Arkansas Medicaid Performance

A Report on Quality and Access to Care

ARKANSAS DEPARTMENT OF HUMAN SERVICES

HEDIS 2012

ARKANSAS

Table of Contents

This publication contains the results of selected performance measures drawn from the Healthcare Effectiveness Data and Information Set (HEDIS®*). In its efforts to continuously improve the quality of care in Arkansas, information is obtained from a variety of performance measure activities, including the collection of HEDIS rates. Analysis of HEDIS data has provided Arkansas Medicaid with the information needed to design and implement its groundbreaking HCPII program and countless other health care quality improvement programs.

*HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).







"For many years, Americans have been burdened by rising health-care costs that, unfortunately, haven't always resulted in improved care...Arkansas is changing the game with a new payment system aimed at lowering costs and improving the quality of care.[1]"

— Gov. Mike Beebe
Weekly Column|Radio Address
Jan. 11, 2013

In an environment of changing health care standards and delivery systems, the Arkansas Department of Human Services has made quality improvement and performance assessment a cornerstone in its efforts to improve the delivery of health care for all Arkansans.

Arkansas's new Health Care Payment Improvement Initiative (HCPII) and the enhanced collaboration between State and private health insurers will work to increase the timely, cost-effective delivery of clinically appropriate health care services.

Bringing together health care providers from different disciplines to target clinical conditions will provide members with a focused continuity of care that allows providers to focus on members' wellness and self-management. Simultaneously, concerted efforts by the State and private payers to develop and implement performance measurement and improvement as a cooperative team will result in changing the way the business of health care is conducted in Arkansas.

In a world of diminishing resources, we must strive to become more judicious in our allocation of these resources. To accomplish this goal, we must have the information necessary to evaluate our progress.

The use of performance measures allows Arkansas to:

- Determine what aspects of healthcare to measure and how to measure it.
- Align its assessments with those of other states through benchmarking.
- Set data-driven goals and performance expectations.
- Communicate with and be accountable to internal and external partners
- Identify and direct future system changes

What's happening in Arkansas Medicaid?

Rising health care costs, funding deficits, and the new Patient Protection and Affordable Care Act (PPACA) have been recent catalysts for change in our nation's health care systems. Arkansas, like other states, is currently in the process of implementing strategies to address and adapt to these challenges. Throughout this process, our state has emerged as a leader, providing a model for innovative healthcare delivery that will improve care for our citizens while reining in costs.

The following innovations have emerged as cutting edge responses to rapidly changing needs:

- Governor Beebe, in conjunction with our state's legislature, recently led the state in an alternative to the usual Medicaid expansion. Instead of simply increasing income levels, making more uninsured citizens eligible for Medicaid coverage, Arkansas proposed to pay the premium costs for citizens to access health care through private insurance companies within the new insurance exchange.
- The Arkansas Payment Improvement Initiative (APII) has partnered Arkansas Medicaid, Arkansas Blue Cross Blue Shield, and QualChoice of Arkansas to develop initiatives to reward health care providers for giving patients high-quality care at reasonable costs. One critical element of APII is the recent implementation of Episodes of Care, which are well-defined treatment algorithms for selected common illnesses or procedures that are approached in a team-like manner, with one physician taking responsibility for the overall treatment plan and costs. Episodes are designed to reward high-quality care that is provided at a "commendable" cost. Several Episodes of Care have been rolled out with more to follow in the coming year.
- Primary Care Medical Homes (PCMH) are a model of care designed to provide patients a local "medical home" from which care is managed, with a focus on preventive care and active chronic disease management. Primary care physicians will be incentivized to more closely monitor and manage the patients entrusted to their care. Physicians will be responsible for monitoring their own performance on selected quality performance measures as well as providing data for independent performance measurement. This model allows for payment to be more closely tied to physician performance, encourages consumer engagement and personal responsibility, and enables more widespread adoption of health information technology.

HEDIS® IS...

- The Healthcare Effectiveness Data and Information Set (HEDIS®).
- A set of standard health care performance measures created and maintained by the National Committee for Quality Assurance (NCQA).
- Used to collect and compare information across health plans and states about the quality of care and services provided to health care beneficiaries.

DATA COLLECTION

- With the exception of the immunization measures, data collected for this report were based solely on claims data submitted to the Division of Medical Services.
- Immunization findings were produced using a hybrid methodology, meaning the claims data were supplemented with information from members' medical records.

INTERPRETING THE RESULTS

- This report summarizes the performance of Arkansas Medicaid on a subset of HEDIS measures for recipients in the primary care case management (PCCM) program. PCCM recipients are assigned a primary care physician (PCP) who is responsible for the delivery of appropriate and timely care.
- The current year's rates are compared to those for a similar population from previous years and national NCQA Medicaid HEDIS benchmarks that are updated annually.
- NCQA's benchmarked rates for managed care plans are generally higher than those of the fee-for-service model used in Arkansas, however, they remain comparable.
- New performance measures were added this year to assess the following:
    - Children's and adolescents' access to primary care (CAP)
    - Follow-up care for members after hospitalization for mental illness (FUH)
    - Utilization of ambulatory care in emergency departments (AMB)

  This being the first year for these measures, there will be no comparison data reported for previous years.

LIMITATIONS

Prior to state fiscal year (SFY) 2011, measures were calculated and reported separately for the ARKids A/Connect Care and ARKids B populations. Calculations were developed for this year's publication using the 2011 PCCM population.

To appropriately compare the 2011 rates with previous years' data, past years' ARKids A/Connect Care and ARKids B results were combined. Previous years' results are presented for the purpose of reviewing reasonably similar historical trends. Due to the differences in the populations evaluated prior to 2011, readers should exercise caution when comparing rates over time.

Pediatric and Adolescent Care

- Rates for well-child visits and adolescent well-child visits continued to show improvement for PCCM members, with a significant increase in the numbers of adolescents receiving well-child visits and children receiving six or more well-child visits during the first 15 months of life. However, performance among PCCM children remained below the NCQA National Medicaid 50th percentile for these measures.

- Well over 80 percent of PCCM children had appropriate access to PCPs during SFY 2011, although these rates did not meet the National Medicaid 50th percentile in any of the four age groups for the first year of reporting.

- Childhood and adolescent immunization rates for PCCM members improved slightly from previous years with the exception of the Hib (H. influenzae type b) vaccine for children. Among the childhood immunization rates, Combination 3 and Hepatitis B vaccines exceeded their respective National Medicaid 50th percentiles. Among adolescents, there was a significantly large increase in the rate of Tdap/Td immunizations.

- Dental visit rates among PCCM members continued to improve and performed above the National Medicaid 75th percentile.

- The rate for appropriate testing for children with pharyngitis continued to rise, but remained below the National Medicaid 50th percentile. However, the rate for appropriate treatment for respiratory infections among children declined significantly in SFY 2011.

WOMEN'S PREVENTIVE CARE

- Breast cancer screening among PCCM members declined sharply in SFY 2010 and reported a significant increase in SFY 2011.

- Rates for cervical cancer screening and chlamydia screening showed large, statistically significant declines in SFY 2011. Neither measure met the National Medicaid 50th percentile.

MANAGEMENT OF CHRONIC DISEASE

- Rates for each of the three diabetes measures showed significant improvement in SFY 2011, although all of the rates continued to perform below the National Medicaid 50th percentile. During SFY 2011, more than half of Arkansas's diabetic PCCM members received a lipid profile and two-thirds of diabetic PCCM members received an HbA1c test.

- In spite of nonsignificant declines among all age groups, approximately 87 percent of PCCM members received the appropriate medication for asthma. The rate for the total number of members receiving appropriate asthma treatment did not meet the National Medicaid 50th percentile, although it was within two percentage points.

