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**MercyCare HMO**  
**Quality Program Evaluation**  
**For 2007**

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## **EXECUTIVE SUMMARY AND INTRODUCTION**

### **Introduction**

MercyCare Insurance Company (MercyCare or MCIC) is dedicated to providing high quality healthcare and personalized service to our members by continually seeking to improve health care quality, safety, availability and transparency in addition to improving our business practices in ways that increase member satisfaction with their healthcare and understanding of their insurance benefits.

This evaluation will provide a detailed review of the overall effectiveness of our QI program by examining the following:

- MercyCare HMO HEDIS® and CAHPS® scores as compared to benchmarks
- Progress with quality initiatives
- Monitoring safety
- Summary of overall findings

### **National Recognition**

In 2007 MercyCare Insurance Company, as a part, of Mercy Health System, achieved the highest United States Presidential honor for quality and organizational performance; the Malcolm Baldrige National Quality Award. Information regarding this award can be found at [www.quality.nist.gov](http://www.quality.nist.gov)

### **Quality Performance**

#### **HEDIS®**

Out of 18 HEDIS® clinical measures in 2008, MercyCare was scored in 16 (not scored in 2 since MercyCare did not have enough eligible members to report). Out of the 16 measures that MercyCare participated in, we demonstrated improvement in more than half of the measures. The measures below contribute to our NCQA score. Bold print indicates those showing improvement over the prior year's score. Medical Assistance with Smoking Cessation has been included in the chart below even though it is a CAHPS® measure, because it is a specific measure of healthcare quality.

The following measures have several sub-measures that are rolled up into one composite score by NCQA:

- Antidepressant Medication Management Measure
- Childhood Immunization Status
- Comprehensive Diabetes Care
- Follow Up After Hospitalization for Mental Illness
- Use of Appropriate Medications for People with Asthma

<b>Measure</b>	<b>2008 HEDIS® Results</b>	<b>Increase or Decrease from 2007 HEDIS®</b>
Antidepressant Medication Management Measure		
▪ Optimal Practitioner Contacts	19.82	-5.76
▪ Acute Phase	<b>63.96</b>	<b>2.33</b>
▪ Continuation Phase	<b>52.25</b>	<b>5.74</b>
<b>Appropriate Testing for Children with Pharyngitis</b>	<b>74.78</b>	<b>10.93</b>
Appropriate Treatment for Children with Upper Respiratory Infection	88.38	-4.17
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	27.45	New Measure
Appropriate Use of Medication for Asthma		
▪ <b>Combined Rate</b>	<b>94.33</b>	<b>2.49</b>
▪ <b>Ages 18-56</b>	<b>93.97</b>	<b>1.73</b>
▪ Ages 10-17	Too few eligible members to report	
▪ Ages 5-9	Too few eligible members to report	
Beta-Blocker Treatment After a Heart Attack	Too few eligible members to report	
Breast Cancer Screening-Total	73.04	N/A-methodology changed
Cervical Cancer Screening	81.11	N/A-methodology changed
Childhood Immunization Status		
▪ Combo 2	91.21	-1.31
▪ <b>Combo 3</b>	<b>89.01</b>	<b>1.16</b>
<b>Cholesterol Management for Patients with Cardiovascular Disease (LDL-C screening performed)</b>	<b>83.04</b>	<b>3.04</b>
Comprehensive Diabetes Care		
▪ LDL-C Screening Performed	83.8	-1.11
▪ HgbA1c Testing	90.61	-2.41
▪ <b>Nephropathy Monitoring</b>	<b>82.39</b>	<b>2.89</b>
▪ HgbA1c Poorly Controlled	16.67	-2.02
<b>Controlling High Blood Pressure</b>	<b>62.13</b>	<b>2.54</b>
Follow-Up After Hospitalization for Mental Illness		
▪ 7 Days	68.75	N/A not scored in 2007
▪ 30 Days	90.63	N/A not scored in 2007
Glaucoma Screening in Older Adults	Too few eligible members to report	
<b>Medical Assistance with Smoking Cessation (Advising smokers to quit)</b>	<b>77.93</b>	<b>2.25</b>
Persistence of Beta-Blocker Treatment After a Heart Attack	Too few eligible members to report	
<b>Timeliness of Prenatal Visits</b>	<b>95.7</b>	<b>3.46</b>
Timeliness of Postpartum Care	69.89	-4.25
Use of Imaging Studies for Low Back Pain	78.17	3.44

Below is a breakdown of the percentile bands that each measure fell into:

