical Activity in Children and Adolescents—BMI Percentile (Overall)	17.4	N/A
Weight Assessment and Counseling for Nutrition and Physical Activity in Children and Adolescents—Counseling for Nutrition (Overall)	20.3	N/A
Weight Assessment and Counseling for Nutrition and Physical Activity in Children and Adolescents—Counseling for Physical Activity (Overall)	17.6	N/A
Measures Targeted Toward Older Adults		

HEDIS EFFECTIVENESS OF CARE MEASURES
NATIONAL PPO MEANS—2009

MEASURE	COMMERCIAL	MEDICARE
Fall Risk Management—Discussion	N/A	30.3
Fall Risk Management—Management	N/A	54.7
Potentially Harmful Drug-Disease Interactions in the Elderly—Chronic Renal Failure and NSAIDS or Cox-2 Selective NSAIDS*	N/A	11.5
Potentially Harmful Drug-Disease Interactions in the Elderly—Dementia and Tricyclic Antidepressants or Anticholinergic Agents*	N/A	27.3
Potentially Harmful Drug-Disease Interactions in the Elderly—Falls and Tricyclic Antidepressants, Antipsychotics and Sleep Agents*	N/A	16.6
Potentially Harmful Drug-Disease Interactions in the Elderly—Overall Rate*	N/A	21.8
Use of High-Risk Medications in the Elderly—At Least One Medication*	N/A	22.3
Use of High-Risk Medications in the Elderly—At Least Two Medications*	N/A	5.3
Management of Urinary Incontinence—Discussion	N/A	58.2
Management of Urinary Incontinence—Treatment	N/A	37.4
Physical Activity in Older Adults—Advice	N/A	47.8
Physical Activity in Older Adults—Discussion	N/A	54.4
Osteoporosis Testing in Older Women	N/A	72.8
Osteoporosis Management in Women Who Had a Fracture	N/A	18.1
Glaucoma Screening in Older Adults	N/A	63.7

**Lower rates signify better performance.*

APPENDIX 3: HEDIS EFFECTIVENESS OF CARE MEASURE—HISTORICAL TRENDS

MONITORING FOR PATIENTS ON PERSISTENT MEDICATIONS

ACE Inhibitors or ARBS: HMO Means

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2009	80.8	89.6	85.9
2008	79.4	86.7	84.8
2007	77.2	84.8	82.5
2006	74.8	82.7	79.9

MONITORING FOR PATIENTS ON PERSISTENT MEDICATIONS

Digoxin: HMO Means

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2009	83.6	92.0	88.9
2008	81.9	90.4	88.5
2007	79.7	87.9	84.9
2006	77.3	86.2	83.0

MONITORING FOR PATIENTS ON PERSISTENT MEDICATIONS

Diuretics: HMO Means

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2009	80.4	89.8	85.4
2008	79.1	87.1	84.2
2007	76.8	84.8	81.3
2006	74.4	83.0	79.1

MONITORING FOR PATIENTS ON PERSISTENT MEDICATIONS

Anticonvulsants: HMO Means

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2009	62.0	69.7	68.7
2008	61.7	67.5	68.7
2007	59.6	65.1	65.9
2006	59.4	63.6	63.6

CHILDHOOD IMMUNIZATION STATUS

Combination 3: HMO Means

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2009	73.4	N/A	69.4
2008	76.6	N/A	67.6
2007	75.5	N/A	65.4
2006	65.7	N/A	60.9

CHILDHOOD IMMUNIZATION STATUS

DTAP/DT: HMO Means

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2009	85.4	N/A	79.6
2008	87.2	N/A	78.6
2007	86.9	N/A	77.8
2006	87.2	N/A	79.3
2005	86.1	N/A	76.9
2004	85.9	N/A	75.6
2003	84.3	N/A	72.6
2002	80.1	N/A	69.4
2001	81.5	N/A	71.2
2000	80.4	N/A	N/A
1999	78.7	N/A	N/A

CHILDHOOD IMMUNIZATION STATUS

Hepatitis B: HMO Means

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2009	90.1	N/A	89.1
2008	91.8	N/A	88.3
2007	91.3	N/A	87.2
2006	91.0	N/A	88.4
2005	90.0	N/A	85.4
2004	87.2	N/A	81.9
2003	85.8	N/A	79.5
2002	81.9	N/A	76.2
2001	79.9	N/A	75.4
2000	77.9	N/A	N/A
1999	75.5	N/A	N/A

CHILDHOOD IMMUNIZATION STATUS
HIB: HMO Means

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2009	94.8	N/A	93.7
2008	94.8	N/A	93.4
2007	93.1	N/A	87.7
2006	93.4	N/A	89.1
2005	92.9	N/A	86.8
2004	87.7	N/A	79.1
2003	86.1	N/A	77.7
2002	83.2	N/A	73.8
2001	83.4	N/A	74.9
2000	82.7	N/A	N/A
1999	80.7	N/A	N/A

CHILDHOOD IMMUNIZATION STATUS
IPV: HMO Means

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2009	91.1	N/A	89.0
2008	92.1	N/A	87.9
2007	91.5	N/A	87.3
2006	91.4	N/A	87.9
2005	90.3	N/A	84.7
2004	90.1	N/A	84.8
2003	88.7	N/A	83.1
2002	86.0	N/A	80.3
2001	85.4	N/A	79.1
2000	84.2	N/A	N/A
1999	82.6	N/A	N/A

CHILDHOOD IMMUNIZATION STATUS
MMR: HMO Means

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2009	90.6	N/A	91.2
2008	93.5	N/A	90.9
2007	93.5	N/A	90.4
2006	93.6	N/A	91.1
2005	93.0	N/A	89.6
2004	92.3	N/A	88.1
2003	91.5	N/A	87.4
2002	90.1	N/A	84.4
2001	89.4	N/A	83.7
2000	88.4	N/A	N/A
1999	87.0	N/A	N/A

CHILDHOOD IMMUNIZATION STATUS
VZV: HMO Means

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2009	90.6	N/A	90.6
2008	92.0	N/A	89.7
2007	91.9	N/A	88.7
2006	90.9	N/A	88.9
2005	89.9	N/A	86.6
2004	87.5	N/A	84.7
2003	85.7	N/A	81.8
2002	82.0	N/A	76.4
2001	75.3	N/A	73.6
2000	70.5	N/A	N/A
1999	63.8	N/A	N/A

CHILDHOOD IMMUNIZATION STATUS
Pneumococcal Conjugate (PCV): HMO Means

YEAR	COMMERCIAL	MEDICARE	MEDICAID
2009	84.6	N/A	77.6
2008	84.8	N/A	75.6
2007	83.6	N/A	73.8
2006	72.8	N/A	68.3

APPENDIX 4A: CAHPS MEMBER SATISFACTION MEASURES—2009 NATIONAL HMO MEANS

CAHPS MEMBER SATISFACTION MEASURES NATIONAL HMO MEANS—2009			
MEASURE	COMMERCIAL	MEDICARE	MEDICAID
Consumer and Patient Engagement and Experience			
Rating of Health Plan—Rating of 8, 9 or 10	62.7	84.4	70.7
Rating of Health Plan—Rating of 9 or 10	38.3	59.0	52.5
Rating of Health Care—Rating of 8, 9 or 10	74.9	84.2	67.3
Rating of Health Care—Rating of 9 or 10	48.7	56.2	47.0
Getting Needed Care—Usually or Always	85.4	89.1	75.0
Getting Needed Care—Always	52.9	63.6	48.5
Getting Care Quickly—Usually or Always	86.4	86.7	79.5
Getting Care Quickly—Always	57.8	64.0	54.7
How Well Doctors Communicate—Usually or Always	93.4	93.5	87.0
How Well Doctors Communicate—Always	72.0	74.7	67.5
Rating of Personal Doctor—Rating of 8, 9 or 10	82.2	92.0	75.6
Rating of Personal Doctor—Rating of 9 or 10	63.2	73.3	60.1
Rating of Specialist—Rating of 8, 9 or 10	80.9	89.8	76.4
Rating of Specialist—Rating of 9 or 10	61.8	69.3	60.5
Customer Service—Usually or Always	84.2	86.5	79.5
Customer Service—Always	57.9	66.4	57.9
Claims Processing—Usually or Always	88.0	N/A	N/A
Claims Processing—Always	54.4	N/A	N/A

APPENDIX 4B: CAHPS MEMBER SATISFACTION MEASURES—2009 NATIONAL PPO MEANS

CAHPS MEMBER SATISFACTION MEASURES NATIONAL PPO MEANS—2009		
MEASURE	COMMERCIAL	MEDICARE
Consumer and Patient Engagement and Experience		
Rating of Health Plan—Rating of 8, 9 or 10	57.3	81.9
Rating of Health Plan—Rating of 9 or 10	32.4	52.2
Rating of Health Care—Rating of 8, 9 or 10	74.3	87.0
Rating of Health Care—Rating of 9 or 10	46.6	57.4
Getting Needed Care—Usually or Always	86.3	91.3
Getting Needed Care—Always	52.7	64.4
Getting Care Quickly—Usually or Always	87.3	88.4
Getting Care Quickly—Always	57.4	64.7
How Well Doctors Communicate—Usually or Always	94.2	94.6
How Well Doctors Communicate—Always	71.7	74.8
Rating of Personal Doctor—Rating of 8, 9 or 10	81.9	93.1
Rating of Personal Doctor—Rating of 9 or 10	61.2	73.9
Rating of Specialist—Rating of 8, 9 or 10	80.9	91.9
Rating of Specialist—Rating of 9 or 10	60.4	70.8
Customer Service—Usually or Always	82.4	N/A
Customer Service—Always	54.5	N/A
Claims Processing—Usually or Always	87.1	N/A
Claims Processing—Always	48.7	N/A

APPENDIX 5A: ACCREDITED VS. NONACCREDITED PLANS—2009 COMMERCIAL HMO MEANS

HEDIS EFFECTIVENESS OF CARE MEASURES ACCREDITED VS. NONACCREDITED PLANS: COMMERCIAL HMO MEANS—2009			
MEASURE	ACCREDITED	NONACCREDITED	DIFFERENCE
Safety and Potential Waste			
Imaging Studies for Low Back Pain	73.9	73.7	0.2
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	23.2	26.9	-3.7
Wellness and Prevention			
Adult Body Mass Index Assessment	41.9	38.4	3.5
Medical Assistance With Smoking Cessation—Advising Smokers to Quit	79.3	80.0	-0.8
Medical Assistance With Smoking Cessation—Discussion of Smoking Cessation Strategies	50.8	47.8	3.1
Medical Assistance With Smoking Cessation—Discussion of Smoking Cessation Medications	52.8	54.3	-1.5
Flu Shots for Adults	50.8	53.3	-2.6
Prenatal and Postpartum Care—Timeliness of Prenatal Care	94.6	87.5	7.1
Prenatal and Postpartum Care—Postpartum Visit Between 21 and 56 Days After Delivery	85.4	76.7	8.7
Breast Cancer Screening	71.6	70.2	1.5
Cervical Cancer Screening	78.0	74.4	3.6
Colorectal Cancer Screening	61.6	57.3	4.3
Chlamydia Screening—16–20 Years	41.8	37.8	4.0
Chlamydia Screening—21–24 Years	46.4	41.7	4.6
Chlamydia Screening—Total Rate	44.0	39.7	4.3
Chronic Disease Management			
Persistence of Beta-Blocker Treatment After a Heart Attack	74.3	75.0	-0.7
Comprehensive Diabetes Care—Blood Pressure Control (<130/80 mm Hg)	34.0	33.1	1.0
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	66.0	61.8	4.2
Comprehensive Diabetes Care—Eye Exams	57.2	53.9	3.3
Comprehensive Diabetes Care—HbA1c Screening	89.6	87.7	1.9
Comprehensive Diabetes Care—Good Glycemic Control (HbA1c <7% for a Selected Population)	42.6	39.8	2.8
Comprehensive Diabetes Care—Good Glycemic Control (HbA1c <8%)	62.3	59.1	3.2
Comprehensive Diabetes Care—Poor Glycemic Control (HbA1c >9%)*	27.4	31.3	-3.9
Comprehensive Diabetes Care—LDL Cholesterol Screening	85.8	82.4	3.4
Comprehensive Diabetes Care—LDL Cholesterol Control (<100 mg/dL)	47.6	44.9	2.7
Comprehensive Diabetes Care—Medical Attention for Nephropathy	83.2	81.9	1.3
Controlling High Blood Pressure	65.2	59.6	5.5
Cholesterol Management for Patients With Cardiovascular Conditions—LDL Cholesterol Screening	89.1	85.9	3.2
Cholesterol Management for Patients With Cardiovascular Conditions—LDL Control (<100 mg/dL)	60.5	53.9	6.6
Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis	86.7	85.2	1.5