- In the first year of reporting, the overall proportion of Arkansas PCCM members with ED visits was below the National Medicaid 50th percentile, with 56.7 ED visits per 1,000 members during SFY 2011. The proportion of visits varied by age group, with the highest proportion of visits among PCCM members 20 through 44 years of age and the lowest proportion among members 10 through 19 years of age.








member demographics

With the State and national focus on the key role of primary care physicians (PCPs) as the driving force behind expanding the reach of preventive care, Arkansas's Primary Care Case Management program (PCCM) plays an important role in coordinating care and contributing to cost-effective health care delivery. The goal of the PCCM program is continuity of care and improved outcomes for members as a result of having one health care provider with whom they can develop an ongoing relationship.

Demographic information in this report is presented for all Medicaid-eligible members enrolled in the PCCM program at any point during state fiscal year (SFY) 2011. Performance measure results are restricted to those members who were eligible for Medicaid and enrolled in the PCCM program for at least 11 months during SFY 2011. Although this reduces the overall number of members included in the report, measurement based on consistent enrollment requirements provides a more accurate snapshot of the performance of the PCCM program.

The following pages contain:

- The number and percentage of PCCM beneficiaries living in each of Arkansas's five regions.
- The number and percentage of PCCM beneficiaries by race.
- The number and percentage of PCCM beneficiaries by age.

Total PCCM Members by Demographic Characteristics

PCCM 2011

664,306

Region

- 198,000 Northwest
- 142,645 Northeast
- 78,388 Southeast
- 161,486 Central
- 83,787 Southwest

Gender

- 367,782 Female
- 296,522 Male
- 2 Unknown

Race

- 369,976 White
- 62,646 Hispanic or Latino
- 5,830 Two or More Races
- 2,523 Native Hawaiian and Other Pacific Islander
- 170,531 Black or African American
- 46,714 Unknown
- 4,064 Asian
- 2,022 American Indian or Alaska Native

Total PCCM Members in Each Age Group

199,193 Toddlers/Children <1-6 Yrs.

294,737 Youth/Adolescents 7-21 Yrs.

130,407 Adult/Retired 22-64 Yrs.

39,969 Senior/Elderly 65-85+ Yrs.

notes

from toddlers to teens

From birth through adolescence, regular check-ups ensure vaccinations are done on time; allow physicians to track physical, emotional, and cognitive development; and allow time for counseling about behaviors that can cause lifelong medical issues or even premature death.

Pediatric and adolescent primary health care is a vital component of national and local efforts to improve our health care system. To make long-term, sustainable changes in our nation's overall health, children must be taught the significance of preventive care and to embrace their personal role in their own wellness and health outcomes.

A performance measure has been added to the report this year that is designed to measure the percentage of children 12 months to 6 years of age who had a visit with a primary care physician (PCP) during the measurement year, and children 7 to 19 years of age who had a PCP visit during the measurement year or during the prior year.

Pediatric and Adolescent Care Measures Reported in this Section:

- Children and Adolescents' Access to Primary Care Practitioners (CAP)
- Well-Child Visits in the First 15 Months of Life (W15)
- Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)
- Adolescent Well-Care Visits (AWC)
- Childhood Immunization Status (CIS)
- Immunizations for Adolescents (IMA)
- Appropriate Treatment for Children with Upper Respiratory Infection (URI)
- Appropriate Testing for Children with Pharyngitis (CWP)
- Annual Dental Visits (ADV)

Measure Definition

Child and Adolescent Access to Primary Care (CAP)

The percentage of members 12 to 24 months and 25 months to 6 years of age who had a visit with a Primary Care Physician during the measurement year.

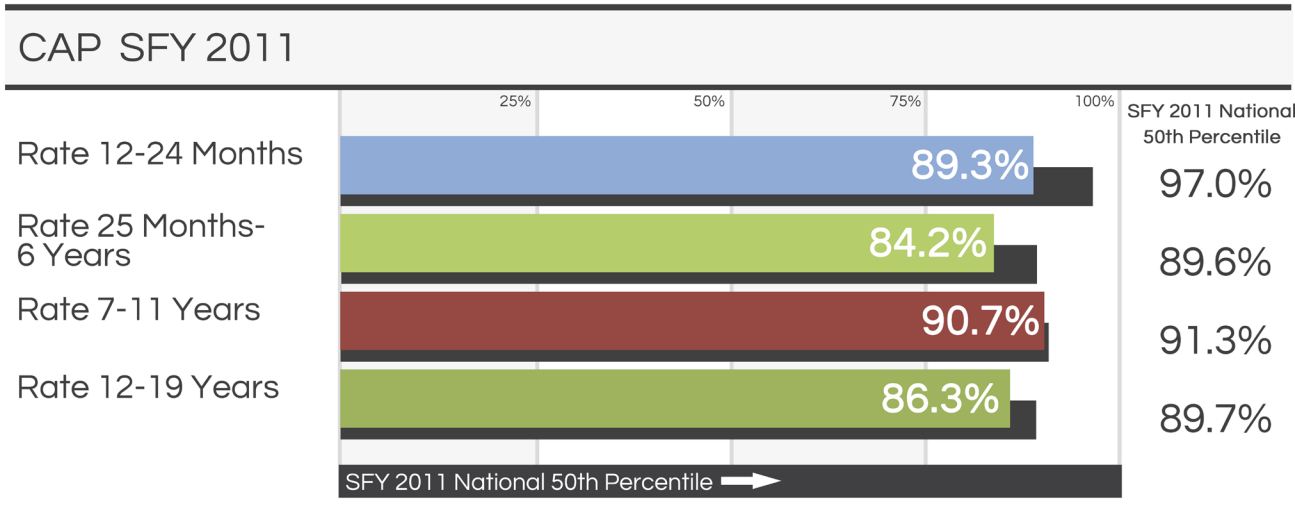
The percentage of members 7 to 12 years and adolescents 12-19 years who had a visit with a Primary Care Physician during the measurement year or one year prior.

Access to primary care, while important for people of all ages, is even more critical for children and adolescents.

Children who do not have access to preventive health care are more likely to experience long-term, debilitating effects from delayed diagnoses, especially when considering the potential consequences of leaving hearing, speech, and sight difficulties untreated.[2]

Health plans, including Medicaid, are taking more of an active role in educating parents about the importance of routine preventive care and addressing barriers to access to care.

As primary care practices move toward the goal of becoming certified as Primary Care Medical Homes, access to care should prove to be one of the first improvements seen in our health care systems.



This is the first year for reporting this measure, therefore no comparison data are available. Black bar represents standard for measure.

Measure Definition

Well-Child Visits in the First 15 Months of Life (W15)

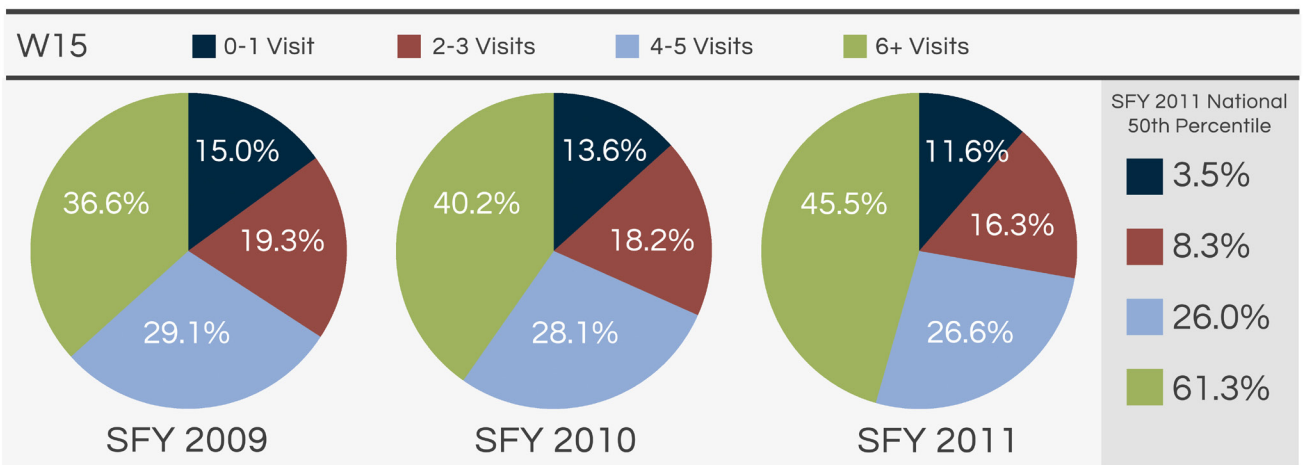
Percentage of members who turned 15 months old during the measurement year and received the recommended number of check-ups with their regular physicians

Because infancy is a time of rapid growth, the American Academy of Pediatrics recommends six or more well-child visits (or check-ups) for infants during the first fifteen months of life.[3]

At these visits, special attention is paid to height, weight, head circumference, vision, hearing, and other signs of normal development.