<b>Below 50<sup>th</sup> Percentile</b>	<b>50<sup>th</sup> to 75<sup>th</sup> Percentile</b>	<b>75<sup>th</sup> to 90<sup>th</sup> Percentile</b>	<b>90<sup>th</sup> Percentile and Above</b>
Appropriate Testing for Children with Pharyngitis	Antidepressant Medication Management Measure-Acute Phase Treatment	Antidepressant Medication Management Measure-Continuation Phase Treatment	Childhood Immunization Status-Combo 2
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	Antidepressant Medication Management Measure-Optimal Practitioner Contacts Cervical Cancer Screening	Breast Cancer Screening-Total	Childhood Immunization Status-Combo 3
Cholesterol Management for Patients with Cardiovascular Disease (LDL-C Screening Performed)		Comprehensive Diabetes Care Screening-HgbA1c Testing	Follow-Up After Hospitalization for Mental Illness-30 Days
Controlling High Blood Pressure	Comprehensive Diabetes Care Screening-LDL-C Screening Performed	Follow-Up After Hospitalization for Mental Illness-7 Days	Hemoglobin A1C-Poorly Controlled
Timeliness of Postpartum Care	Comprehensive Diabetes Care Screening-Nephropathy Monitoring Medical Assistance with Smoking Cessation-Advising members to Quit	Timeliness of Prenatal Care  Appropriate Use of Medication for People with Asthma-Combined Rate Appropriate Use of Medication for People with Asthma-18-56 Use of Imaging Studies for Low Back Pain	

Our ultimate goal is to have all of the key measures at or above the 75<sup>th</sup> percentile. As a first step to get to that goal, MercyCare is focusing on those measures that have fallen below the 50<sup>th</sup> percentile. Stronger interventions have been put into place for appropriate testing for children with pharyngitis and timeliness of postpartum care. Our expectation is that these two measures will be above the 50<sup>th</sup> percentile in next year’s HEDIS report. We are currently ramping up a new “Healthy Heart” disease management program to impact Cholesterol Management for Patients with Cardiovascular Disease and Controlling High Blood Pressure scores. We will also undertake a retrospective review of cases that did not pass the HEDIS measure. We have not previously had an intervention for the other measure now falling below the 50th percentile, “Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis.” Our Medical Director will be sending out a letter to our physicians reminding them to refrain from using antibiotics in adults with acute bronchitis without co-morbid conditions with accompanying references. We will also be analyzing our results by physician to reveal any pattern that would be amenable to a stronger intervention.

## **CAHPS®**

CAHPS® scores are a result of surveys sent out in the spring to assess members' satisfaction with MercyCare from the prior year. Results summarize member experiences through ratings, related to five composite scores (composite scores are made up of several questions) and four overall ratings of consumer experience:

### **Composite Scores**

- Claims Processing
- Customer Service
- Getting Care Quickly
- Getting Needed Care
- How Well Doctors Communicate

### **Overall Ratings**

- Rating of All Health Care
- Rating of Health Plan
- Rating of Personal Doctor
- Rating of Specialist Seen Most Often

The results of these CAHPS® questions are also factored into our NCQA score. Out of the nine survey items above, comparisons can be made for eight of them. The results for the customer service composite cannot be compared to 2007 results. Results were not reported last year by any health plan due to the impact of changing from the CAHPS 3.0H to CAHPS 4.0H. MercyCare demonstrated improvement in three of the eight CAHPS 4.0H survey items. Those items that did show improvement are identified as bolded in the table below.

<b>Survey Item</b>	<b>2008 Results</b>	<b>Increase or Decrease from 2007 Results</b>
<b>Claims Processing Composite</b>	<b>84.52</b>	<b>.89</b>
Customer Service Composite	77.3	Not reported
Getting Care Quickly Composite	83.07	-.1%
<b>Getting Needed Care Composite</b>	<b>83.16</b>	<b>.23</b>
<b>How Well Doctors Communicate Composite</b>	<b>93.09</b>	<b>.98</b>
Rating of All Health Care	70.05	-2.47
Rating of Health Plan	61.13	-1.37
Rating of Personal Doctor	82.13	-1.87

Rating of Specialist Seen Most Often	73.77	-2.65
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Below is a breakdown of the percentile bands that each measure fell into:

<b>Below 50th Percentile</b>	<b>50th to 75th Percentile</b>
Claims Processing Composite	Rating of Health Plan
Customer Service Composite	Rating of Personal Doctor
Getting Care Quickly Composite Rating of Specialist	
Getting Needed Care Composite	
How Well Doctors Communicate	
Rating of All Health Care	
Rating of Specialist Seen Most Often	

Our member's perception of many aspects of our health plan and our services has continued to remain well below our goal. Most of our scores remained below the 50th percentile band despite significant efforts last year to better understand our customer's needs. In fact, there appears to be a disconnect between the internal survey process, which occurred immediately following a members visit to one of our providers and this annual survey. It does appear that there is a direct correlation between the benefit plan offered by the employer and the member satisfaction. Given that more and more employers in our service area are choosing HMO plans with higher deductibles and co-pays seems to have hurt our relative performance. This year the score for Rating of Health Plan did move up from below the 50th percentile to between the 50th and 75th percentile. When comparing MercyCare results to national percentages, and to those of our primary regional competitor, it is evident that the trending is equivalent. Moving forward, we need to work to improve our member's perception of our health plan by increasing direct communications with our membership to promote, the positive aspects of our plan, including MercyCare accessibility standards, our commitment to quality and our commitment to getting the care that they need, and their questions answered promptly.