HEDIS EFFECTIVENESS OF CARE MEASURES

ACCREDITED VS. NONACCREDITED PLANS: COMMERCIAL HMO MEANS—2009

MEASURE	ACCREDITED	NONACCREDITED	DIFFERENCE
Use of Appropriate Medications for People With Asthma—5–11 Years	96.7	95.9	0.8
Use of Appropriate Medications for People With Asthma—12–50 Years	91.6	90.5	1.1
Use of Appropriate Medications for People With Asthma—Overall Rate	92.9	91.9	1.0
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	39.5	35.9	3.6
Pharmacotherapy Management of COPD—Bronchodilators	78.1	77.1	1.0
Pharmacotherapy Management of COPD—Systemic Corticosteroids	66.4	64.2	2.2
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	80.9	80.4	0.6
Annual Monitoring for Patients on Persistent Medications—Anticonvulsants	61.8	62.7	-0.9
Annual Monitoring for Patients on Persistent Medications—Digoxin	83.7	83.1	0.6
Annual Monitoring for Patients on Persistent Medications—Diuretics	80.5	80.3	0.2
Annual Monitoring for Patients on Persistent Medications—Combined	80.3	79.9	0.4
Antidepressant Medication Management—Acute Phase	62.9	62.9	0.0
Antidepressant Medication Management—Continuation Phase	46.2	46.2	-0.1
Follow-Up After Hospitalization for Mental Illness—Within 7 Days Post-Discharge	61.1	48.8	12.2
Follow-Up After Hospitalization for Mental Illness—Within 30 Days Post-Discharge	78.3	70.5	7.8
Alcohol and Other Drug Dependence Treatment—Engagement	16.5	14.7	1.8
Alcohol and Other Drug Dependence Treatment—Initiation	43.2	40.5	2.6
Measures Targeted Toward Children			
Appropriate Testing for Children With Pharyngitis	78.5	72.8	5.7
Appropriate Testing for Children With Upper Respiratory Infection	84.9	81.2	3.6
Childhood Immunization Status—DTaP/DT	86.9	79.6	7.3
Childhood Immunization Status—Hepatitis B	91.7	83.2	8.5
Childhood Immunization Status—HiB	95.9	90.5	5.4
Childhood Immunization Status—IPV	92.3	86.2	6.1
Childhood Immunization Status—MMR	91.0	89.1	1.9
Childhood Immunization Status—Pneumococcal Conjugate (PCV)	86.0	79.2	6.8
Childhood Immunization Status—VZV	91.1	88.4	2.6
Childhood Immunization Status—Combination 2 (DTaP, IPV, MMR, HiB, Hepatitis B and VZV)	79.3	71.1	8.2
Childhood Immunization Status—Combination 3 (DTaP, IPV, MMR, HiB, Hepatitis B, VZV and PCV)	74.8	67.7	7.1
Follow-Up Care for Children Prescribed ADHD Medication—Initiation	36.8	35.3	1.5
Follow-Up Care for Children Prescribed ADHD Medication—Continuation	42.1	37.9	4.2
Weight Assessment and Counseling for Nutrition and Physical Activity in Children and Adolescents—BMI Percentile (Overall)	36.5	31.0	5.5
Weight Assessment and Counseling for Nutrition and Physical Activity in Children and Adolescents—Counseling for Nutrition (Overall)	43.0	33.0	9.9
Weight Assessment and Counseling for Nutrition and Physical Activity in Children and Adolescents—Counseling for Physical Activity (Overall)	37.9	30.5	7.4

**Lower rates signify better performance.*

APPENDIX 5B: ACCREDITED VS. NONACCREDITED PLANS—2009 COMMERCIAL PPO MEANS

HEDIS EFFECTIVENESS OF CARE MEASURES ACCREDITED VS. NONACCREDITED PLANS: COMMERCIAL PPO MEANS—2009			
MEASURE	ACCREDITED	NONACCREDITED	DIFFERENCE
Safety and Potential Waste			
Imaging Studies for Low Back Pain	72.9	72.6	0.3
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	23.1	22.2	0.9
Wellness and Prevention			
Adult Body Mass Index Assessment	19.9	8.5	11.3
Medical Assistance With Smoking Cessation—Advising Smokers to Quit	72.9	N/A	-
Medical Assistance With Smoking Cessation—Discussion of Smoking Cessation Strategies	41.1	N/A	-
Medical Assistance With Smoking Cessation—Discussion of Smoking Cessation Medications	47.3	N/A	-
Flu Shots for Adults	50.0	50.8	-0.8
Prenatal and Postpartum Care—Timeliness of Prenatal Care	57.0	66.6	-9.7
Prenatal and Postpartum Care—Postpartum Visit Between 21 and 56 Days After Delivery	49.0	59.4	-10.3
Breast Cancer Screening	67.6	66.7	0.9
Cervical Cancer Screening	74.1	75.0	-0.8
Colorectal Cancer Screening	47.6	46.6	1.0
Chlamydia Screening—16–20 Years	37.6	37.7	-0.1
Chlamydia Screening—21–24 Years	41.3	41.4	-0.2
Chlamydia Screening—Total Rate	39.5	39.5	0.0
Chronic Disease Management			
Persistence of Beta-Blocker Treatment After a Heart Attack	70.2	69.1	1.1
Comprehensive Diabetes Care—Blood Pressure Control (<130/80 mm Hg)	26.5	20.1	6.4
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	50.5	41.1	9.4
Comprehensive Diabetes Care—Eye Exams	43.9	41.2	2.7
Comprehensive Diabetes Care—HbA1c Screening	82.8	83.8	-1.1
Comprehensive Diabetes Care—Good Glycemic Control (HbA1c <7% for a Selected Population)	34.5	23.9	10.6
Comprehensive Diabetes Care—Good Glycemic Control (HbA1c <8%)	52.1	43.9	8.2
Comprehensive Diabetes Care—Poor Glycemic Control (HbA1c >9%)*	40.7	49.0	-8.3
Comprehensive Diabetes Care—LDL Cholesterol Screening	78.1	79.1	-1.0
Comprehensive Diabetes Care—LDL Cholesterol Control (<100 mg/dL)	38.8	34.7	4.1
Comprehensive Diabetes Care—Medical Attention for Nephropathy	69.3	70.6	-1.3
Controlling High Blood Pressure	53.9	45.9	8.1
Cholesterol Management for Patients With Cardiovascular Conditions—LDL Cholesterol Screening	79.7	80.6	-1.0
Cholesterol Management for Patients With Cardiovascular Conditions—LDL Control (<100 mg/dL)	47.0	37.6	9.4
Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis	86.2	86.9	-0.8

HEDIS EFFECTIVENESS OF CARE MEASURES

ACCREDITED VS. NONACCREDITED PLANS: COMMERCIAL PPO MEANS—2009

MEASURE	ACCREDITED	NONACCREDITED	DIFFERENCE
Use of Appropriate Medications for People With Asthma—5–11 Years	96.8	97.1	-0.3
Use of Appropriate Medications for People With Asthma—12–50 Years	91.3	91.7	-0.4
Use of Appropriate Medications for People With Asthma—Overall Rate	92.6	92.9	-0.4
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	35.8	37.4	-1.6
Pharmacotherapy Management of COPD—Bronchodilators	74.8	75.1	-0.2
Pharmacotherapy Management of COPD—Systemic Corticosteroids	63.2	65.0	-1.8
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	76.8	78.2	-1.5
Annual Monitoring for Patients on Persistent Medications—Anticonvulsants	58.8	59.5	-0.7
Annual Monitoring for Patients on Persistent Medications—Digoxin	77.3	78.4	-1.2
Annual Monitoring for Patients on Persistent Medications—Diuretics	76.3	77.9	-1.5
Annual Monitoring for Patients on Persistent Medications—Combined	76.1	77.6	-1.5
Antidepressant Medication Management—Acute Phase	62.7	63.6	-0.9
Antidepressant Medication Management—Continuation Phase	46.0	46.7	-0.6
Follow-Up After Hospitalization for Mental Illness—Within 7 Days Post-Discharge	58.0	48.9	9.1
Follow-Up After Hospitalization for Mental Illness—Within 30 Days Post-Discharge	74.9	70.2	4.7
Alcohol and Other Drug Dependence Treatment—Engagement	14.7	16.3	-1.6
Alcohol and Other Drug Dependence Treatment—Initiation	42.5	41.3	1.3
Measures Targeted Toward Children			
Appropriate Testing for Children With Pharyngitis	75.3	75.6	-0.3
Appropriate Testing for Children With Upper Respiratory Infection	82.2	82.7	-0.5
Childhood Immunization Status—DTaP/DT	58.4	61.5	-3.2
Childhood Immunization Status—Hepatitis B	49.2	58.7	-9.5
Childhood Immunization Status—HiB	73.5	76.1	-2.6
Childhood Immunization Status—IPV	63.7	67.0	-3.3
Childhood Immunization Status—MMR	80.0	81.2	-1.2
Childhood Immunization Status—Pneumococcal Conjugate (PCV)	58.8	61.6	-2.8
Childhood Immunization Status—VZV	78.4	81.1	-2.7
Childhood Immunization Status—Combination 2 (DTaP, IPV, MMR, HiB, Hepatitis B and VZV)	38.8	47.9	-9.1
Childhood Immunization Status—Combination 3 (DTaP, IPV, MMR, HiB, Hepatitis B, VZV and PCV)	36.3	45.0	-8.7
Follow-Up Care for Children Prescribed ADHD Medication—Initiation	36.2	34.8	1.3
Follow-Up Care for Children Prescribed ADHD Medication—Continuation	40.4	37.9	2.5
Weight Assessment and Counseling for Nutrition and Physical Activity in Children and Adolescents—BMI Percentile (Overall)	20.5	11.0	9.6
Weight Assessment and Counseling for Nutrition and Physical Activity in Children and Adolescents—Counseling for Nutrition (Overall)	22.4	15.9	6.5
Weight Assessment and Counseling for Nutrition and Physical Activity in Children and Adolescents—Counseling for Physical Activity (Overall)	20.0	12.9	7.1

**Lower rates signify better performance.*

APPENDIX 6: ACCREDITED VS. NONACCREDITED PLANS—2009 MEDICAID HMO MEANS

HEDIS EFFECTIVENESS OF CARE MEASURES ACCREDITED VS. NONACCREDITED PLANS: MEDICAID HMO MEANS—2009			
MEASURE	ACCREDITED	NONACCREDITED	DIFFERENCE
Safety and Potential Waste			
Imaging Studies for Low Back Pain	75.5	76.8	-1.3
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	23.3	27.8	-4.4
Wellness and Prevention			
Adult Body Mass Index Assessment	39.9	26.4	13.6
Medical Assistance With Smoking Cessation—Advising Smokers to Quit	75.2	73.1	2.0
Medical Assistance With Smoking Cessation—Discussion of Smoking Cessation Strategies	40.4	36.8	3.6
Medical Assistance With Smoking Cessation—Discussion of Smoking Cessation Medications	45.8	40.3	5.6
Prenatal and Postpartum Care—Timeliness of Prenatal Care	85.8	81.5	4.3
Prenatal and Postpartum Care—Postpartum Visit Between 21 and 56 Days After Delivery	65.8	62.9	2.9
Breast Cancer Screening	53.8	51.2	2.6
Cervical Cancer Screening	68.9	63.3	5.6
Chlamydia Screening—16–20 Years	55.6	53.3	2.3
Chlamydia Screening—21–24 Years	62.7	60.6	2.1
Chlamydia Screening—Total Rate	57.9	55.7	2.2
Chronic Disease Management			
Persistence of Beta-Blocker Treatment After a Heart Attack	77.2	75.3	1.9
Comprehensive Diabetes Care—Blood Pressure Control (<130/80 mm Hg)	34.2	30.4	3.8
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	62.3	57.8	4.5
Comprehensive Diabetes Care—Eye Exams	56.1	50.2	5.9
Comprehensive Diabetes Care—HbA1c Screening	83.2	78.8	4.4
Comprehensive Diabetes Care—Good Glycemic Control (HbA1c <7% for a Selected Population)	36.8	30.9	5.9
Comprehensive Diabetes Care—Good Glycemic Control (HbA1c <8%)	49.2	43.1	6.1
Comprehensive Diabetes Care—Poor Glycemic Control (HbA1c >9%)*	39.5	48.8	-9.3
Comprehensive Diabetes Care—LDL Cholesterol Screening	77.1	72.1	5.0
Comprehensive Diabetes Care—LDL Cholesterol Control (<100 mg/dL)	36.7	31.1	5.6
Comprehensive Diabetes Care—Medical Attention for Nephropathy	79.6	75.0	4.6
Controlling High Blood Pressure	59.3	50.8	8.6
Cholesterol Management for Patients With Cardiovascular Conditions—LDL Cholesterol Screening	82.5	78.1	4.4
Cholesterol Management for Patients With Cardiovascular Conditions—LDL Control (<100 mg/dL)	45.2	35.6	9.7
Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis	71.4	69.0	2.4
Use of Appropriate Medications for People With Asthma—5–11 Years	91.9	91.7	0.3
Use of Appropriate Medications for People With Asthma—12–50 Years	86.0	86.0	0.0