These check-ups allow the child's primary care physician to keep track of their physical and behavioral development and address any issues before they become serious problems. They also allow parents the chance to learn about what to expect as their baby grows; information about nutrition, sleep, and preventive care; and other important topics.

Researchers have found that children who receive the recommended check-ups are less likely to be hospitalized or visit the emergency department and are more likely to experience better health.



Measure Definition

Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)

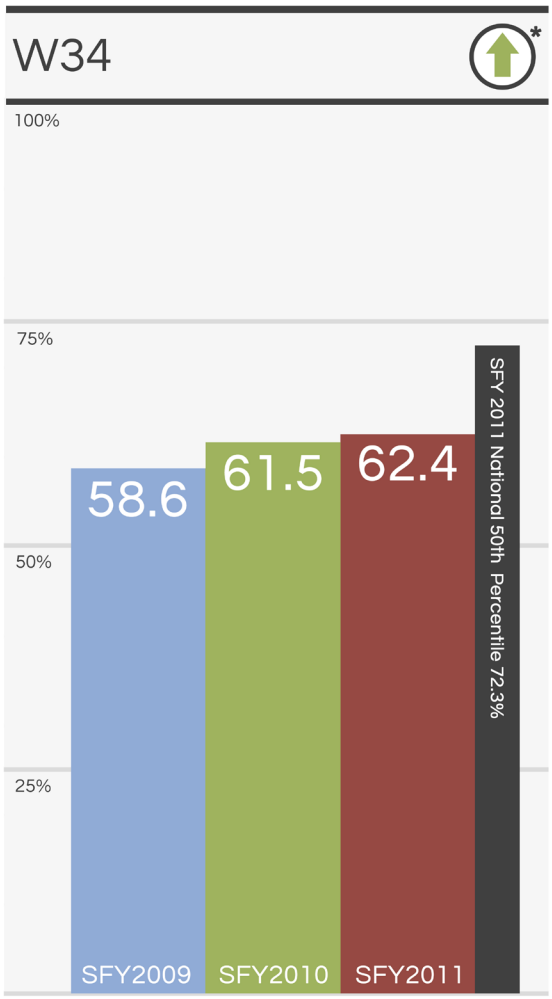
Percentage of members who turned three to six years of age during the measurement year and received one or more check-ups with their regular physician.

When a child has moved beyond the toddler stage, well-child visits (check-ups) are still important, even if there are no significant health issues.

Children between 3 and 6 years of age who are growing and developing normally should be seen once a year by their regular physician.

Check-ups allow for monitoring of physical and psychosocial growth and development, Body Mass Index (BMI), immunization schedules, and a host of childhood milestones and physical issues.

These visits set the stage for a lifetime of preventive care.



* Direction of arrow indicates change in performance between 2010 and 2011.

Measure Definition

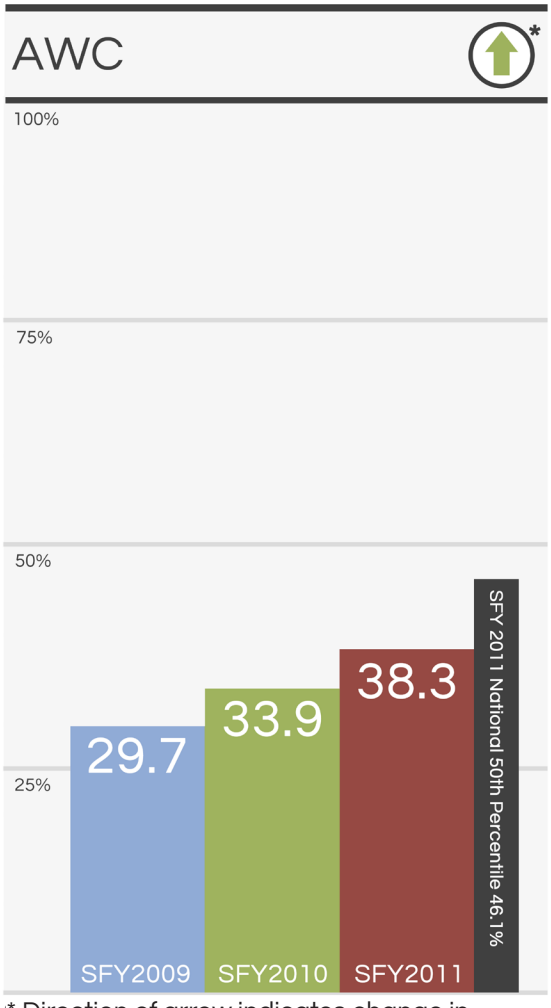
Adolescent Well-Care Visits (AWC)

Percentage of members 12-21 years of age who had at least one complete check-up with a physician during the measurement year.

Adolescence is a time of dramatic emotional, physical, and social change; a time during which children are at the highest risk for engaging in dangerous behavior that can lead to lifelong negative outcomes or even death. This is a time when preventive care conversations can influence how adolescents will view their health while transitioning into adulthood.

It is a critical time for regular check-ups, which include immunization updates and screening tests. The American Academy of Pediatrics recommends annual preventive care visits for all children 11 through 21 years of age.[4] Unfortunately, the National Medicaid 50th percentile is low, indicating that fewer than 50 percent of all adolescents covered under Medicaid have an annual preventive care visit.

Because adolescents often do not receive the recommended preventive care, opportunities are missed for meaningful, ongoing dialogue between physicians and their young patients, resulting in the use of non-routine visits for preventive care.



* Direction of arrow indicates change in performance between 2010 and 2011.

Measure Definition

Childhood Immunization Status (CIS)

Combo 3: Percentage of members who turned two year of age during the measurement year and had all of their recommended vaccinations on or before their second birthday.

While the majority of children today receive their recommended immunizations, there is still an alarming number who do not.

Evidence has shown that minority children from low-income families and children who live in inner cities or rural areas are at the greatest risk of not receiving timely vaccinations.[5]