HEDIS EFFECTIVENESS OF CARE MEASURES

ACCREDITED VS. NONACCREDITED PLANS: MEDICAID HMO MEANS—2009

MEASURE	ACCREDITED	NONACCREDITED	DIFFERENCE
Use of Appropriate Medications for People With Asthma—Overall Rate	88.4	88.7	-0.2
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	28.3	29.2	-0.9
Pharmacotherapy Management of COPD—Bronchodilators	81.9	79.0	2.9
Pharmacotherapy Management of COPD—Systemic Corticosteroids	62.0	61.5	0.4
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	86.6	85.2	1.4
Annual Monitoring for Patients on Persistent Medications—Anticonvulsants	69.6	67.7	1.9
Annual Monitoring for Patients on Persistent Medications—Digoxin	88.7	89.3	-0.6
Annual Monitoring for Patients on Persistent Medications—Diuretics	86.0	84.9	1.1
Annual Monitoring for Patients on Persistent Medications—Combined	83.7	82.7	1.0
Antidepressant Medication Management—Acute Phase	51.0	48.6	2.5
Antidepressant Medication Management—Continuation Phase	34.2	32.0	2.3
Follow-Up After Hospitalization for Mental Illness—Within 7 Days Post-Discharge	46.7	39.8	7.0
Follow-Up After Hospitalization for Mental Illness—Within 30 Days Post-Discharge	63.7	57.3	6.4
Alcohol and Other Drug Dependence Treatment—Engagement	15.3	9.8	5.5
Alcohol and Other Drug Dependence Treatment—Initiation	47.3	41.8	5.5
Measures Targeted Toward Children			
Appropriate Testing for Children With Pharyngitis	62.8	61.8	1.0
Appropriate Testing for Children With Upper Respiratory Infection	85.3	86.6	-1.3
Childhood Immunization Status—DTaP/DT	81.8	77.9	3.9
Childhood Immunization Status—Hepatitis B	91.7	87.1	4.6
Childhood Immunization Status—HiB	95.0	92.8	2.3
Childhood Immunization Status—IPV	91.2	87.4	3.8
Childhood Immunization Status—MMR	91.7	90.8	1.0
Childhood Immunization Status—Pneumococcal Conjugate (PCV)	80.2	75.7	4.4
Childhood Immunization Status—VZV	91.4	90.0	1.4
Childhood Immunization Status—Combination 2 (DTaP, IPV, MMR, HiB, Hepatitis B and VZV)	77.4	71.7	5.7
Childhood Immunization Status—Combination 3 (DTaP, IPV, MMR, HiB, Hepatitis B, VZV and PCV)	72.7	66.9	5.7
Follow-Up Care for Children Prescribed ADHD Medication—Initiation	37.0	36.1	0.9
Follow-Up Care for Children Prescribed ADHD Medication—Continuation	41.2	42.3	-1.1
Lead Screening in Children	70.0	63.1	6.9
Weight Assessment and Counseling for Nutrition and Physical Activity in Children and Adolescents—BMI Percentile (Overall)	32.2	28.6	3.6
Weight Assessment and Counseling for Nutrition and Physical Activity in Children and Adolescents—Counseling for Nutrition (Overall)	45.3	38.9	6.4
Weight Assessment and Counseling for Nutrition and Physical Activity in Children and Adolescents—Counseling for Physical Activity (Overall)	35.3	30.0	5.3

**Lower rates signify better performance.*

APPENDIX 7A: ACCREDITED VS. NONACCREDITED PLANS—2009 MEDICARE HMO MEANS

HEDIS EFFECTIVENESS OF CARE MEASURES ACCREDITED VS. NONACCREDITED PLANS: MEDICARE HMO MEANS—2009			
MEASURE	ACCREDITED	NONACCREDITED	DIFFERENCE
Wellness and Prevention			
Adult Body Mass Index Assessment	46.2	35.0	11.2
Medical Assistance With Smoking Cessation—Advising Smokers to Quit	78.2	77.8	0.4
Flu Shots for Adults	68.5	62.5	6.0
Breast Cancer Screening	73.0	67.4	5.6
Colorectal Cancer Screening	64.5	50.0	14.4
Chronic Disease Management			
Persistence of Beta-Blocker Treatment After a Heart Attack	84.1	81.3	2.8
Comprehensive Diabetes Care—Blood Pressure Control (<130/80 mm Hg)	35.8	32.0	3.8
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	64.8	58.3	6.5
Comprehensive Diabetes Care—Eye Exams	70.8	59.9	10.9
Comprehensive Diabetes Care—HbA1c Screening	92.2	88.4	3.8
Comprehensive Diabetes Care—Good Glycemic Control (HbA1c <8%)	72.1	59.5	12.6
Comprehensive Diabetes Care—Poor Glycemic Control (HbA1c >9%)*	19.1	32.4	-13.3
Comprehensive Diabetes Care—LDL Cholesterol Screening	90.1	85.9	4.2
Comprehensive Diabetes Care—LDL Cholesterol Control (<100 mg/dL)	58.3	45.9	12.4
Comprehensive Diabetes Care—Medical Attention for Nephropathy	90.1	87.8	2.3
Controlling High Blood Pressure	64.8	57.2	7.6
Cholesterol Management for Patients With Cardiovascular Conditions—LDL Cholesterol Screening	90.9	87.1	3.9
Cholesterol Management for Patients With Cardiovascular Conditions—LDL Control (<100 mg/dL)	64.0	51.1	12.8
Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis	76.4	69.8	6.6
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	31.7	26.4	5.4
Pharmacotherapy Management of COPD—Bronchodilators	77.1	75.8	1.3
Pharmacotherapy Management of COPD—Systemic Corticosteroids	63.7	59.3	4.5
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	90.3	89.3	1.0
Annual Monitoring for Patients on Persistent Medications—Anticonvulsants	70.3	69.4	0.9
Annual Monitoring for Patients on Persistent Medications—Digoxin	92.9	91.6	1.3
Annual Monitoring for Patients on Persistent Medications—Diuretics	90.6	89.4	1.1
Annual Monitoring for Patients on Persistent Medications—Combined	90.1	88.7	1.4
Antidepressant Medication Management—Acute Phase	66.1	62.0	4.1
Antidepressant Medication Management—Continuation Phase	52.6	49.1	3.5
Follow-Up After Hospitalization for Mental Illness—Within 7 Days Post-Discharge	47.2	31.7	15.5
Follow-Up After Hospitalization for Mental Illness—Within 30 Days Post-Discharge	64.7	49.0	15.7

HEDIS EFFECTIVENESS OF CARE MEASURES

ACCREDITED VS. NONACCREDITED PLANS: MEDICARE HMO MEANS—2009

MEASURE	ACCREDITED	NONACCREDITED	DIFFERENCE
Alcohol and Other Drug Dependence Treatment—Engagement	4.9	4.5	0.4
Alcohol and Other Drug Dependence Treatment—Initiation	48.9	44.7	4.2
Measures Targeted Toward Older Adults			
Fall Risk Management—Discussion	28.0	32.7	-4.7
Fall Risk Management—Management	56.0	58.6	-2.6
Potentially Harmful Drug-Disease Interactions in the Elderly—Chronic Renal Failure and NSAIDS or Cox-2 Selective NSAIDS*	9.1	13.5	-4.4
Potentially Harmful Drug-Disease Interactions in the Elderly—Dementia and Tricyclic Antidepressants or Anticholinergic Agents*	24.2	31.0	-6.8
Potentially Harmful Drug-Disease Interactions in the Elderly—Falls and Tricyclic Antidepressants, Antipsychotics and Sleep Agents*	15.2	17.6	-2.4
Potentially Harmful Drug-Disease Interactions in the Elderly—Overall Rate*	19.4	25.2	-5.8
Use of High-Risk Medications in the Elderly—At Least One Medication*	18.3	25.3	-7.0
Use of High-Risk Medications in the Elderly—At Least Two Medications*	3.8	6.6	-2.9
Management of Urinary Incontinence—Discussion	56.9	57.3	-0.4
Management of Urinary Incontinence—Treatment	35.8	35.3	0.5
Physical Activity in Older Adults—Advice	46.6	47.1	-0.5
Physical Activity in Older Adults—Discussion	52.6	50.7	2.0
Osteoporosis Testing in Older Women	72.7	65.5	7.2
Osteoporosis Management in Women Who Had a Fracture	24.0	18.3	5.8
Glaucoma Screening in Older Adults	66.2	60.3	5.9

**Lower rates signify better performance.*

APPENDIX 7B: ACCREDITED VS. NONACCREDITED PLANS—2009 MEDICARE PPO MEANS

HEDIS EFFECTIVENESS OF CARE MEASURES ACCREDITED VS. NONACCREDITED PLANS: MEDICARE PPO MEANS—2009			
MEASURE	ACCREDITED	NONACCREDITED	DIFFERENCE
Wellness and Prevention			
Adult Body Mass Index Assessment	24.1	24.1	0.0
Medical Assistance With Smoking Cessation—Advising Smokers to Quit	75.8	75.0	0.7
Flu Shots for Adults	67.5	64.6	2.9
Breast Cancer Screening	65.9	65.4	0.5
Colorectal Cancer Screening	43.8	39.1	4.7
Chronic Disease Management			
Persistence of Beta-Blocker Treatment After a Heart Attack	79.7	78.8	0.9
Comprehensive Diabetes Care—Blood Pressure Control (<130/80 mm Hg)	30.6	25.6	5.0
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	53.8	47.8	6.1
Comprehensive Diabetes Care—Eye Exams	61.9	58.9	3.0
Comprehensive Diabetes Care—HbA1c Screening	90.3	89.1	1.2
Comprehensive Diabetes Care—Good Glycemic Control (HbA1c <8%)	61.0	49.6	11.4
Comprehensive Diabetes Care—Poor Glycemic Control (HbA1c >9%)*	31.2	43.7	-12.5
Comprehensive Diabetes Care—LDL Cholesterol Screening	87.3	85.2	2.1
Comprehensive Diabetes Care—LDL Cholesterol Control (<100 mg/dL)	49.2	38.4	10.7
Comprehensive Diabetes Care—Medical Attention for Nephropathy	86.4	84.9	1.5
Controlling High Blood Pressure	52.9	55.3	-2.5
Cholesterol Management for Patients With Cardiovascular Conditions—LDL Cholesterol Screening	88.1	86.3	1.8
Cholesterol Management for Patients With Cardiovascular Conditions—LDL Control (<100 mg/dL)	54.1	45.1	9.0
Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis	78.1	76.0	2.1
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	26.5	29.5	-3.1
Pharmacotherapy Management of COPD—Bronchodilators	77.9	74.1	3.8
Pharmacotherapy Management of COPD—Systemic Corticosteroids	64.4	64.2	0.2
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	89.1	89.9	-0.8
Annual Monitoring for Patients on Persistent Medications—Anticonvulsants	65.2	69.2	-4.0
Annual Monitoring for Patients on Persistent Medications—Digoxin	92.4	92.2	0.2
Annual Monitoring for Patients on Persistent Medications—Diuretics	90.0	90.4	-0.4
Annual Monitoring for Patients on Persistent Medications—Combined	89.1	89.8	-0.6
Antidepressant Medication Management—Acute Phase	64.1	63.2	1.0
Antidepressant Medication Management—Continuation Phase	50.2	51.2	-1.0
Follow-Up After Hospitalization for Mental Illness—Within 7 Days Post-Discharge	38.2	41.2	-3.0
Follow-Up After Hospitalization for Mental Illness—Within 30 Days Post-Discharge	59.5	60.8	-1.3

HEDIS EFFECTIVENESS OF CARE MEASURES

ACCREDITED VS. NONACCREDITED PLANS: MEDICARE PPO MEANS—2009

MEASURE	ACCREDITED	NONACCREDITED	DIFFERENCE
Alcohol and Other Drug Dependence Treatment—Engagement	3.8	4.3	-0.5
Alcohol and Other Drug Dependence Treatment—Initiation	52.5	58.5	-6.0
Measures Targeted Toward Older Adults			
Fall Risk Management—Discussion	29.4	30.5	-1.1
Fall Risk Management—Management	55.1	54.6	0.5
Potentially Harmful Drug-Disease Interactions in the Elderly—Chronic Renal Failure and NSAIDS or Cox-2 Selective NSAIDS*	9.2	12.1	-2.9
Potentially Harmful Drug-Disease Interactions in the Elderly—Dementia and Tricyclic Antidepressants or Anticholinergic Agents*	25.4	27.8	-2.4
Potentially Harmful Drug-Disease Interactions in the Elderly—Falls and Tricyclic Antidepressants, Antipsychotics and Sleep Agents*	15.1	17.1	-2.0
Potentially Harmful Drug-Disease Interactions in the Elderly—Overall Rate*	20.4	22.2	-1.8
Use of High-Risk Medications in the Elderly—At Least One Medication*	18.3	23.1	-4.8
Use of High-Risk Medications in the Elderly—At Least Two Medications*	3.5	5.7	-2.2
Management of Urinary Incontinence—Discussion	57.9	58.3	-0.4
Management of Urinary Incontinence—Treatment	37.3	37.4	0.0
Physical Activity in Older Adults—Advice	48.6	47.6	1.0
Physical Activity in Older Adults—Discussion	55.4	54.1	1.2
Osteoporosis Testing in Older Women	74.2	72.5	1.7
Osteoporosis Management in Women Who Had a Fracture	19.6	17.7	2.0
Glaucoma Screening in Older Adults	63.1	63.8	-0.7

**Lower rates signify better performance.*

APPENDIX 8A: PUBLICLY REPORTING VS. NONPUBLICLY REPORTING PLANS—2009 COMMERCIAL HMOS

HEDIS EFFECTIVENESS OF CARE MEASURES PUBLICLY REPORTING VS. NONPUBLICLY REPORTING PLANS: COMMERCIAL HMO MEANS—2009			
MEASURE	PUBLIC	NONPUBLIC	DIFFERENCE
Safety and Potential Waste			
Imaging Studies for Low Back Pain	74.0	72.6	1.4
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	23.9	25.2	-1.3
Wellness and Prevention			
Adult Body Mass Index Assessment	41.5	37.8	3.6
Medical Assistance With Smoking Cessation—Advising Smokers to Quit	79.9	73.9	6.0
Medical Assistance With Smoking Cessation—Discussion of Smoking Cessation Strategies	50.3	45.6	4.7
Medical Assistance With Smoking Cessation—Discussion of Smoking Cessation Medications	53.7	47.8	5.8
Flu Shots for Adults	51.1	53.0	-1.9
Prenatal and Postpartum Care—Timeliness of Prenatal Care	94.1	83.8	10.2
Prenatal and Postpartum Care—Postpartum Visit Between 21 and 56 Days After Delivery	84.7	73.0	11.8
Breast Cancer Screening	71.7	67.2	4.5
Cervical Cancer Screening	77.7	73.1	4.6
Colorectal Cancer Screening	61.4	53.2	8.2
Chlamydia Screening—16–20 Years	41.4	36.9	4.5
Chlamydia Screening—21–24 Years	45.8	41.0	4.9
Chlamydia Screening—Total Rate	43.5	38.9	4.6
Chronic Disease Management			
Persistence of Beta-Blocker Treatment After a Heart Attack	74.5	71.3	3.3
Comprehensive Diabetes Care—Blood Pressure Control (<130/80 mm Hg)	34.0	32.1	1.9
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	65.6	60.3	5.3
Comprehensive Diabetes Care—Eye Exams	57.0	51.9	5.0
Comprehensive Diabetes Care—HbA1c Screening	89.4	86.9	2.5
Comprehensive Diabetes Care—Good Glycemic Control (HbA1c <7% for a Selected Population)	42.6	35.6	7.1
Comprehensive Diabetes Care—Good Glycemic Control (HbA1c <8%)	62.2	55.2	7.1
Comprehensive Diabetes Care—Poor Glycemic Control (HbA1c >9%)*	27.6	34.9	-7.4
Comprehensive Diabetes Care—LDL Cholesterol Screening	85.4	81.4	4.0
Comprehensive Diabetes Care—LDL Cholesterol Control (<100 mg/dL)	47.5	42.6	4.9
Comprehensive Diabetes Care—Medical Attention for Nephropathy	83.2	80.3	2.9
Controlling High Blood Pressure	64.4	60.5	3.9
Cholesterol Management for Patients With Cardiovascular Conditions—LDL Cholesterol Screening	88.8	84.8	3.9
Cholesterol Management for Patients With Cardiovascular Conditions—LDL Control (<100 mg/dL)	60.2	48.1	12.1
Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis	86.5	85.5	1.0
Use of Appropriate Medications for People With Asthma—5–11 Years	96.6	96.5	0.1
Use of Appropriate Medications for People With Asthma—12–50 Years	91.5	90.4	1.1

HEDIS EFFECTIVENESS OF CARE MEASURES

PUBLICLY REPORTING VS. NONPUBLICLY REPORTING PLANS: COMMERCIAL HMO MEANS—2009

MEASURE	PUBLIC	NONPUBLIC	DIFFERENCE
Use of Appropriate Medications for People With Asthma—Overall Rate	92.7	91.9	0.8
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	39.1	36.0	3.0
Pharmacotherapy Management of COPD—Bronchodilators	77.9	79.4	-1.5
Pharmacotherapy Management of COPD—Systemic Corticosteroids	66.3	62.9	3.4
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	81.0	78.1	2.9
Annual Monitoring for Patients on Persistent Medications—Anticonvulsants	62.0	61.5	0.5
Annual Monitoring for Patients on Persistent Medications—Digoxin	83.7	82.4	1.2
Annual Monitoring for Patients on Persistent Medications—Diuretics	80.6	77.7	3.0
Annual Monitoring for Patients on Persistent Medications—Combined	80.5	77.5	2.9
Antidepressant Medication Management—Acute Phase	63.0	62.3	0.6
Antidepressant Medication Management—Continuation Phase	46.3	44.7	1.6
Follow-Up After Hospitalization for Mental Illness—Within 7 Days Post-Discharge	59.9	45.7	14.2
Follow-Up After Hospitalization for Mental Illness—Within 30 Days Post-Discharge	77.7	67.1	10.6
Alcohol and Other Drug Dependence Treatment—Engagement	16.2	14.7	1.5
Alcohol and Other Drug Dependence Treatment—Initiation	42.9	39.2	3.8
Measures Targeted Toward Children			
Appropriate Testing for Children With Pharyngitis	78.0	70.7	7.3
Appropriate Testing for Children With Upper Respiratory Infection	84.5	79.8	4.8
Childhood Immunization Status—DTaP/DT	86.3	77.5	8.8
Childhood Immunization Status—Hepatitis B	90.8	82.7	8.1
Childhood Immunization Status—HiB	95.4	88.4	7.1
Childhood Immunization Status—IPV	91.8	84.0	7.7
Childhood Immunization Status—MMR	90.8	88.9	1.9
Childhood Immunization Status—Pneumococcal Conjugate (PCV)	85.4	76.9	8.5
Childhood Immunization Status—VZV	90.8	88.3	2.5
Childhood Immunization Status—Combination 2 (DTaP, IPV, MMR, HiB, Hepatitis B and VZV)	78.4	70.8	7.6
Childhood Immunization Status—Combination 3 (DTaP, IPV, MMR, HiB, Hepatitis B, VZV and PCV)	74.0	67.2	6.8
Follow-Up Care for Children Prescribed ADHD Medication—Initiation	36.7	35.4	1.3
Follow-Up Care for Children Prescribed ADHD Medication—Continuation	41.7	41.9	-0.2
Weight Assessment and Counseling for Nutrition and Physical Activity in Children and Adolescents—BMI Percentile (Overall)	35.9	26.8	9.1
Weight Assessment and Counseling for Nutrition and Physical Activity in Children and Adolescents—Counseling for Nutrition (Overall)	41.6	31.8	9.8
Weight Assessment and Counseling for Nutrition and Physical Activity in Children and Adolescents—Counseling for Physical Activity (Overall)	37.1	25.9	11.2

**Lower rates signify better performance.*

APPENDIX 8B: PUBLICLY REPORTING VS. NONPUBLICLY REPORTING PLANS—2009 COMMERCIAL PPOS

HEDIS EFFECTIVENESS OF CARE MEASURES PUBLICLY REPORTING VS. NONPUBLICLY REPORTING PLANS: COMMERCIAL PPO MEANS—2009			
MEASURE	PUBLIC	NONPUBLIC	DIFFERENCE
Safety and Potential Waste			
Imaging Studies for Low Back Pain	72.5	78.0	-5.4
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	22.5	25.0	-2.5
Wellness and Prevention			
Adult Body Mass Index Assessment	15.9	14.6	1.3
Medical Assistance With Smoking Cessation—Advising Smokers to Quit	72.9	N/A	-
Medical Assistance With Smoking Cessation—Discussion of Smoking Cessation Strategies	41.1	N/A	-
Medical Assistance With Smoking Cessation—Discussion of Smoking Cessation Medications	47.3	N/A	-
Flu Shots for Adults	50.5	48.5	2.0
Prenatal and Postpartum Care—Timeliness of Prenatal Care	62.3	52.6	9.6
Prenatal and Postpartum Care—Postpartum Visit Between 21 and 56 Days After Delivery	54.4	46.9	7.5
Breast Cancer Screening	67.1	66.2	0.9
Cervical Cancer Screening	74.6	75.4	-0.8
Colorectal Cancer Screening	47.1	43.5	3.6
Chlamydia Screening—16–20 Years	37.6	39.5	-1.9
Chlamydia Screening—21–24 Years	41.3	43.4	-2.1
Chlamydia Screening—Total Rate	39.5	41.5	-2.0
Chronic Disease Management			
Persistence of Beta-Blocker Treatment After a Heart Attack	69.7	67.9	1.7
Comprehensive Diabetes Care—Blood Pressure Control (<130/80 mm Hg)	24.1	9.3	14.8
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	47.3	19.2	28.1
Comprehensive Diabetes Care—Eye Exams	42.7	40.3	2.4
Comprehensive Diabetes Care—HbA1c Screening	83.5	78.5	5.0
Comprehensive Diabetes Care—Good Glycemic Control (HbA1c <7% for a Selected Population)	30.6	24.9	5.8
Comprehensive Diabetes Care—Good Glycemic Control (HbA1c <8%)	48.9	28.3	20.6
Comprehensive Diabetes Care—Poor Glycemic Control (HbA1c >9%)*	43.7	67.2	-23.6
Comprehensive Diabetes Care—LDL Cholesterol Screening	78.7	75.1	3.6
Comprehensive Diabetes Care—LDL Cholesterol Control (<100 mg/dL)	37.5	21.5	16.0
Comprehensive Diabetes Care—Medical Attention for Nephropathy	69.8	73.1	-3.3
Controlling High Blood Pressure	48.3	47.0	1.4
Cholesterol Management for Patients With Cardiovascular Conditions—LDL Cholesterol Screening	80.3	76.1	4.2
Cholesterol Management for Patients With Cardiovascular Conditions—LDL Control (<100 mg/dL)	42.9	26.1	16.8
Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis	86.6	87.3	-0.7
Use of Appropriate Medications for People With Asthma—5–11 Years	97.0	95.9	1.1
Use of Appropriate Medications for People With Asthma—12–50 Years	91.6	90.7	0.9

HEDIS EFFECTIVENESS OF CARE MEASURES

PUBLICLY REPORTING VS. NONPUBLICLY REPORTING PLANS: COMMERCIAL PPO MEANS—2009

MEASURE	PUBLIC	NONPUBLIC	DIFFERENCE
Use of Appropriate Medications for People With Asthma—Overall Rate	92.8	91.6	1.2
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	36.6	40.1	-3.4
Pharmacotherapy Management of COPD—Bronchodilators	75.1	60.4	14.7
Pharmacotherapy Management of COPD—Systemic Corticosteroids	64.2	55.3	8.9
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	77.7	75.8	1.8
Annual Monitoring for Patients on Persistent Medications—Anticonvulsants	59.1	63.2	-4.1
Annual Monitoring for Patients on Persistent Medications—Digoxin	77.8	81.2	-3.4
Annual Monitoring for Patients on Persistent Medications—Diuretics	77.3	75.1	2.2
Annual Monitoring for Patients on Persistent Medications—Combined	77.0	75.4	1.7
Antidepressant Medication Management—Acute Phase	63.3	61.0	2.3
Antidepressant Medication Management—Continuation Phase	46.4	45.9	0.5
Follow-Up After Hospitalization for Mental Illness—Within 7 Days Post-Discharge	52.5	55.3	-2.8
Follow-Up After Hospitalization for Mental Illness—Within 30 Days Post-Discharge	72.2	69.1	3.1
Alcohol and Other Drug Dependence Treatment—Engagement	15.6	20.1	-4.6
Alcohol and Other Drug Dependence Treatment—Initiation	41.6	49.8	-8.2
Measures Targeted Toward Children			
Appropriate Testing for Children With Pharyngitis	75.6	71.1	4.5
Appropriate Testing for Children With Upper Respiratory Infection	82.5	82.2	0.3
Childhood Immunization Status—DTaP/DT	60.1	54.8	5.2
Childhood Immunization Status—Hepatitis B	54.0	46.9	7.1
Childhood Immunization Status—HiB	74.9	71.4	3.5
Childhood Immunization Status—IPV	65.5	59.8	5.7
Childhood Immunization Status—MMR	80.6	78.4	2.2
Childhood Immunization Status—Pneumococcal Conjugate (PCV)	60.4	53.5	6.9
Childhood Immunization Status—VZV	79.7	78.6	1.1
Childhood Immunization Status—Combination 2 (DTaP, IPV, MMR, HiB, Hepatitis B and VZV)	43.4	35.0	8.4
Childhood Immunization Status—Combination 3 (DTaP, IPV, MMR, HiB, Hepatitis B, VZV and PCV)	40.7	32.1	8.6
Follow-Up Care for Children Prescribed ADHD Medication—Initiation	35.5	29.3	6.2
Follow-Up Care for Children Prescribed ADHD Medication—Continuation	38.9	43.5	-4.6
Weight Assessment and Counseling for Nutrition and Physical Activity in Children and Adolescents—BMI Percentile (Overall)	17.5	15.7	1.8
Weight Assessment and Counseling for Nutrition and Physical Activity in Children and Adolescents—Counseling for Nutrition (Overall)	20.6	17.2	3.4
Weight Assessment and Counseling for Nutrition and Physical Activity in Children and Adolescents—Counseling for Physical Activity (Overall)	18.1	13.3	4.8

**Lower rates signify better performance.*

APPENDIX 9: PUBLICLY REPORTING VS. NONPUBLICLY REPORTING PLANS—2009 MEDICAID HMOS

HEDIS EFFECTIVENESS OF CARE MEASURES PUBLICLY REPORTING VS. NONPUBLICLY REPORTING PLANS: MEDICAID HMO MEANS—2009			
MEASURE	PUBLIC	NONPUBLIC	DIFFERENCE
Safety and Potential Waste			
Imaging Studies for Low Back Pain	75.9	76.7	-0.8
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	25.4	26.0	-0.6
Wellness and Prevention			
Adult Body Mass Index Assessment	37.1	24.8	12.3
Medical Assistance With Smoking Cessation—Advising Smokers to Quit	74.3	74.0	0.3
Medical Assistance With Smoking Cessation—Discussion of Smoking Cessation Strategies	39.2	37.7	1.6
Medical Assistance With Smoking Cessation—Discussion of Smoking Cessation Medications	44.2	41.2	2.9
Prenatal and Postpartum Care—Timeliness of Prenatal Care	85.3	79.1	6.2
Prenatal and Postpartum Care—Postpartum Visit Between 21 and 56 Days After Delivery	65.6	60.9	4.7
Breast Cancer Screening	52.7	51.5	1.2
Cervical Cancer Screening	68.2	60.5	7.7
Chlamydia Screening—16–20 Years	54.3	54.6	-0.2
Chlamydia Screening—21–24 Years	61.7	61.4	0.3
Chlamydia Screening—Total Rate	57.1	56.0	1.1
Chronic Disease Management			
Persistence of Beta-Blocker Treatment After a Heart Attack	77.6	73.6	4.0
Comprehensive Diabetes Care—Blood Pressure Control (<130/80 mm Hg)	33.6	29.1	4.5
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	61.9	54.9	7.0
Comprehensive Diabetes Care—Eye Exams	53.9	50.1	3.8
Comprehensive Diabetes Care—HbA1c Screening	82.4	76.9	5.6
Comprehensive Diabetes Care—Good Glycemic Control (HbA1c <7% for a Selected Population)	35.5	29.1	6.4
Comprehensive Diabetes Care—Good Glycemic Control (HbA1c <8%)	48.8	39.0	9.8
Comprehensive Diabetes Care—Poor Glycemic Control (HbA1c >9%)*	40.5	54.2	-13.8
Comprehensive Diabetes Care—LDL Cholesterol Screening	75.7	71.0	4.8
Comprehensive Diabetes Care—LDL Cholesterol Control (<100 mg/dL)	35.4	29.5	5.9
Comprehensive Diabetes Care—Medical Attention for Nephropathy	78.0	74.7	3.3
Controlling High Blood Pressure	57.5	49.6	7.9
Cholesterol Management for Patients With Cardiovascular Conditions—LDL Cholesterol Screening	81.6	78.0	3.6
Cholesterol Management for Patients With Cardiovascular Conditions—LDL Control (<100 mg/dL)	43.5	34.8	8.7
Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis	70.2	71.1	-0.8
Use of Appropriate Medications for People With Asthma—5–11 Years	91.7	92.1	-0.4
Use of Appropriate Medications for People With Asthma—12–50 Years	85.7	86.7	-1.0
Use of Appropriate Medications for People With Asthma—Overall Rate	88.3	89.2	-0.9
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	27.8	30.8	-3.0