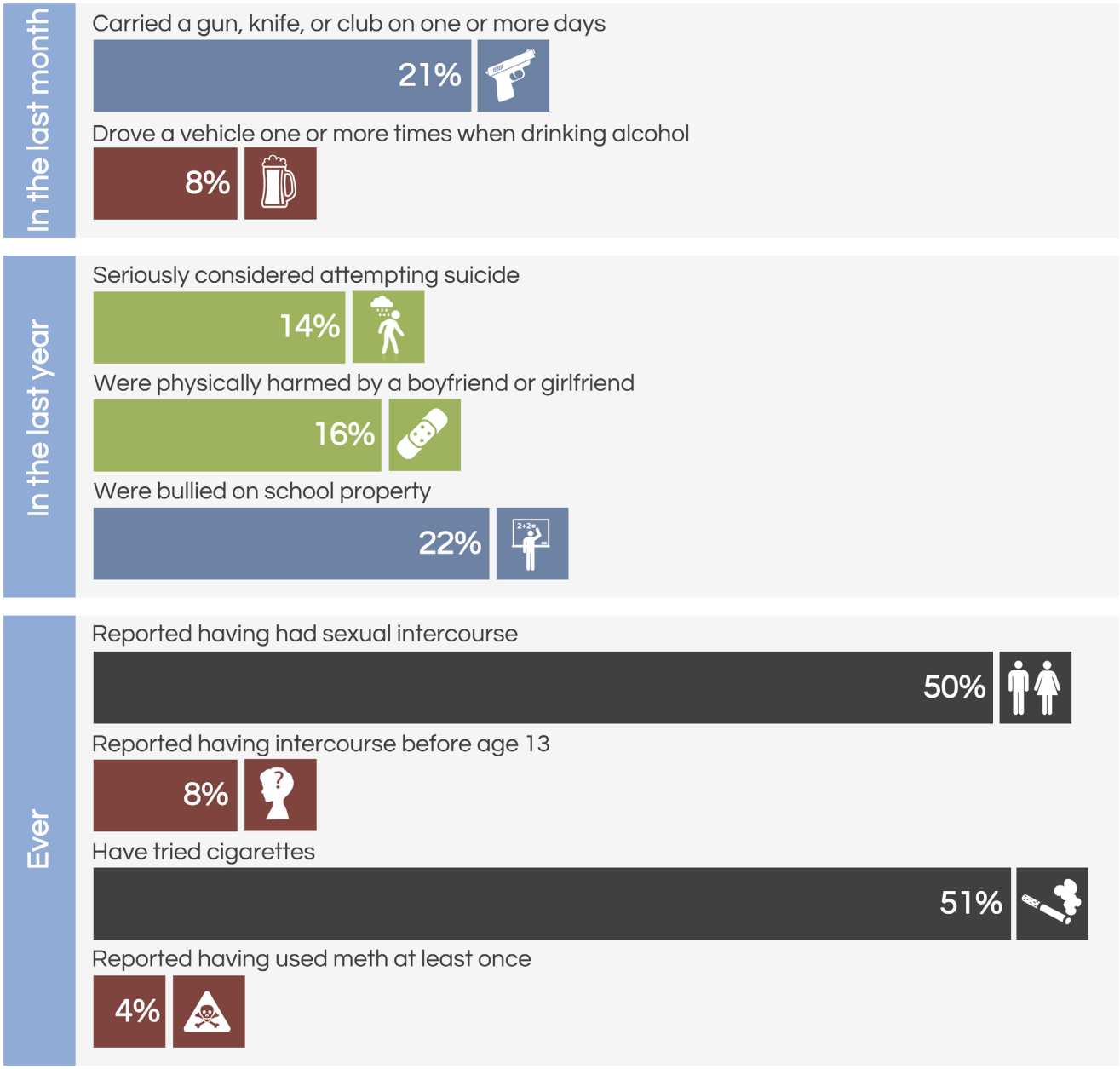
CIS	SFY 2009 (Ark-A, Ark-B)	SFY 2010 (Ark-A, Ark-B)	SFY 2011 (PCCM)	*	SFY 2011 National 50th Percentile
Combo 3	67.5%	66.6%	71.1%	↑	71.0%
Combo 2	73.3%	71.5%	74.5%	↑	75.1%
MMR	88.5%	88.1%	89.4%	↑	91.9%
Chicken Pox (VZV)	88.5%	88.4%	89.6%	↑	91.3%
DTP	76.0%	75.3%	77.1%	↑	81.7%
Polio (IPV)	90.3%	89.4%	92.1%	↑	92.3%
Hepatitis B (HEPB)	91.2%	89.1%	92.4%	↑	91.8%
H. influenzae (HIB)	94.4%	94.5%	91.7%	↓	91.0%
Pneumococcal Conjugate	76.0%	75.3%	77.3%	↑	91.3%

* Direction of arrow indicates change in performance between 2010 and 2011.

Immunization Facts

- Most childhood vaccines are between 90 percent and 99 percent effective in preventing diseases.
- Vaccines protect children as well as the whole community.
- Vaccines are required for school admission.
- Vaccines prevent outbreaks of rare diseases when given according to the recommended schedules.
- Immunization saves nearly $14 billion in direct costs and $69 billion in societal costs each year.

2011 Arkansas Youth Risk Behavioral Survey Highlights (Grades 9-12)[6]



The Centers for Disease Control (CDC) developed the Youth Risk Behavior Surveillance System (YRBSS) to monitor priority, health risk behaviors among youth. It was completed by 1,375 students in 39 public high schools in Arkansas during spring of 2011. The results are representative of all students in grades 9-12.

Measure Definition

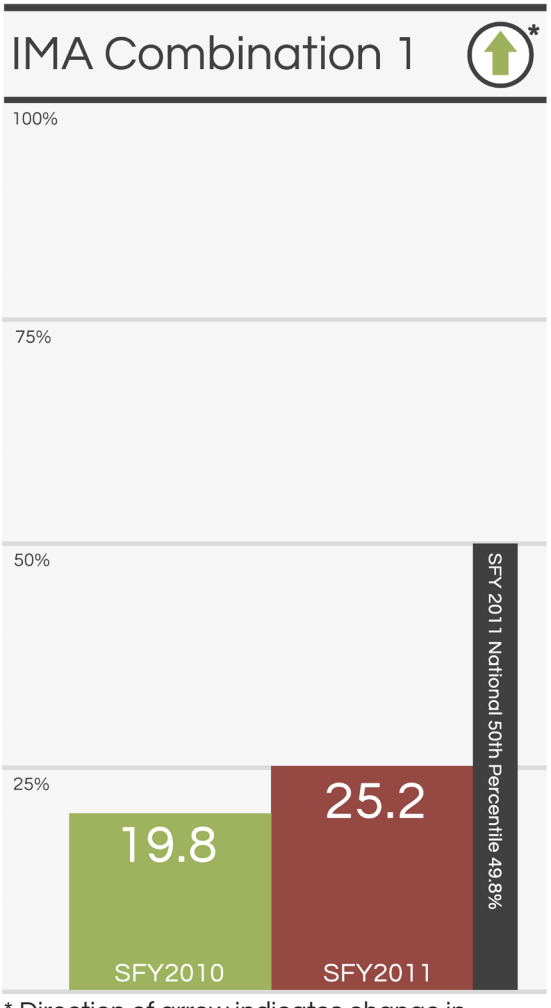
Immunization for Adolescents (IMA)

Percentage of teens 13 years of age who had one dose of meningococcal vaccine and one Tdap (tetanus, diptheria and pertussis) or one Td (tetanus and diptheria) by their 13th birthday.

It is recommended that older children receive booster shots of vaccines that can wear off over time to ensure ongoing protection from diseases.

Many of today's adolescents were born after the current recommendations were established for some immunizations, such as hepatitis B, meaning they did not receive all of the necessary vaccinations during early childhood.

Any time a teen is getting a regular check-up or a physical, the health care provider should work with them to make sure they are brought up to date on important booster shots.



* Direction of arrow indicates change in performance between 2010 and 2011.

IMA	SFY 2010 (Ark-A, Ark-B)	SFY 2011 (PCCM)	*	SFY 2011 National 50th Percentile
Meningococcal	20.7%	26.3%	↑	54.8%
Tdap/Td	35.1%	64.0%	↑	68.5%

* Direction of arrow indicates change in performance between 2010 and 2011.