HEDIS EFFECTIVENESS OF CARE MEASURES

PUBLICLY REPORTING VS. NONPUBLICLY REPORTING PLANS: MEDICAID HMO MEANS—2009

MEASURE	PUBLIC	NONPUBLIC	DIFFERENCE
Pharmacotherapy Management of COPD—Bronchodilators	80.9	80.2	0.7
Pharmacotherapy Management of COPD—Systemic Corticosteroids	61.5	62.7	-1.2
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	86.4	84.9	1.5
Annual Monitoring for Patients on Persistent Medications—Anticonvulsants	69.8	65.9	4.0
Annual Monitoring for Patients on Persistent Medications—Digoxin	89.6	87.3	2.4
Annual Monitoring for Patients on Persistent Medications—Diuretics	85.8	84.7	1.2
Annual Monitoring for Patients on Persistent Medications—Combined	83.6	82.5	1.0
Antidepressant Medication Management—Acute Phase	50.5	47.8	2.7
Antidepressant Medication Management—Continuation Phase	34.0	30.5	3.5
Follow-Up After Hospitalization for Mental Illness—Within 7 Days Post-Discharge	43.5	41.6	1.9
Follow-Up After Hospitalization for Mental Illness—Within 30 Days Post-Discharge	61.3	57.9	3.4
Alcohol and Other Drug Dependence Treatment—Engagement	12.5	11.9	0.6
Alcohol and Other Drug Dependence Treatment—Initiation	44.6	43.9	0.7
Measures Targeted Toward Children			
Appropriate Testing for Children With Pharyngitis	63.2	60.3	2.9
Appropriate Testing for Children With Upper Respiratory Infection	85.9	86.5	-0.6
Childhood Immunization Status—DTaP/DT	79.9	78.9	0.9
Childhood Immunization Status—Hepatitis B	89.8	87.4	2.4
Childhood Immunization Status—HiB	94.4	92.2	2.2
Childhood Immunization Status—IPV	89.6	87.5	2.2
Childhood Immunization Status—MMR	91.3	90.9	0.5
Childhood Immunization Status—Pneumococcal Conjugate (PCV)	78.4	75.9	2.5
Childhood Immunization Status—VZV	90.7	90.4	0.3
Childhood Immunization Status—Combination 2 (DTaP, IPV, MMR, HiB, Hepatitis B and VZV)	75.0	72.6	2.4
Childhood Immunization Status—Combination 3 (DTaP, IPV, MMR, HiB, Hepatitis B, VZV and PCV)	70.4	67.0	3.4
Follow-Up Care for Children Prescribed ADHD Medication—Initiation	37.5	34.4	3.0
Follow-Up Care for Children Prescribed ADHD Medication—Continuation	42.9	38.9	3.9
Lead Screening in Children	67.4	64.3	3.1
Weight Assessment and Counseling for Nutrition and Physical Activity in Children and Adolescents—BMI Percentile (Overall)	33.0	22.7	10.3
Weight Assessment and Counseling for Nutrition and Physical Activity in Children and Adolescents—Counseling for Nutrition (Overall)	44.5	34.7	9.7
Weight Assessment and Counseling for Nutrition and Physical Activity in Children and Adolescents—Counseling for Physical Activity (Overall)	34.4	27.4	6.9

**Lower rates signify better performance.*

APPENDIX 10A: PUBLICLY REPORTING VS. NONPUBLICLY REPORTING PLANS—2009 MEDICARE HMOS

HEDIS EFFECTIVENESS OF CARE MEASURES PUBLICLY REPORTING VS. NONPUBLICLY REPORTING PLANS: MEDICARE HMO MEANS—2009			
MEASURE	PUBLIC	NONPUBLIC	DIFFERENCE
Wellness and Prevention			
Adult Body Mass Index Assessment	41.0	30.6	10.4
Medical Assistance With Smoking Cessation—Advising Smokers to Quit	77.7	78.6	-0.9
Flu Shots for Adults	65.2	62.0	3.2
Breast Cancer Screening	70.3	65.6	4.7
Colorectal Cancer Screening	56.8	47.8	9.0
Chronic Disease Management			
Persistence of Beta-Blocker Treatment After a Heart Attack	82.7	81.6	1.1
Comprehensive Diabetes Care—Blood Pressure Control (<130/80 mm Hg)	33.4	32.7	0.7
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	60.9	58.9	1.9
Comprehensive Diabetes Care—Eye Exams	64.4	60.5	3.8
Comprehensive Diabetes Care—HbA1c Screening	90.2	87.6	2.6
Comprehensive Diabetes Care—Good Glycemic Control (HbA1c <8%)	65.5	57.0	8.4
Comprehensive Diabetes Care—Poor Glycemic Control (HbA1c >9%)*	25.9	35.4	-9.4
Comprehensive Diabetes Care—LDL Cholesterol Screening	88.0	84.8	3.2
Comprehensive Diabetes Care—LDL Cholesterol Control (<100 mg/dL)	51.6	44.3	7.2
Comprehensive Diabetes Care—Medical Attention for Nephropathy	88.9	87.2	1.7
Controlling High Blood Pressure	60.7	56.1	4.6
Cholesterol Management for Patients With Cardiovascular Conditions—LDL Cholesterol Screening	89.0	86.1	2.9
Cholesterol Management for Patients With Cardiovascular Conditions—LDL Control (<100 mg/dL)	57.6	48.3	9.3
Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis	73.0	69.2	3.8
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	29.1	25.8	3.4
Pharmacotherapy Management of COPD—Bronchodilators	75.9	77.7	-1.8
Pharmacotherapy Management of COPD—Systemic Corticosteroids	61.8	57.2	4.6
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	90.0	88.2	1.7
Annual Monitoring for Patients on Persistent Medications—Anticonvulsants	69.4	70.6	-1.2
Annual Monitoring for Patients on Persistent Medications—Digoxin	92.3	90.9	1.3
Annual Monitoring for Patients on Persistent Medications—Diuretics	90.3	88.1	2.2
Annual Monitoring for Patients on Persistent Medications—Combined	89.6	87.5	2.1
Antidepressant Medication Management—Acute Phase	63.9	62.4	1.5
Antidepressant Medication Management—Continuation Phase	50.6	50.4	0.2
Follow-Up After Hospitalization for Mental Illness—Within 7 Days Post-Discharge	39.9	27.4	12.5
Follow-Up After Hospitalization for Mental Illness—Within 30 Days Post-Discharge	57.9	43.1	14.7

HEDIS EFFECTIVENESS OF CARE MEASURES
PUBLICLY REPORTING VS. NONPUBLICLY REPORTING PLANS: MEDICARE HMO MEANS—2009

MEASURE	PUBLIC	NONPUBLIC	DIFFERENCE
Alcohol and Other Drug Dependence Treatment—Engagement	4.5	5.1	-0.6
Alcohol and Other Drug Dependence Treatment—Initiation	46.4	45.7	0.6
Measures Targeted Toward Older Adults			
Fall Risk Management—Discussion	30.1	34.9	-4.7
Fall Risk Management—Management	57.0	60.4	-3.4
Potentially Harmful Drug-Disease Interactions in the Elderly—Chronic Renal Failure and NSAIDS or Cox-2 Selective NSAIDS*	11.1	13.7	-2.7
Potentially Harmful Drug-Disease Interactions in the Elderly—Dementia and Tricyclic Antidepressants or Anticholinergic Agents*	28.0	31.4	-3.4
Potentially Harmful Drug-Disease Interactions in the Elderly—Falls and Tricyclic Antidepressants, Antipsychotics and Sleep Agents*	16.2	18.9	-2.7
Potentially Harmful Drug-Disease Interactions in the Elderly—Overall Rate*	22.4	26.1	-3.7
Use of High-Risk Medications in the Elderly—At Least One Medication*	22.3	25.6	-3.3
Use of High-Risk Medications in the Elderly—At Least Two Medications*	5.4	6.7	-1.2
Management of Urinary Incontinence—Discussion	56.7	59.4	-2.7
Management of Urinary Incontinence—Treatment	35.3	36.4	-1.1
Physical Activity in Older Adults—Advice	46.7	47.6	-0.8
Physical Activity in Older Adults—Discussion	51.4	50.9	0.5
Osteoporosis Testing in Older Women	69.0	63.9	5.1
Osteoporosis Management in Women Who Had a Fracture	21.4	17.4	4.0
Glaucoma Screening in Older Adults	62.9	60.1	2.8

**Lower rates signify better performance.*

APPENDIX 10B: PUBLICLY REPORTING VS. NONPUBLICLY REPORTING PLANS—2009 MEDICARE PPOS

HEDIS EFFECTIVENESS OF CARE MEASURES PUBLICLY REPORTING VS. NONPUBLICLY REPORTING PLANS: MEDICARE PPO MEANS—2009			
MEASURE	PUBLIC	NONPUBLIC	DIFFERENCE
Wellness and Prevention			
Adult Body Mass Index Assessment	25.2	15.8	9.4
Medical Assistance With Smoking Cessation—Advising Smokers to Quit	75.7	70.8	5.0
Flu Shots for Adults	65.7	61.1	4.5
Breast Cancer Screening	65.4	66.8	-1.4
Colorectal Cancer Screening	40.4	37.6	2.8
Chronic Disease Management			
Persistence of Beta-Blocker Treatment After a Heart Attack	79.2	77.5	1.7
Comprehensive Diabetes Care—Blood Pressure Control (<130/80 mm Hg)	27.9	13.6	14.2
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	51.3	24.4	26.9
Comprehensive Diabetes Care—Eye Exams	59.9	56.0	3.9
Comprehensive Diabetes Care—HbA1c Screening	89.7	86.5	3.2
Comprehensive Diabetes Care—Good Glycemic Control (HbA1c <8%)	56.4	17.9	38.5
Comprehensive Diabetes Care—Poor Glycemic Control (HbA1c >9%)*	36.1	79.7	-43.6
Comprehensive Diabetes Care—LDL Cholesterol Screening	85.7	84.1	1.6
Comprehensive Diabetes Care—LDL Cholesterol Control (<100 mg/dL)	43.6	17.7	25.9
Comprehensive Diabetes Care—Medical Attention for Nephropathy	85.4	84.0	1.4
Controlling High Blood Pressure	54.8	55.2	-0.4
Cholesterol Management for Patients With Cardiovascular Conditions—LDL Cholesterol Screening	87.0	84.4	2.6
Cholesterol Management for Patients With Cardiovascular Conditions—LDL Control (<100 mg/dL)	49.1	30.2	18.9
Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis	76.9	73.7	3.2
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	28.5	30.7	-2.2
Pharmacotherapy Management of COPD—Bronchodilators	76.2	67.6	8.6
Pharmacotherapy Management of COPD—Systemic Corticosteroids	64.9	60.4	4.5
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	89.6	91.1	-1.5
Annual Monitoring for Patients on Persistent Medications—Anticonvulsants	68.5	67.7	0.8
Annual Monitoring for Patients on Persistent Medications—Digoxin	92.3	91.9	0.3
Annual Monitoring for Patients on Persistent Medications—Diuretics	90.1	91.7	-1.6
Annual Monitoring for Patients on Persistent Medications—Combined	89.5	91.0	-1.5
Antidepressant Medication Management—Acute Phase	64.5	56.3	8.1
Antidepressant Medication Management—Continuation Phase	52.3	42.1	10.2
Follow-Up After Hospitalization for Mental Illness—Within 7 Days Post-Discharge	42.0	30.5	11.5
Follow-Up After Hospitalization for Mental Illness—Within 30 Days Post-Discharge	61.6	53.0	8.6