Measure Definition

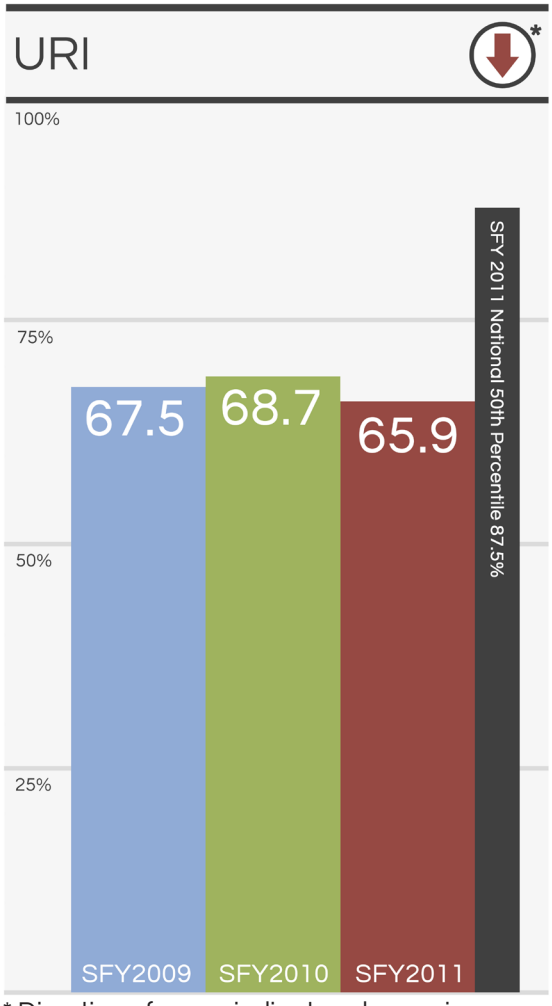
Appropriate Treatment for Children with Upper Respiratory Infection (URI)

The percentage of members who were three months to 18 years of age, were diagnosed with a URI and were not prescribed an antibiotic. A higher rate represents better performance.

Antibiotics do not kill viruses, which cause most upper respiratory infections (URIs). Therefore, using antibiotics to treat URIs is not considered an effective approach.

Antibiotics can cause serious side effects in some patients, which lead to further illness and even death. Excessive and frequent use of unnecessary antibiotics is also causing many bacteria to become drug-resistant, making it more difficult to treat many illnesses such as pneumonia and meningitis.

Appropriate treatment of URIs is the focus of the first episode of care that was implemented as part of the Arkansas Payment Improvement Initiative (APII).



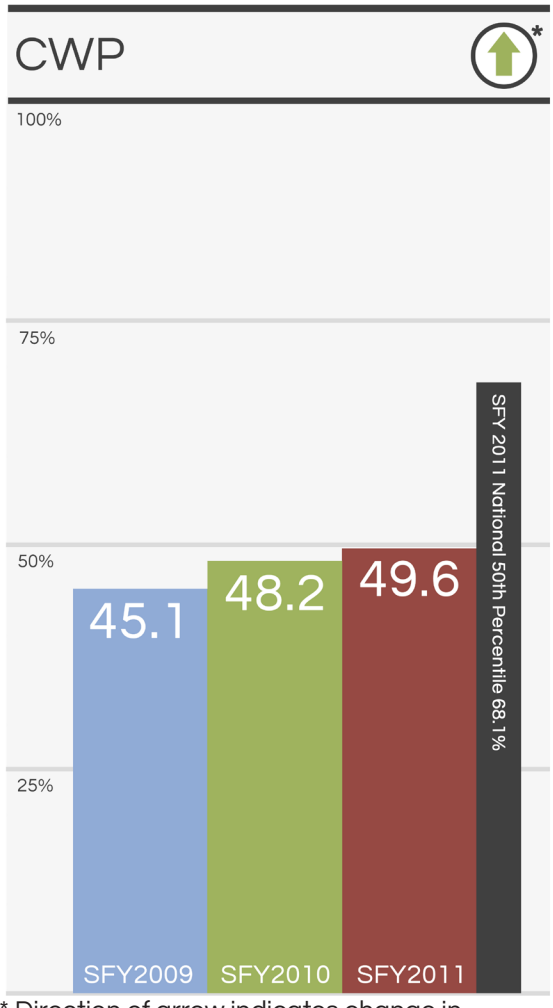
* Direction of arrow indicates change in performance between 2010 and 2011.

Children receiving an antibiotic for a URI have a higher likelihood of a return visit to the treating physician within 30 days than those not receiving an antibiotic, placing a greater burden on both clinicians and patients.[7]

Measure Definition

Appropriate Treatment for Children with Pharyngitis (CWP)

The percentage of members two to 18 years of age who were diagnosed with a sore throat (pharyngitis), given a Group A strep test and prescribed an antibiotic during the measurement year. A higher rate represents better performance.



* Direction of arrow indicates change in performance between 2010 and 2011.

Sore throats (pharyngitis) are most common in children and adolescents, and are responsible for 12 million primary care visits each year in the United States.[8]

They are usually caused by one of two types of infections: (1) a viral, upper respiratory tract infection, or (2) a Group A streptococcus (strep) bacterial infection (strep throat).

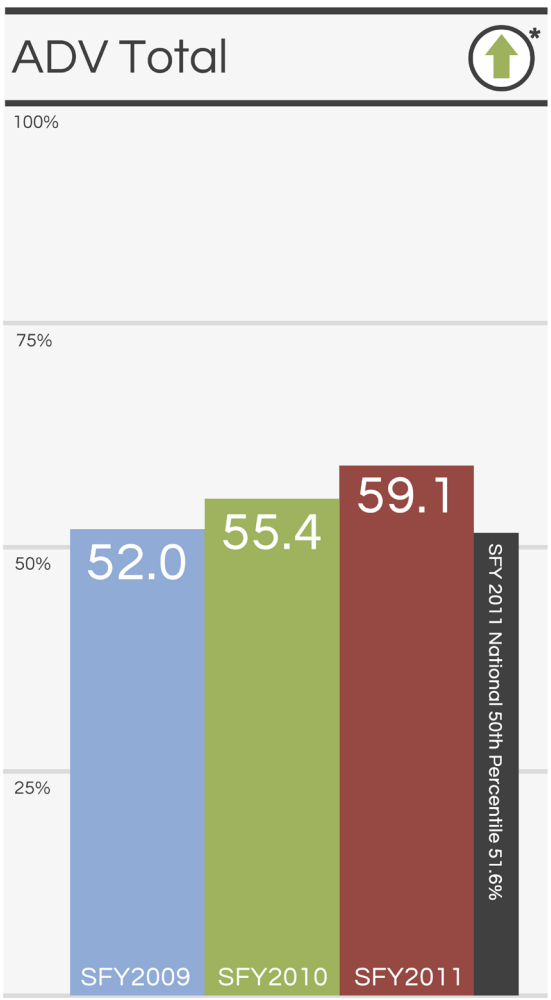
Accurately identifying the cause of a sore throat is important since antibiotics are not effective against the viral infections, which cause most sore throats.

Although Strep A is the cause in only 15% - 30% of pediatric cases, antibiotics are prescribed in 55% - 75% of cases.[9]

Measure Definition

Annual Dental Visits (ADV)

Percentage of members two to 21 years of age who had at least one dental visit during the measurement year.



* Direction of arrow indicates change in performance between 2010 and 2011.

Introducing good dental habits early in life can prevent serious tooth and gum problems and help prevent even more serious health issues now and later in adulthood. During regular dental check-ups children receive exams, fluoride treatments, and molar sealants that prevent cavities from forming.

Once a tooth becomes painful the damage usually cannot be reversed, and the tooth often needs a filling, root canal, crown, or extraction. Preventive exams allow dentists to spot problems early enough to prevent these painful and often expensive treatments.

As is true of other health issues, fostering the development of preventive habits can preserve good health and save resources throughout a child's lifetime.

women's preventive care

Preventive health care is necessary throughout life, and the United States Preventive Services Task Force publishes clinical recommendations for preventive health screenings for adults.[10] Specific recommendations are available for health concerns unique to women, including illnesses that may develop over time with few symptoms.

Screening tests for specific diseases or conditions are most effective for diseases in which early detection can increase the likelihood of survival and improve individuals' quality of life.

The following section presents results for measures designed to evaluate whether women are routinely screened for three diseases that are generally treatable if diagnosed early in their clinical progression.