HEDIS EFFECTIVENESS OF CARE MEASURES
PUBLICLY REPORTING VS. NONPUBLICLY REPORTING PLANS: MEDICARE PPO MEANS—2009

MEASURE	PUBLIC	NONPUBLIC	DIFFERENCE
Alcohol and Other Drug Dependence Treatment—Engagement	4.3	3.7	0.6
Alcohol and Other Drug Dependence Treatment—Initiation	57.8	53.6	4.2
Measures Targeted Toward Older Adults			
Fall Risk Management—Discussion	29.9	33.8	-4.0
Fall Risk Management—Management	54.5	56.0	-1.5
Potentially Harmful Drug-Disease Interactions in the Elderly—Chronic Renal Failure and NSAIDS or Cox-2 Selective NSAIDS*	9.7	20.1	-10.4
Potentially Harmful Drug-Disease Interactions in the Elderly—Dementia and Tricyclic Antidepressants or Anticholinergic Agents*	26.5	34.0	-7.5
Potentially Harmful Drug-Disease Interactions in the Elderly—Falls and Tricyclic Antidepressants, Antipsychotics and Sleep Agents*	16.6	17.1	-0.5
Potentially Harmful Drug-Disease Interactions in the Elderly—Overall Rate*	21.4	25.7	-4.3
Use of High-Risk Medications in the Elderly—At Least One Medication*	21.9	25.6	-3.7
Use of High-Risk Medications in the Elderly—At Least Two Medications*	5.1	6.9	-1.8
Management of Urinary Incontinence—Discussion	58.2	58.9	-0.7
Management of Urinary Incontinence—Treatment	37.5	36.3	1.2
Physical Activity in Older Adults—Advice	47.9	47.0	0.9
Physical Activity in Older Adults—Discussion	54.8	51.4	3.4
Osteoporosis Testing in Older Women	73.4	68.2	5.2
Osteoporosis Management in Women Who Had a Fracture	18.3	16.9	1.4
Glaucoma Screening in Older Adults	63.6	64.0	-0.4

**Lower rates signify better performance.*

APPENDIX 11: HMOS VS. PPOS—COMMERCIAL PLANS

HEDIS EFFECTIVENESS OF CARE MEASURES HMOS VS. PPOS: COMMERCIAL MEANS—2009			
MEASURE	HMO	PPO	DIFFERENCE
Safety and Potential Waste			
Imaging Studies for Low Back Pain	73.9	72.7	-1.2
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	24.0	22.6	-1.4
Wellness and Prevention			
Medical Assistance With Smoking Cessation—Advising Smokers to Quit	79.5	72.9	-6.6
Medical Assistance With Smoking Cessation—Discussion of Smoking Cessation Strategies	50.0	41.1	-8.8
Medical Assistance With Smoking Cessation—Discussion of Smoking Cessation Medications	53.3	47.3	-6.0
Flu Shots for Adults	51.3	50.5	-0.8
Breast Cancer Screening	71.3	67.1	-4.3
Cervical Cancer Screening	77.3	74.6	-2.7
Chlamydia Screening—16–20 Years	41.0	37.7	-3.3
Chlamydia Screening—21–24 Years	45.4	41.4	-4.1
Chlamydia Screening—Total Rate	43.1	39.5	-3.6
Chronic Disease Management			
Persistence of Beta-Blocker Treatment After a Heart Attack	74.4	69.6	-4.8
Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis	86.4	86.6	0.2
Use of Appropriate Medications for People With Asthma—5–11 Years	96.6	97.0	0.4
Use of Appropriate Medications for People With Asthma—12–50 Years	91.4	91.6	0.2
Use of Appropriate Medications for People With Asthma—Overall Rate	92.7	92.8	0.1
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	38.8	36.7	-2.1
Pharmacotherapy Management of COPD—Bronchodilators	78.0	75.0	-3.0
Pharmacotherapy Management of COPD—Systemic Corticosteroids	66.1	64.1	-2.0
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	80.8	77.6	-3.2
Annual Monitoring for Patients on Persistent Medications—Anticonvulsants	62.0	59.2	-2.8
Annual Monitoring for Patients on Persistent Medications—Digoxin	83.6	77.9	-5.7
Annual Monitoring for Patients on Persistent Medications—Diuretics	80.4	77.2	-3.2
Annual Monitoring for Patients on Persistent Medications—Combined	80.3	77.0	-3.3
Antidepressant Medication Management—Acute Phase	62.9	63.2	0.3
Antidepressant Medication Management—Continuation Phase	46.2	46.4	0.2
Follow-Up After Hospitalization for Mental Illness—Within 7 Days Post-Discharge	58.7	52.6	-6.2
Follow-Up After Hospitalization for Mental Illness—Within 30 Days Post-Discharge	76.8	72.1	-4.7
Alcohol and Other Drug Dependence Treatment—Engagement	16.1	15.7	-0.5
Alcohol and Other Drug Dependence Treatment—Initiation	42.7	41.8	-0.9
Measures Targeted Toward Children			

HEDIS EFFECTIVENESS OF CARE MEASURES
HMOS VS. PPOS: COMMERCIAL MEANS—2009

MEASURE	HMO	PPO	DIFFERENCE
Appropriate Testing for Children With Pharyngitis	77.4	75.5	-1.9
Appropriate Testing for Children With Upper Respiratory Infection	84.1	82.5	-1.6
Follow-Up Care for Children Prescribed ADHD Medication—Initiation	36.6	35.4	-1.2
Follow-Up Care for Children Prescribed ADHD Medication—Continuation	41.7	39.0	-2.7

**Lower rates signify better performance.*

APPENDIX 12: HMOS VS. PPOS—MEDICARE PLANS

HEDIS EFFECTIVENESS OF CARE MEASURES HMOS VS. PPOS: MEDICARE MEANS—2009			
MEASURE	HMO	PPO	DIFFERENCE
Wellness and Prevention			
Medical Assistance With Smoking Cessation—Advising Smokers to Quit	77.9	75.2	-2.7
Flu Shots for Adults	64.5	65.1	0.6
Breast Cancer Screening	69.3	65.5	-3.8
Chronic Disease Management			
Persistence of Beta-Blocker Treatment After a Heart Attack	82.6	78.9	-3.6
Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis	72.3	76.4	4.1
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	28.5	28.8	0.3
Pharmacotherapy Management of COPD—Bronchodilators	76.2	74.9	-1.3
Pharmacotherapy Management of COPD—Systemic Corticosteroids	60.9	64.2	3.3
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	89.6	89.8	0.2
Annual Monitoring for Patients on Persistent Medications—Anticonvulsants	69.7	68.5	-1.2
Annual Monitoring for Patients on Persistent Medications—Digoxin	92.0	92.2	0.2
Annual Monitoring for Patients on Persistent Medications—Diuretics	89.8	90.3	0.5
Annual Monitoring for Patients on Persistent Medications—Combined	89.2	89.7	0.5
Antidepressant Medication Management—Acute Phase	63.7	63.4	-0.3
Antidepressant Medication Management—Continuation Phase	50.6	51.0	0.4
Follow-Up After Hospitalization for Mental Illness—Within 7 Days Post-Discharge	37.3	40.6	3.3
Follow-Up After Hospitalization for Mental Illness—Within 30 Days Post-Discharge	54.8	60.5	5.7
Alcohol and Other Drug Dependence Treatment—Engagement	4.6	4.2	-0.4
Alcohol and Other Drug Dependence Treatment—Initiation	46.2	57.4	11.1
Measures Targeted Toward Older Adults			
Fall Risk Management—Discussion	31.1	30.3	-0.8
Fall Risk Management—Management	57.7	54.7	-3.0
Potentially Harmful Drug-Disease Interactions in the Elderly—Chronic Renal Failure and NSAIDS or Cox-2 Selective NSAIDS*	11.5	11.5	0.0
Potentially Harmful Drug-Disease Interactions in the Elderly—Dementia and Tricyclic Antidepressants or Anticholinergic Agents*	28.6	27.3	-1.3
Potentially Harmful Drug-Disease Interactions in the Elderly—Falls and Tricyclic Antidepressants, Antipsychotics and Sleep Agents*	16.7	16.6	-0.1
Potentially Harmful Drug-Disease Interactions in the Elderly—Overall Rate*	23.2	21.8	-1.3
Use of High-Risk Medications in the Elderly—At Least One Medication*	23.0	22.3	-0.7
Use of High-Risk Medications in the Elderly—At Least Two Medications*	5.7	5.3	-0.3
Management of Urinary Incontinence—Discussion	57.1	58.2	1.1
Management of Urinary Incontinence—Treatment	35.5	37.4	1.9
Physical Activity in Older Adults—Advice	46.9	47.8	0.9

HEDIS EFFECTIVENESS OF CARE MEASURES
HMOS VS. PPOS: MEDICARE MEANS—2009

MEASURE	HMO	PPO	DIFFERENCE
Physical Activity in Older Adults—Discussion	51.3	54.4	3.1
Osteoporosis Testing in Older Women	68.0	72.8	4.9
Osteoporosis Management in Women Who Had a Fracture	20.7	18.1	-2.5
Glaucoma Screening in Older Adults	62.3	63.7	1.3

**Lower rates signify better performance.*

APPENDIX 13: HMOS VS. PPOS—COMMERCIAL PLANS

CAHPS MEMBER SATISFACTION MEASURES HMOS VS. PPOS: COMMERCIAL MEANS—2009			
MEASURE	HMO	PPO	DIFFERENCE
Consumer and Patient Engagement and Experience			
Rating of Health Plan—Rating of 8, 9 or 10	62.7	57.3	-5.4
Rating of Health Plan—Rating of 9 or 10	38.3	32.4	-5.9
Rating of Health Care—Rating of 8, 9 or 10	74.9	74.3	-0.6
Rating of Health Care—Rating of 9 or 10	48.7	46.6	-2.1
Getting Needed Care—Usually or Always	85.4	86.3	0.9
Getting Needed Care—Always	52.9	52.7	-0.1
Getting Care Quickly—Usually or Always	86.4	87.3	0.9
Getting Care Quickly—Always	57.8	57.4	-0.4
How Well Doctors Communicate—Usually or Always	93.4	94.2	0.7
How Well Doctors Communicate—Always	72.0	71.7	-0.3
Rating of Personal Doctor—Rating of 8, 9 or 10	82.2	81.9	-0.3
Rating of Personal Doctor—Rating of 9 or 10	63.2	61.2	-2.0
Rating of Specialist—Rating of 8, 9 or 10	80.9	80.9	-0.1
Rating of Specialist—Rating of 9 or 10	61.8	60.4	-1.4
Customer Service—Usually or Always	84.2	82.4	-1.8
Customer Service—Always	57.9	54.5	-3.4
Claims Processing—Usually or Always	88.0	87.1	-0.9
Claims Processing—Always	54.4	48.7	-5.7

APPENDIX 14: HMOS VS. PPOS—MEDICARE PLANS

CAHPS MEMBER SATISFACTION MEASURES HMOS VS. PPOS: MEDICARE MEANS—2009			
MEASURE	HMO	PPO	DIFFERENCE
Consumer and Patient Engagement and Experience			
Rating of Health Plan—Rating of 8, 9 or 10	84.4	81.9	-2.5
Rating of Health Plan—Rating of 9 or 10	59.0	52.2	-6.7
Rating of Health Care—Rating of 8, 9 or 10	84.2	87.0	2.8
Rating of Health Care—Rating of 9 or 10	56.2	57.4	1.2
Getting Needed Care—Usually or Always	89.1	91.3	2.2
Getting Needed Care—Always	63.6	64.4	0.9
Getting Care Quickly—Usually or Always	86.7	88.4	1.7
Getting Care Quickly—Always	64.0	64.7	0.7
How Well Doctors Communicate—Usually or Always	93.5	94.6	1.2
How Well Doctors Communicate—Always	74.7	74.8	0.1
Rating of Personal Doctor—Rating of 8, 9 or 10	92.0	93.1	1.1
Rating of Personal Doctor—Rating of 9 or 10	73.3	73.9	0.5
Rating of Specialist—Rating of 8, 9 or 10	89.8	91.9	2.1
Rating of Specialist—Rating of 9 or 10	69.3	70.8	1.5
Customer Service—Usually or Always	86.5	N/A	-
Customer Service—Always	66.4	N/A	-

APPENDIX 15A: VARIATION IN PLAN PERFORMANCE—THE 90TH PERCENTILE VS. THE 10TH PERCENTILE: COMMERCIAL HMOS

HEDIS EFFECTIVENESS OF CARE MEASURES COMMERCIAL HMO STATISTICS—2009			
MEASURE	90TH PERCENTILE	10TH PERCENTILE	DIFFERENCE
Safety and Potential Waste			
Imaging Studies for Low Back Pain	81.4	66.0	15.5
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	31.0	16.8	14.2
Wellness and Prevention			
Adult Body Mass Index Assessment	71.5	1.2	70.3
Medical Assistance With Smoking Cessation—Advising Smokers to Quit	87.7	73.8	13.9
Medical Assistance With Smoking Cessation—Discussion of Smoking Cessation Strategies	61.2	38.6	22.6
Medical Assistance With Smoking Cessation—Discussion of Smoking Cessation Medications	64.4	46.8	17.6
Flu Shots for Adults	61.7	41.2	20.4
Prenatal and Postpartum Care—Timeliness of Prenatal Care	98.1	87.1	11.0
Prenatal and Postpartum Care—Postpartum Visit Between 21 and 56 Days After Delivery	91.3	75.2	16.0
Breast Cancer Screening	80.1	64.2	15.9
Cervical Cancer Screening	82.5	71.2	11.3
Colorectal Cancer Screening	72.3	47.0	25.3
Chlamydia Screening—16–20 Years	51.5	30.1	21.4
Chlamydia Screening—21–24 Years	58.9	32.9	26.0
Chlamydia Screening—Total Rate	56.0	31.6	24.3
Chronic Disease Management			
Persistence of Beta-Blocker Treatment After a Heart Attack	85.6	62.5	23.1
Comprehensive Diabetes Care—Blood Pressure Control (<130/80 mm Hg)	43.8	25.2	18.6
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	75.7	54.1	21.6
Comprehensive Diabetes Care—Eye Exams	73.7	39.2	34.5
Comprehensive Diabetes Care—HbA1c Screening	93.7	84.9	8.8
Comprehensive Diabetes Care—Good Glycemic Control (HbA1c <7% for a Selected Population)	50.6	32.0	18.6
Comprehensive Diabetes Care—Good Glycemic Control (HbA1c <8%)	71.0	51.3	19.7
Comprehensive Diabetes Care—Poor Glycemic Control (HbA1c >9%)*	38.9	17.8	21.1
Comprehensive Diabetes Care—LDL Cholesterol Screening	90.5	79.7	10.8
Comprehensive Diabetes Care—LDL Cholesterol Control (<100 mg/dL)	56.3	37.7	18.7
Comprehensive Diabetes Care—Medical Attention for Nephropathy	89.5	76.3	13.2
Controlling High Blood Pressure	73.0	52.8	20.2
Cholesterol Management for Patients With Cardiovascular Conditions—LDL Cholesterol Screening	93.3	84.1	9.2
Cholesterol Management for Patients With Cardiovascular Conditions—LDL Control (<100 mg/dL)	71.0	47.4	23.5
Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis	92.8	78.6	14.2
Use of Appropriate Medications for People With Asthma—5–11 Years	99.1	94.0	5.1

HEDIS EFFECTIVENESS OF CARE MEASURES
COMMERCIAL HMO STATISTICS—2009

MEASURE	90TH PERCENTILE	10TH PERCENTILE	DIFFERENCE
Use of Appropriate Medications for People With Asthma—12–50 Years	94.8	87.8	6.9
Use of Appropriate Medications for People With Asthma—Overall Rate	95.5	89.4	6.1
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	50.0	28.3	21.7
Pharmacotherapy Management of COPD—Bronchodilators	87.4	68.9	18.5
Pharmacotherapy Management of COPD—Systemic Corticosteroids	77.3	53.6	23.6
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	85.8	75.3	10.5
Annual Monitoring for Patients on Persistent Medications—Anticonvulsants	71.1	53.6	17.4
Annual Monitoring for Patients on Persistent Medications—Digoxin	90.9	76.6	14.3
Annual Monitoring for Patients on Persistent Medications—Diuretics	86.0	75.0	11.0
Annual Monitoring for Patients on Persistent Medications—Combined	85.2	74.8	10.4
Antidepressant Medication Management—Acute Phase	72.2	55.1	17.1
Antidepressant Medication Management—Continuation Phase	55.2	38.1	17.2
Follow-Up After Hospitalization for Mental Illness—Within 7 Days Post-Discharge	73.6	40.9	32.6
Follow-Up After Hospitalization for Mental Illness—Within 30 Days Post-Discharge	87.9	63.2	24.7
Alcohol and Other Drug Dependence Treatment—Engagement	23.7	7.5	16.1
Alcohol and Other Drug Dependence Treatment—Initiation	52.5	32.6	19.9
Measures Targeted Toward Children			
Appropriate Testing for Children With Pharyngitis	89.4	63.3	26.1
Appropriate Testing for Children With Upper Respiratory Infection	93.4	73.9	19.5
Childhood Immunization Status—DTaP/DT	92.1	79.9	12.3
Childhood Immunization Status—Hepatitis B	96.1	84.7	11.4
Childhood Immunization Status—HiB	98.0	91.6	6.4
Childhood Immunization Status—IPV	96.1	86.6	9.5
Childhood Immunization Status—MMR	94.9	86.1	8.7
Childhood Immunization Status—Pneumococcal Conjugate (PCV)	91.4	78.4	13.0
Childhood Immunization Status—VZV	94.1	86.9	7.2
Childhood Immunization Status—Combination 2 (DTaP, IPV, MMR, HiB, Hepatitis B and VZV)	86.0	69.1	16.9
Childhood Immunization Status—Combination 3 (DTaP, IPV, MMR, HiB, Hepatitis B, VZV and PCV)	83.2	63.6	19.7
Follow-Up Care for Children Prescribed ADHD Medication—Initiation	44.5	29.0	15.5
Follow-Up Care for Children Prescribed ADHD Medication—Continuation	52.4	32.1	20.2
Weight Assessment and Counseling for Nutrition and Physical Activity in Children and Adolescents—BMI Percentile (Overall)	68.4	0.4	67.9
Weight Assessment and Counseling for Nutrition and Physical Activity in Children and Adolescents—Counseling for Nutrition (Overall)	67.6	0.5	67.1
Weight Assessment and Counseling for Nutrition and Physical Activity in Children and Adolescents—Counseling for Physical Activity (Overall)	64.4	0.0	64.3

**Lower rates signify better performance.*

APPENDIX 15B: VARIATION IN PLAN PERFORMANCE—THE 90TH PERCENTILE VS. THE 10TH PERCENTILE: COMMERCIAL PPOS

HEDIS EFFECTIVENESS OF CARE MEASURES COMMERCIAL PPO STATISTICS—2009			
MEASURE	90TH PERCENTILE	10TH PERCENTILE	DIFFERENCE
Safety and Potential Waste			
Imaging Studies for Low Back Pain	79.9	65.5	14.4
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	28.8	17.3	11.5
Wellness and Prevention			
Adult Body Mass Index Assessment	43.7	0.6	43.1
Medical Assistance With Smoking Cessation—Advising Smokers to Quit	78.4	67.6	10.8
Medical Assistance With Smoking Cessation—Discussion of Smoking Cessation Strategies	46.3	35.8	10.4
Medical Assistance With Smoking Cessation—Discussion of Smoking Cessation Medications	51.9	40.0	11.9
Flu Shots for Adults	57.6	43.5	14.1
Prenatal and Postpartum Care—Timeliness of Prenatal Care	91.5	34.9	56.5
Prenatal and Postpartum Care—Postpartum Visit Between 21 and 56 Days After Delivery	80.1	33.8	46.3
Breast Cancer Screening	72.5	61.6	10.9
Cervical Cancer Screening	79.5	68.9	10.5
Colorectal Cancer Screening	54.4	39.4	15.0
Chlamydia Screening—16–20 Years	47.7	28.3	19.4
Chlamydia Screening—21–24 Years	55.1	29.6	25.5
Chlamydia Screening—Total Rate	50.7	29.2	21.4
Chronic Disease Management			
Persistence of Beta-Blocker Treatment After a Heart Attack	80.2	58.7	21.5
Comprehensive Diabetes Care—Blood Pressure Control (<130/80 mm Hg)	36.4	0.1	36.3
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	68.4	0.1	68.2
Comprehensive Diabetes Care—Eye Exams	54.4	29.4	25.0
Comprehensive Diabetes Care—HbA1c Screening	89.8	75.0	14.8
Comprehensive Diabetes Care—Good Glycemic Control (HbA1c <7% for a Selected Population)	46.3	11.1	35.2
Comprehensive Diabetes Care—Good Glycemic Control (HbA1c <8%)	64.2	20.3	43.9
Comprehensive Diabetes Care—Poor Glycemic Control (HbA1c >9%)*	77.4	25.9	51.5
Comprehensive Diabetes Care—LDL Cholesterol Screening	86.8	69.0	17.8
Comprehensive Diabetes Care—LDL Cholesterol Control (<100 mg/dL)	49.9	17.2	32.8
Comprehensive Diabetes Care—Medical Attention for Nephropathy	80.3	53.4	26.9
Controlling High Blood Pressure	64.8	28.9	35.9
Cholesterol Management for Patients With Cardiovascular Conditions—LDL Cholesterol Screening	89.0	66.1	23.0
Cholesterol Management for Patients With Cardiovascular Conditions—LDL Control (<100 mg/dL)	62.0	13.8	48.3
Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis	92.2	81.4	10.9
Use of Appropriate Medications for People With Asthma—5–11 Years	99.1	94.5	4.5

HEDIS EFFECTIVENESS OF CARE MEASURES
COMMERCIAL PPO STATISTICS—2009

MEASURE	90TH PERCENTILE	10TH PERCENTILE	DIFFERENCE
Use of Appropriate Medications for People With Asthma—12–50 Years	94.5	88.9	5.6
Use of Appropriate Medications for People With Asthma—Overall Rate	95.5	90.2	5.3
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	46.1	29.7	16.4
Pharmacotherapy Management of COPD—Bronchodilators	83.3	64.9	18.5
Pharmacotherapy Management of COPD—Systemic Corticosteroids	72.9	54.5	18.4
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	82.3	71.8	10.4
Annual Monitoring for Patients on Persistent Medications—Anticonvulsants	66.7	52.5	14.2
Annual Monitoring for Patients on Persistent Medications—Digoxin	86.4	68.8	17.6
Annual Monitoring for Patients on Persistent Medications—Diuretics	82.1	71.4	10.7
Annual Monitoring for Patients on Persistent Medications—Combined	81.5	71.5	10.0
Antidepressant Medication Management—Acute Phase	69.6	57.5	12.1
Antidepressant Medication Management—Continuation Phase	54.3	39.0	15.3
Follow-Up After Hospitalization for Mental Illness—Within 7 Days Post-Discharge	68.2	38.3	29.9
Follow-Up After Hospitalization for Mental Illness—Within 30 Days Post-Discharge	83.8	60.0	23.8
Alcohol and Other Drug Dependence Treatment—Engagement	20.9	9.9	11.0
Alcohol and Other Drug Dependence Treatment—Initiation	48.6	34.9	13.7
Measures Targeted Toward Children			
Appropriate Testing for Children With Pharyngitis	87.1	61.7	25.4
Appropriate Testing for Children With Upper Respiratory Infection	91.5	71.8	19.7
Childhood Immunization Status—DTaP/DT	85.1	38.0	47.1
Childhood Immunization Status—Hepatitis B	90.3	26.5	63.7
Childhood Immunization Status—HiB	95.4	55.7	39.7
Childhood Immunization Status—IPV	90.5	42.4	48.1
Childhood Immunization Status—MMR	89.8	69.7	20.1
Childhood Immunization Status—Pneumococcal Conjugate (PCV)	84.2	38.0	46.2
Childhood Immunization Status—VZV	90.7	67.5	23.3
Childhood Immunization Status—Combination 2 (DTaP, IPV, MMR, HiB, Hepatitis B and VZV)	75.7	19.5	56.2
Childhood Immunization Status—Combination 3 (DTaP, IPV, MMR, HiB, Hepatitis B, VZV and PCV)	72.5	18.8	53.7
Follow-Up Care for Children Prescribed ADHD Medication—Initiation	45.2	28.6	16.6
Follow-Up Care for Children Prescribed ADHD Medication—Continuation	48.8	30.3	18.5
Weight Assessment and Counseling for Nutrition and Physical Activity in Children and Adolescents—BMI Percentile (Overall)	54.7	0.1	54.6
Weight Assessment and Counseling for Nutrition and Physical Activity in Children and Adolescents—Counseling for Nutrition (Overall)	63.5	0.1	63.4
Weight Assessment and Counseling for Nutrition and Physical Activity in Children and Adolescents—Counseling for Physical Activity (Overall)	60.1	0.0	60.1

**Lower rates signify better performance.*

APPENDIX 16: VARIATION IN PLAN PERFORMANCE—THE 90TH PERCENTILE VS. THE 10TH PERCENTILE: MEDICAID HMOS

HEDIS EFFECTIVENESS OF CARE MEASURES MEDICAID HMO STATISTICS—2009			
MEASURE	90TH PERCENTILE	10TH PERCENTILE	DIFFERENCE
Safety and Potential Waste			
Imaging Studies for Low Back Pain	84.1	68.6	15.6
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	35.9	16.8	19.1
Wellness and Prevention			
Adult Body Mass Index Assessment	60.8	2.6	58.2
Medical Assistance With Smoking Cessation—Advising Smokers to Quit	80.8	67.1	13.7
Medical Assistance With Smoking Cessation—Discussion of Smoking Cessation Strategies	50.0	28.4	21.6
Medical Assistance With Smoking Cessation—Discussion of Smoking Cessation Medications	56.6	29.4	27.2
Prenatal and Postpartum Care—Timeliness of Prenatal Care	92.7	70.6	22.1
Prenatal and Postpartum Care—Postpartum Visit Between 21 and 56 Days After Delivery	74.4	53.0	21.3
Breast Cancer Screening	63.8	39.8	24.0
Cervical Cancer Screening	78.9	50.4	28.5
Chlamydia Screening—16–20 Years	66.4	43.8	22.7
Chlamydia Screening—21–24 Years	73.4	49.5	23.9
Chlamydia Screening—Total Rate	69.5	44.2	25.3
Chronic Disease Management			
Persistence of Beta-Blocker Treatment After a Heart Attack	88.9	59.2	29.7
Comprehensive Diabetes Care—Blood Pressure Control (<130/80 mm Hg)	44.3	21.4	22.9
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	73.4	43.8	29.6
Comprehensive Diabetes Care—Eye Exams	70.1	32.1	38.0
Comprehensive Diabetes Care—HbA1c Screening	90.2	69.4	20.9
Comprehensive Diabetes Care—Good Glycemic Control (HbA1c <7% for a Selected Population)	44.5	20.0	24.5
Comprehensive Diabetes Care—Good Glycemic Control (HbA1c <8%)	58.8	29.9	28.9
Comprehensive Diabetes Care—Poor Glycemic Control (HbA1c >9%)*	63.5	27.7	35.8
Comprehensive Diabetes Care—LDL Cholesterol Screening	84.0	62.6	21.4
Comprehensive Diabetes Care—LDL Cholesterol Control (<100 mg/dL)	45.5	19.5	26.1
Comprehensive Diabetes Care—Medical Attention for Nephropathy	86.2	65.7	20.5
Controlling High Blood Pressure	67.2	41.9	25.2
Cholesterol Management for Patients With Cardiovascular Conditions—LDL Cholesterol Screening	88.8	72.1	16.7
Cholesterol Management for Patients With Cardiovascular Conditions—LDL Control (<100 mg/dL)	54.4	22.9	31.5
Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis	83.3	57.3	26.0
Use of Appropriate Medications for People With Asthma—5–11 Years	95.5	88.2	7.3
Use of Appropriate Medications for People With Asthma—12–50 Years	90.7	79.9	10.8