Women's Care Measures Reported in this Section:

- Breast Cancer Screening (BCS)
- Chlamydia Screening in Women (CHL)
- Cervical Cancer Screening (CCS)

Measure Definition

Breast Cancer Screening (BCS)

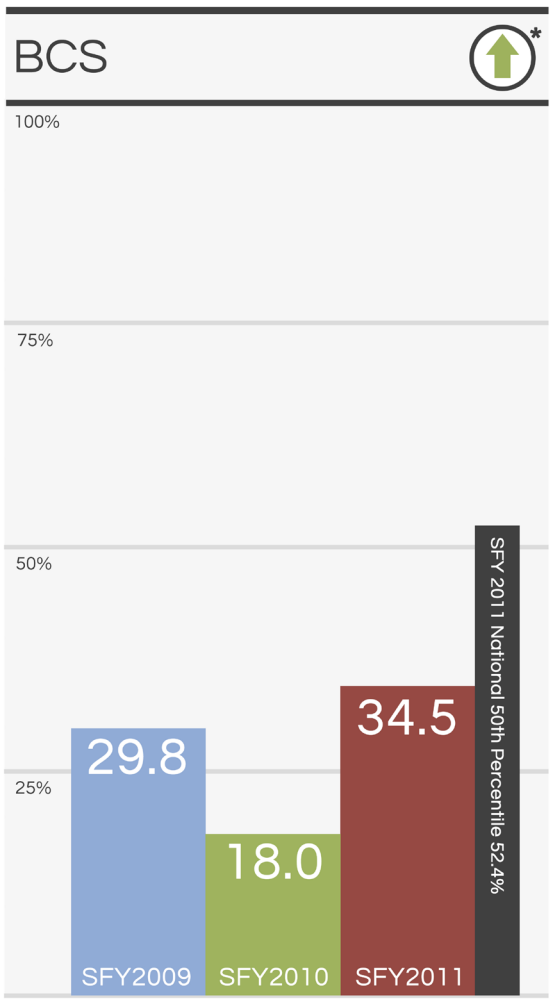
Percentage of women 40 to 69 years of age who had one or more mammograms during the measurement year or the year before.

Breast cancer is the most common cancer and the second leading cause of cancer deaths among women in the United States, with approximately 178,000 new cases reported each year.

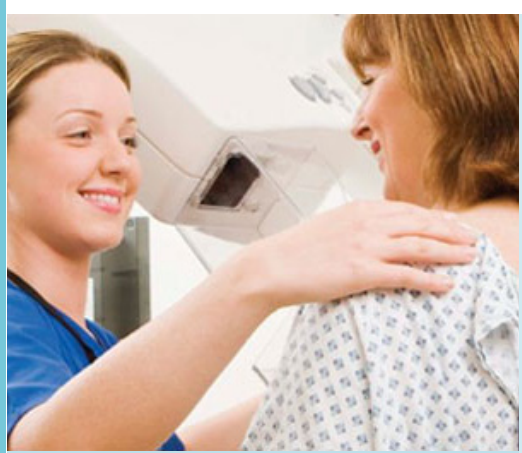
On average, mammography will detect about 80% to 90% of breast cancers in women without symptoms, making it a critical tool to help ensure early detection and increase survival rates.[11]

Since 2009, it is recommended that women who have an average risk of breast cancer receive a routine mammogram every two years beginning at age 50.

The current HEDIS measure, which assesses annual mammography of women 40 to 69 years of age, has not been amended to reflect the new recommendations.



* Direction of arrow indicates change in performance between 2010 and 2011.



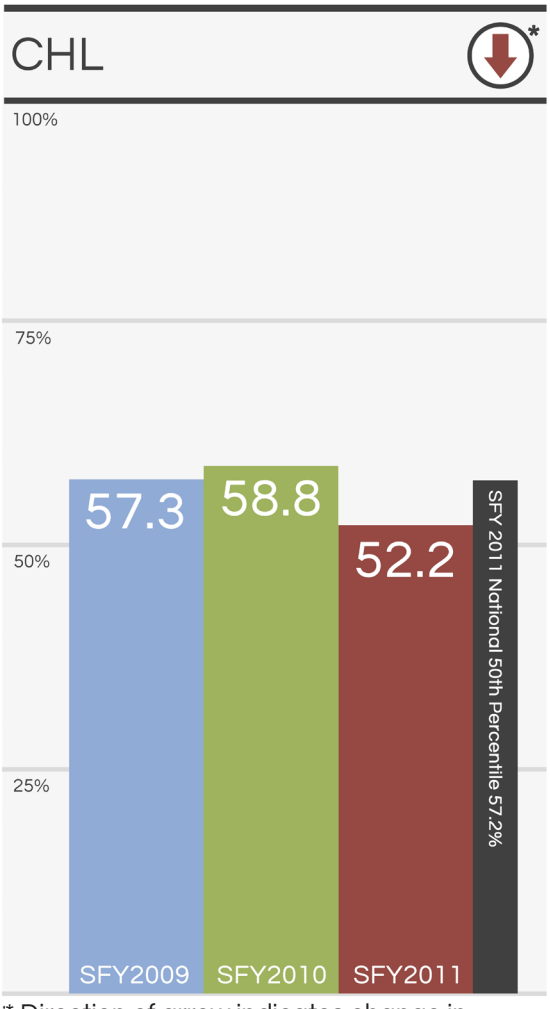
Why Screen for Breast Cancer?[12]

- Breast cancer is the second most common type of cancer among U.S. women.
- Breast cancer is the second leading cause of cancer deaths in women.
- The five-year survival rate is 98 percent if detected early and 23 percent if detected late.
- Treatment costs in the United States total nearly $7 billion annually.
- Early-stage treatment is more effective and less expensive.

Measure Definition

Chlamydia Screening (CHL)

Percentage of women 16 to 24 years of age, identified as sexually active and having had at least one test for Chlamydia during the measurement year.



* Direction of arrow indicates change in performance between 2010 and 2011.

About 70 to 90 percent of women and a large percentage of men infected with chlamydia will show no symptoms. Infected pregnant women can pass it to their infants during birth, which can lead to serious eye damage or pneumonia, making screening tests very important. Significant declines in prevalence have been noted over the last 10 years in areas where screening programs have been in place.[13]

Why Screen for Chlamydia?[14]

- Chlamydia is extremely common and is the leading cause of infertility in the United States.
- Fifty percent of untreated pregnant women with Chlamydia will pass it on to their infants.
- About 70 percent of infected women have no symptoms to alert them to the problem.
- Chlamydia increases the likelihood of becoming infected with HIV if exposed.
- Chlamydia infections are readily treated with antibiotics.

Measure Definition

Cervical Cancer Screening (CCS)

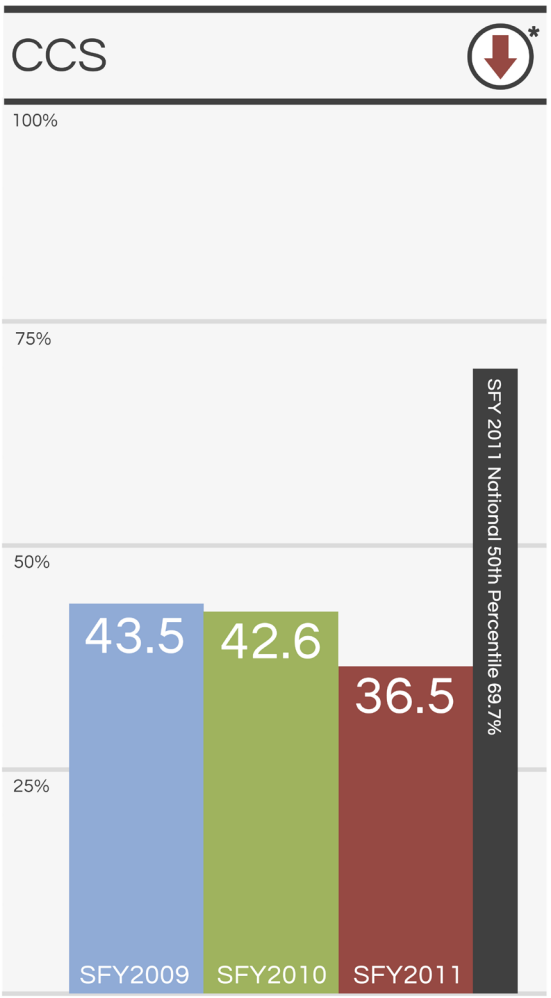
Percentage of women 21 through 64 years of age who had one or more Pap smears during the measurement year or one or two years before.

Cervical cancer is a disease suffered by women that can be more easily and successfully treated if detected early.

The Pap smear is a simple and reliable test designed to look for changes in cervical cells before full-scale, aggressive cancer develops.

Regular screening can detect pre-cancers and decrease the chances of death from cervical cancer for women in most age groups.

Caution should be used in interpreting these results, as current clinical guidelines for cervical cancer screening have changed in the time following the data measurement period.

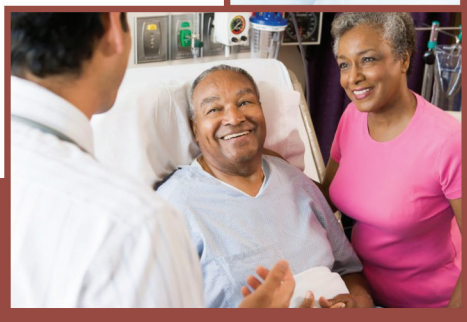


* Direction of arrow indicates change in performance between 2010 and 2011.

Why Screen for Cervical Cancer?[15]

- Cervical cancer is the second most common cancer among women worldwide.
- Pre-cancers and early cancers usually show no symptoms.
- The survival rate is nearly 100 percent if caught early and treated appropriately.
- The cost of cervical cancer treatment is $300 to $400 million annually in the United States.
- Lack of regular Pap tests significantly increases the risk of developing cervical cancer.

notes



management of chronic disease

Nearly half (about 133 million) of all Americans suffer with a long-term or "chronic" illness.[16] Approximately 75 percent of the nation's health care costs are spent on treating chronic illness.[17] For more than 25 million people, chronic illness causes daily limitation of activities and often immeasurable emotional consequences.

Appropriate diagnosis, treatment, and management plans can work to limit the physical, psychological, and financial burdens that plague patients with a long-term illness. Identification and implementation of such practices is critical as we struggle to contain health care costs in the United States and for the individuals dealing with these illnesses on a daily basis.

Measures Reported in this Section:

- Comprehensive Diabetes Care (CDC)
  - HbA1c Testing
  - Lipid Profile
  - Eye Exam
- Use of Appropriate Medications for People with Asthma (ASM)
- Follow-Up after Hospitalization for Mental Illness (FUH)
- Ambulatory Care: Emergency Department Visits (AMB)

Measure Definition

Comprehensive Diabetes Care (CDC)

HbA1C Testing — The percentage of persons with Type 1 or Type 2 diabetes, 18 to17 years of age, who had one or more hemoglobin tests during the measurement year.

LDL-C Screening — The percentage of people 18 to 75 years of age with diabetes who had at least one LDL cholesterol (LDL-C) test during the measurement year.

Eye Exam — The percentage of persons with diabetes 18 to 75 years of age who were tested for diabetic retinal disease during the measurement year.

The American Diabetes Association reports that 8.3 percent of the U.S. population has Type 1 or Type 2 diabetes, which continues to be the leading cause of kidney failure, non-traumatic lower-extremity amputations, and new cases of blindness among adults 20–74 years of age.[18]

Diabetes also increases the risk of glaucoma and cataracts. Routine eye exams promote early detection of problems and can prevent minor vision problems from becoming major ones, such as vision loss.

An effective management plan for diabetes includes one-on-one treatment provided by a comprehensive team of health care providers. Such teams may be comprised of endocrinologists, dietitians, nurse educators, eye doctors, podiatrists, pharmacists, dentists, and therapists.

CDC	SFY 2009 (Ark-A, Ark-B)	SFY 2010 (Ark-A, Ark-B)	SFY 2011 (PCCM)	*	SFY 2011 National 50th Percentile
HbA1c Testing	63.2%	58.4%	67.7%	↑	82.2%
Lipid Profile Performed	51.1%	48.7%	55.4%	↑	75.4%
Eye Exam	48.7%	44.7%	49.3%	↑	52.8%

* Direction of arrow indicates change in performance between 2010 and 2011.

Measure Definition

Use of Appropriate Medications for People with Asthma (ASM)

Percentage of asthma patients five to 50 years of age who were appropriately prescribed medication during the measurement year.

Asthma has become pervasive in the United States. More than 38 million U.S. residents will be diagnosed with asthma in their lifetime, including 8.7 million children.[19] Proper treatment can help patients to lead full and active lives. However, when not treated properly, asthma can lead to repeated trips to the emergency room, many missed work and school days, limitation of daily activities, and even hospitalization.

ASM	SFY 2009 (Ark-A, Ark-B)	SFY 2010 (Ark-A, Ark-B)	SFY 2011 (PCCM)	*	SFY 2011 National 50th Percentile
Years 5-9	94.7%	93.0%	92.1%	↓	
Years 10-17	90.3%	88.8%	87.2%	↓	
Years 18-56	62.7%	61.6%	57.7%	↓	
Years 5-11	94.2%	93.1%	91.9%	↓	92.3%
Years 12-50	83.2%	82.2%	80.7%	↓	
Total	89.5%	88.4%	87.2%	↓	88.9%

* Direction of arrow indicates change in performance between 2010 and 2011.

The age groupings for reporting this measure were changed in 2011, and comparative data for the National 50th Percentile are not available for all age groups presented for SFY 2011.

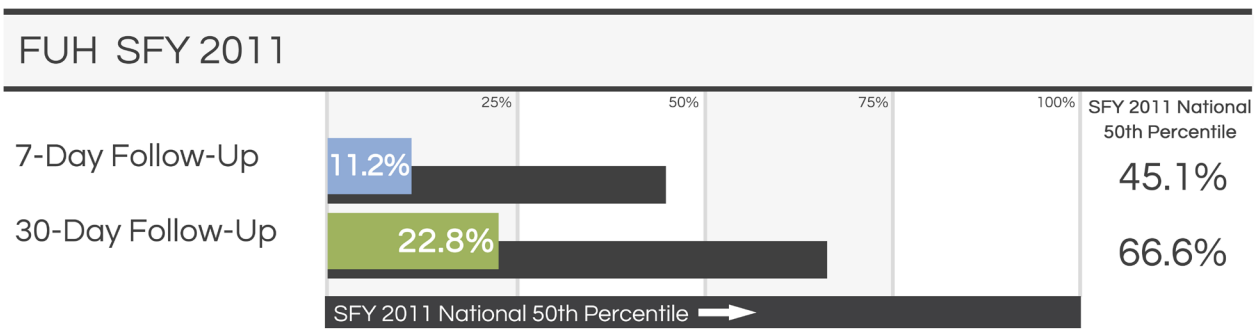
Measure Definition

Follow-Up After Hospitalization for Mental Illness (FUH)

For members six years of age and over, who were hospitalized for selected mental illness and received subsequent outpatient treatment, two measurements are reported:

- The percentage of discharges after which follow-up care was received within 7 days of discharge
- The percentage of discharges after which follow-up care was received within 30 days of discharge

Close monitoring of patients returning home after being hospitalized for a mental illness is important to ensure that progress made during the inpatient stay is not lost. Monitoring is necessary to identify any adverse medication reactions and to assess the patient's adherence to a new treatment routine or adjustments to their previous treatment plan. Successful transition of a patient back into his or her home and community can be greatly enhanced by observation in the immediate post-hospitalization period and after the patient has had some time to settle back into a routine.



This is the first year for reporting this measure, therefore no comparison data are available. Black bar represents the standard for the measure.

1 in 5 people nationally suffer from mental illness; approximately **57.7 million Americans** yearly.