HEDIS EFFECTIVENESS OF CARE MEASURES
MEDICAID HMO STATISTICS—2009

MEASURE	90TH PERCENTILE	10TH PERCENTILE	DIFFERENCE
Use of Appropriate Medications for People With Asthma—Overall Rate	92.8	84.6	8.2
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	39.9	17.4	22.6
Pharmacotherapy Management of COPD—Bronchodilators	90.0	64.5	25.5
Pharmacotherapy Management of COPD—Systemic Corticosteroids	76.2	42.6	33.6
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	90.5	80.0	10.4
Annual Monitoring for Patients on Persistent Medications—Anticonvulsants	78.1	60.4	17.7
Annual Monitoring for Patients on Persistent Medications—Digoxin	95.2	82.0	13.2
Annual Monitoring for Patients on Persistent Medications—Diuretics	90.6	79.4	11.2
Annual Monitoring for Patients on Persistent Medications—Combined	88.5	77.2	11.3
Antidepressant Medication Management—Acute Phase	58.4	40.9	17.5
Antidepressant Medication Management—Continuation Phase	43.3	24.8	18.6
Follow-Up After Hospitalization for Mental Illness—Within 7 Days Post-Discharge	64.3	18.2	46.0
Follow-Up After Hospitalization for Mental Illness—Within 30 Days Post-Discharge	83.6	31.8	51.8
Alcohol and Other Drug Dependence Treatment—Engagement	21.4	2.3	19.1
Alcohol and Other Drug Dependence Treatment—Initiation	57.3	31.8	25.5
Measures Targeted Toward Children			
Appropriate Testing for Children With Pharyngitis	80.9	40.2	40.7
Appropriate Testing for Children With Upper Respiratory Infection	94.9	77.7	17.3
Childhood Immunization Status—DTaP/DT	88.5	68.8	19.7
Childhood Immunization Status—Hepatitis B	96.4	82.6	13.7
Childhood Immunization Status—HiB	97.8	88.3	9.5
Childhood Immunization Status—IPV	95.6	83.8	11.8
Childhood Immunization Status—MMR	95.8	86.3	9.4
Childhood Immunization Status—Pneumococcal Conjugate (PCV)	87.8	65.9	21.9
Childhood Immunization Status—VZV	95.4	84.5	10.9
Childhood Immunization Status—Combination 2 (DTaP, IPV, MMR, HiB, Hepatitis B and VZV)	85.6	61.8	23.8
Childhood Immunization Status—Combination 3 (DTaP, IPV, MMR, HiB, Hepatitis B, VZV and PCV)	82.0	56.0	26.0
Follow-Up Care for Children Prescribed ADHD Medication—Initiation	48.1	24.8	23.3
Follow-Up Care for Children Prescribed ADHD Medication—Continuation	57.6	24.8	32.7
Lead Screening in Children	88.4	42.3	46.1
Weight Assessment and Counseling for Nutrition and Physical Activity in Children and Adolescents—BMI Percentile (Overall)	63.0	0.3	62.7
Weight Assessment and Counseling for Nutrition and Physical Activity in Children and Adolescents—Counseling for Nutrition (Overall)	67.9	0.4	67.5
Weight Assessment and Counseling for Nutrition and Physical Activity in Children and Adolescents—Counseling for Physical Activity (Overall)	56.7	0.0	56.7

**Lower rates signify better performance.*

APPENDIX 17A: VARIATION IN PLAN PERFORMANCE—THE 90TH PERCENTILE VS. THE 10TH PERCENTILE: MEDICARE HMOS

HEDIS EFFECTIVENESS OF CARE MEASURES MEDICARE HMO STATISTICS—2009			
MEASURE	90TH PERCENTILE	10TH PERCENTILE	DIFFERENCE
Wellness and Prevention			
Adult Body Mass Index Assessment	74.4	5.2	69.3
Medical Assistance With Smoking Cessation—Advising Smokers to Quit	87.5	67.7	19.8
Flu Shots for Adults	77.6	49.9	27.7
Breast Cancer Screening	82.7	55.8	27.0
Colorectal Cancer Screening	73.8	34.8	39.0
Chronic Disease Management			
Persistence of Beta-Blocker Treatment After a Heart Attack	91.4	72.1	19.3
Comprehensive Diabetes Care—Blood Pressure Control (<130/80 mm Hg)	46.0	21.6	24.4
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	74.2	45.0	29.2
Comprehensive Diabetes Care—Eye Exams	82.1	44.5	37.5
Comprehensive Diabetes Care—HbA1c Screening	95.6	82.5	13.1
Comprehensive Diabetes Care—Good Glycemic Control (HbA1c <8%)	80.0	43.1	37.0
Comprehensive Diabetes Care—Poor Glycemic Control (HbA1c >9%)*	50.9	10.7	40.1
Comprehensive Diabetes Care—LDL Cholesterol Screening	93.9	80.1	13.9
Comprehensive Diabetes Care—LDL Cholesterol Control (<100 mg/dL)	64.7	33.9	30.9
Comprehensive Diabetes Care—Medical Attention for Nephropathy	93.6	83.1	10.5
Controlling High Blood Pressure	71.6	45.5	26.2
Cholesterol Management for Patients With Cardiovascular Conditions—LDL Cholesterol Screening	94.9	81.0	13.9
Cholesterol Management for Patients With Cardiovascular Conditions—LDL Control (<100 mg/dL)	72.4	36.3	36.2
Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis	87.0	57.1	29.9
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	40.8	16.7	24.1
Pharmacotherapy Management of COPD—Bronchodilators	86.7	62.5	24.2
Pharmacotherapy Management of COPD—Systemic Corticosteroids	73.9	43.5	30.4
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	94.4	84.7	9.7
Annual Monitoring for Patients on Persistent Medications—Anticonvulsants	83.9	56.8	27.2
Annual Monitoring for Patients on Persistent Medications—Digoxin	96.6	87.5	9.1
Annual Monitoring for Patients on Persistent Medications—Diuretics	94.6	84.6	10.0
Annual Monitoring for Patients on Persistent Medications—Combined	93.9	84.3	9.6
Antidepressant Medication Management—Acute Phase	77.5	50.8	26.7
Antidepressant Medication Management—Continuation Phase	66.5	36.1	30.4
Follow-Up After Hospitalization for Mental Illness—Within 7 Days Post-Discharge	65.3	13.3	52.0

HEDIS EFFECTIVENESS OF CARE MEASURES

MEDICARE HMO STATISTICS—2009

MEASURE	90TH PERCENTILE	10TH PERCENTILE	DIFFERENCE
Follow-Up After Hospitalization for Mental Illness—Within 30 Days Post-Discharge	80.0	26.3	53.7
Alcohol and Other Drug Dependence Treatment—Engagement	8.9	0.8	8.1
Alcohol and Other Drug Dependence Treatment—Initiation	63.7	26.3	37.4
Measures Targeted Toward Older Adults			
Fall Risk Management—Discussion	40.1	24.6	15.4
Fall Risk Management—Management	66.9	50.0	16.9
Potentially Harmful Drug-Disease Interactions in the Elderly—Chronic Renal Failure and NSAIDS or Cox-2 Selective NSAIDS*	20.8	5.0	15.8
Potentially Harmful Drug-Disease Interactions in the Elderly—Dementia and Tricyclic Antidepressants or Anticholinergic Agents*	40.9	18.9	22.0
Potentially Harmful Drug-Disease Interactions in the Elderly—Falls and Tricyclic Antidepressants, Antipsychotics and Sleep Agents*	22.7	11.6	11.1
Potentially Harmful Drug-Disease Interactions in the Elderly—Overall Rate*	32.0	15.7	16.2
Use of High-Risk Medications in the Elderly—At Least One Medication*	35.2	13.3	21.9
Use of High-Risk Medications in the Elderly—At Least Two Medications*	10.7	1.6	9.1
Management of Urinary Incontinence—Discussion	63.7	51.0	12.7
Management of Urinary Incontinence—Treatment	40.1	31.2	8.9
Physical Activity in Older Adults—Advice	53.1	40.3	12.8
Physical Activity in Older Adults—Discussion	59.0	43.6	15.3
Osteoporosis Testing in Older Women	80.2	51.2	29.0
Osteoporosis Management in Women Who Had a Fracture	27.7	13.2	14.6
Glaucoma Screening in Older Adults	77.2	44.0	33.2

**Lower rates signify better performance.*

APPENDIX 17B: VARIATION IN PLAN PERFORMANCE—THE 90TH PERCENTILE VS. THE 10TH PERCENTILE: MEDICARE PPOS

HEDIS EFFECTIVENESS OF CARE MEASURES MEDICARE PPO STATISTICS—2009			
MEASURE	90TH PERCENTILE	10TH PERCENTILE	DIFFERENCE
Wellness and Prevention			
Adult Body Mass Index Assessment	48.2	1.3	46.9
Medical Assistance With Smoking Cessation—Advising Smokers to Quit	84.3	64.3	20.0
Flu Shots for Adults	73.8	57.1	16.7
Breast Cancer Screening	78.2	52.7	25.4
Colorectal Cancer Screening	53.4	28.2	25.2
Chronic Disease Management			
Persistence of Beta-Blocker Treatment After a Heart Attack	87.2	68.0	19.2
Comprehensive Diabetes Care—Blood Pressure Control (<130/80 mm Hg)	38.9	0.6	38.3
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	68.0	0.9	67.0
Comprehensive Diabetes Care—Eye Exams	72.7	47.5	25.2
Comprehensive Diabetes Care—HbA1c Screening	93.8	85.0	8.8
Comprehensive Diabetes Care—Good Glycemic Control (HbA1c <8%)	73.9	7.9	66.0
Comprehensive Diabetes Care—Poor Glycemic Control (HbA1c >9%)*	90.4	17.8	72.6
Comprehensive Diabetes Care—LDL Cholesterol Screening	91.6	78.5	13.2
Comprehensive Diabetes Care—LDL Cholesterol Control (<100 mg/dL)	57.2	9.4	47.8
Comprehensive Diabetes Care—Medical Attention for Nephropathy	90.3	79.9	10.3
Controlling High Blood Pressure	67.2	40.6	26.5
Cholesterol Management for Patients With Cardiovascular Conditions—LDL Cholesterol Screening	92.3	80.8	11.5
Cholesterol Management for Patients With Cardiovascular Conditions—LDL Control (<100 mg/dL)	64.8	13.6	51.3
Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis	86.0	66.2	19.9
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	41.0	15.8	25.2
Pharmacotherapy Management of COPD—Bronchodilators	83.3	60.0	23.3
Pharmacotherapy Management of COPD—Systemic Corticosteroids	73.5	52.8	20.7
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	93.1	85.6	7.5
Annual Monitoring for Patients on Persistent Medications—Anticonvulsants	89.4	56.9	32.4
Annual Monitoring for Patients on Persistent Medications—Digoxin	96.0	87.9	8.2
Annual Monitoring for Patients on Persistent Medications—Diuretics	93.5	86.2	7.3
Annual Monitoring for Patients on Persistent Medications—Combined	93.0	85.2	7.8
Antidepressant Medication Management—Acute Phase	73.8	50.0	23.8
Antidepressant Medication Management—Continuation Phase	59.5	38.2	21.3
Follow-Up After Hospitalization for Mental Illness—Within 7 Days Post-Discharge	60.3	23.3	37.0
Follow-Up After Hospitalization for Mental Illness—Within 30 Days Post-Discharge	76.7	37.9	38.8

HEDIS EFFECTIVENESS OF CARE MEASURES

MEDICARE PPO STATISTICS—2009

MEASURE	90TH PERCENTILE	10TH PERCENTILE	DIFFERENCE
Alcohol and Other Drug Dependence Treatment—Engagement	8.3	0.6	7.7
Alcohol and Other Drug Dependence Treatment—Initiation	78.7	39.0	39.7
Measures Targeted Toward Older Adults			
Fall Risk Management—Discussion	39.2	23.3	15.9
Fall Risk Management—Management	66.0	45.7	20.3
Potentially Harmful Drug-Disease Interactions in the Elderly—Chronic Renal Failure and NSAIDS or Cox-2 Selective NSAIDS*	19.6	4.7	15.0
Potentially Harmful Drug-Disease Interactions in the Elderly—Dementia and Tricyclic Antidepressants or Anticholinergic Agents*	36.7	18.8	18.0
Potentially Harmful Drug-Disease Interactions in the Elderly—Falls and Tricyclic Antidepressants, Antipsychotics and Sleep Agents*	23.5	11.4	12.0
Potentially Harmful Drug-Disease Interactions in the Elderly—Overall Rate*	29.8	14.4	15.5
Use of High-Risk Medications in the Elderly—At Least One Medication*	29.8	14.7	15.1
Use of High-Risk Medications in the Elderly—At Least Two Medications*	8.5	2.0	6.6
Management of Urinary Incontinence—Discussion	65.4	51.9	13.5
Management of Urinary Incontinence—Treatment	42.6	31.5	11.1
Physical Activity in Older Adults—Advice	53.9	42.2	11.8
Physical Activity in Older Adults—Discussion	60.3	47.3	13.0
Osteoporosis Testing in Older Women	81.7	59.3	22.4
Osteoporosis Management in Women Who Had a Fracture	26.5	8.7	17.8
Glaucoma Screening in Older Adults	77.1	49.6	27.5

**Lower rates signify better performance.*

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The State of Health Care Quality Report would not be possible without the hundreds of commercial, Medicare and Medicaid HMO, point-of-service and PPO plans willing to disclose their performance data. Almost 300 PPO plans and more than 700 HMO and POS plans submitted performance information for this report. These plans collectively cover over 118 million Americans, and are to be commended for their commitment to accountability and quality improvement.

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