Source: National Council for Community Behavioral Healthcare. http://www.preventionlane.org/mh/mh-stats-infographic.jpg

Timely follow-up care can reduce the risk of repeat hospitalization to treat a mental health episode.

Source: Health Net Federal Services https://www.hnfs.com

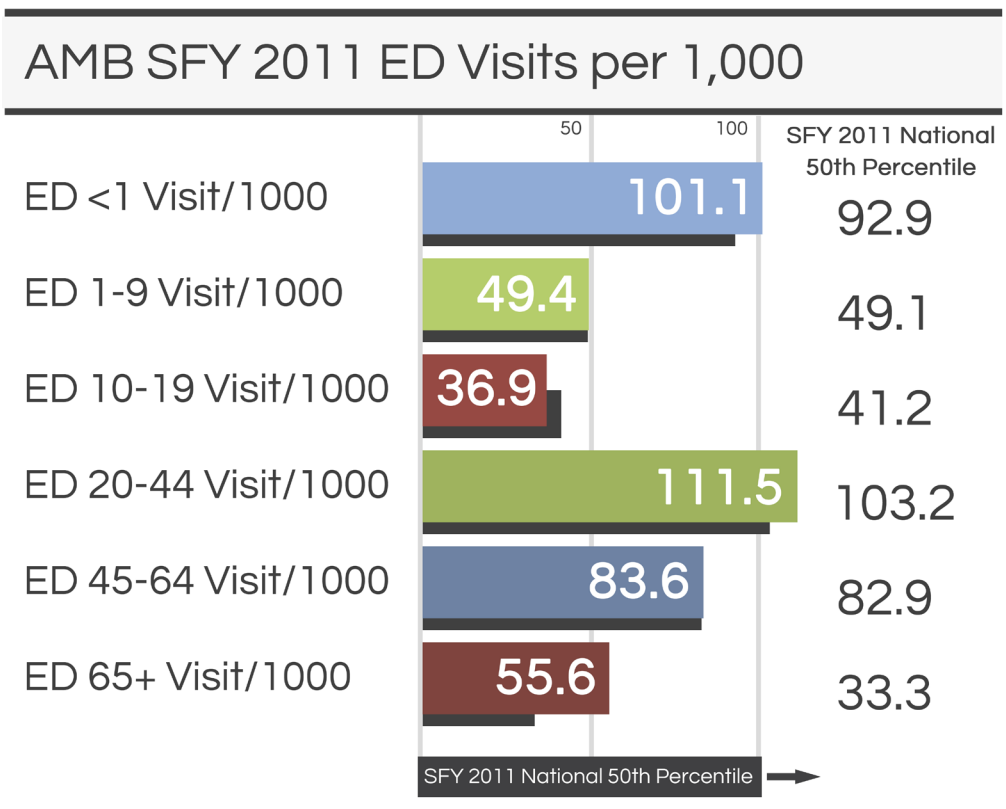
Measure Definition

Ambulatory Care: Emergency Department Visits (AMB)

Summary of the use of ambulatory care in the Emergency Department (ED) during the measurement year; reported as total number of visits per 1,000 member months. All visits not resulting in hospital admission, but occurring on different days, are included.

Unlike other rates presented, Ambulatory Care: ED Visits results show ED utilization by counting the the number of ED visits per 1,000 member months among members by age group. As shown in the chart, members 20 through 44 years of age had the highest rate of ED visits during SFY 2011 when compared to the other five age groups.

Performance on this measure does not directly indicate quality of care, but can be used in conjunction with other measures and subsequent investigation to uncover deeper issues surrounding members who seek care in the ED when more appropriate sources of medical care are available, such as the member's assigned primary care physician.



This is the first year for reporting this measure, therefore no comparison data are available. Black bar represents the standard for the measure.

1 Governor Beebe's weekly column and radio address: A New Partner in Improving Health Care. Available at: http://governor.arkansas.gov/newsroom/index.php?do:newsDetail=1&news_id=3739. Accessed on August 29, 2013.

2 National Committee for Quality Assurance (NCQA), Quality Compass®. Available at: https://www.qualitycompass.org/QcsExternal/docs/InterpretingtheMeasures.pdf, page 7. Accessed on June 10, 2013.

3 Committee on Practice and Ambulatory Medicine and Bright Futures Steering Committee. Recommendations for preventive pediatric health care. Pediatrics. 2007 Dec; 120: 1376.

4 U.S. Department of Health & Human Services, Agency for Healthcare Research and Quality. National Quality Measures Clearinghouse. Available at: http://www.qualitymeasures.ahrq.gov/content.aspx?id=38931&search=(awc). Accessed on September 3, 2013.

5 U.S. Department of Health & Human Services, Agency for Healthcare Research and Quality. National Quality Measures Clearinghouse. Available at: http://www.qualitymeasures.ahrq.gov/content.aspx?id=34627&search=(cis). Accessed on July 25, 2013.

6 Arkansas Youth Risk Behavior Survey. Available at: http://www.arkansascsh.org/tinymce/filemanager/files/2011%20YRBS%20Booklet.pdf. Accessed on September 3, 2013.

7 U.S. Department of Health & Human Services, Agency for Healthcare Research and Quality. National Quality Measures Clearinghouse. Available at: http://www.qualitymeasures.ahrq.gov/content.aspx?id=38859&search=uri. Accessed on September 11, 2013.

8 Huhtala, T.A. 2011. Updates on Sinusitis, Pharyngitis and UTI. February 27–March 4, Salt Lake City, Utah.

9 Maltezou, H.C. et al. (2008) Evaluation of a rapid antigen detection test in the diagnosis of streptococcal pharyngitis in children and its impact on antibiotic prescription. Journal of Antimicrobial Chemotherapy, 62:1407–1412.

10 U.S. Preventive Services Task Force. Recommendations for Adults. Available at: http://www.uspreventiveservicestaskforce.org/adultrec.htm. Accessed on September 3, 2013.

11 American Cancer Society. Cancer facts & figures 2011. Atlanta (GA): American Cancer Society; 2011, 9 p.

12 U.S. Department of Health & Human Services, Agency for Healthcare Research and Quality. National Quality Measures Clearinghouse. Available at: http://www.qualitymeasures.ahrq.gov/content.aspx?id=34639. Accessed on July 1, 2013.

13 U.S. Department of Health & Human Services, Agency for Healthcare Research and Quality. Screening for Chlamydial Infection. Available at: http://archive.ahrq.gov/clinic/ajpmsuppl/chlarr.htm#section2. Accessed on July 1, 2013.

14 Maloney, Susan K and Johnson, Christianne. Why Screen For Chlamydia? An Implementation Guide for Healthcare Providers. Partnership for Prevention, Washington D.C. 2008. Available at: http://www.prevent.org/data/files/ncc/whyscreenforchlamydia_web25_8-13-10.pdf. Accessed on July 1, 2013.

15 U.S. Department of Health & Human Services, Agency for Healthcare Research and Quality. National Quality Measures Clearinghouse. Available at: http://www.qualitymeasures.ahrq.gov/content.aspx?id=34640. Accessed on July 1, 2013.

16 Wu SY, Green A. Projection of chronic illness prevalence and cost inflation. Santa Monica, CA: RAND Health; 2000.

17 Centers for Disease Control and Prevention. Chronic Disease Prevention and Health Promotion. Available at: http://www.cdc.gov/chronicdisease/index.htm. Accessed on July 25, 2013.

18 American Diabetes Association. Diabetes Statistics. Available at: http://www.diabetes.org/diabetes-basics/diabetes-statistics/. Accessed on July 25, 2013.

19 American Lung Association Epidemiology & Statistics Unit Research and Program Services. Trends in Asthma Morbidity and Mortality. Washington, D.C.: American Lung Association; February 2010.

For more information about this report please contact:

Health Services Advisory Group, Inc.
124 West Capitol Avenue, Suite 710
Little Rock, AR 72201
501-801-5881
www.hsag.com