### **Safety**

The safety of our members is of the utmost importance. Our commitment to ensuring safety is addressed in the following ways:

<b>Safety Mechanism</b>	<b>Description</b>
Providing education to our members	The MercyCare website provides members with information regarding WI CheckPoint, a site sponsored by the Wisconsin Hospital Association in partnership with the State of Wisconsin. We also encourage improved patient-physician communication through the Ask Me 3 website. We educate our member regarding the importance of electronic medical records and notify members of their rights and responsibilities, and give additional

	quality and safety resources.
Monitoring adverse events	MCIC identifies possible quality issues during all health plan activities such as member complaints, hospital reviews, or case management. Potential quality issues are referred to a peer review process.
Medical record audit	MercyCare audits medical records to ensure practitioners are keeping with organizational standards for documentation, and monitors medical and behavioral health continuity and coordination of care.
Site visits	Prior to a site being credentialed, the provider site is reviewed to ensure the site is in compliance with our safety requirements.
Member complaint review	Member complaints are reviewed routinely to identify complaints related to quality of care, accessibility, and availability.
Pharmacy management	MCIC implements prior authorization processes and quantity limits on specific drugs to prevent over-utilization, ensure appropriateness of medications, identify poly-pharmacy issues, identify abuse of narcotics, and reduce the exposure of members to new medications with uncertain side-effects.
Continuity and coordination of care	MCIC reviews psychiatric admission to make certain the psychiatric discharge summary is sent to the members' primary care physician. MercyCare intervenes when possible to ensure the summary is sent.
Clinical Practice Guidelines	MCIC has clinical practice guidelines in place ensure the care members are receiving is in keeping with the latest standards. These guidelines are made available to all physicians.
Electronic Medical Records	MCIC encourages the use of electronic medical records. Mercy Health System has a timeline in place to implement electronic medical records (EMR) at all sites. Implementation of the EMR will allow practitioners to share information more efficiently and reduce handwritten medical errors.
Safety Improvement Committee	This committee will be responsible for reviewing and analyzing the results of our network hospitals as published by WI CheckPoint. We will interact with our hospitals to encourage appropriate quality improvement efforts. Members will be notified of the availability of comparative results.

### **Overall Summary**

MercyCare continues to exhibit progress amongst quality measures and improvement projects. We will continue to maintain our current quality task forces to serve as improvement forums to identify barriers and implement specific interventions. Our CAHPS scores continue to challenge us to change the perception that our members have of the health plan. We will work to do this through our website, member newsletters, and annual mailings to members. We have also increased our education of members regarding aspects of safety this year. MercyCare will expand this effort by organizing a Safety Committee. We will interact with our hospitals to encourage appropriate quality improvement efforts. Members will be notified of the availability of comparative results.

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## **Report and Analysis**

The following report and analysis reviews individual HEDIS® 2008 scores including interventions completed in 2007 to September 2008.

### **Antidepressant Medication Management**

#### **Measure**

The following components of this measure assess different facets of the successful pharmacological management of major depression.

- **Optimal Practitioner Contacts for Medication Management.** The percentage of members 18 years of age and older as of April 30 of the measurement year who were diagnosed with a new episode of major depression and treated with antidepressant medication, and who had at least three follow-up contacts with a practitioner coded with a mental health diagnosis during the 84-day (12-week) Acute Treatment Phase. At least one of the three follow-up contacts must be with a prescribing practitioner.
- **Effective Acute Phase Treatment.** The percentage of members 18 years of age and older as of April 30 of the measurement year who were diagnosed with a new episode of major depression, were treated with antidepressant medication and remained on an antidepressant drug during the entire 84-day (12-week) Acute Treatment Phase.
- **Effective Continuation Phase Treatment.** The percentage of members 18 years of age and older as of April 30 of the measurement year who were diagnosed with a new episode of major depression and treated with anti-depressant medication and who remained on an antidepressant drug for at least 180 days.

#### **Quality Improvement Activities For Optimal Practitioner Contacts**

- The depression care management program is managed by a certified case manager/RN
- The depression care manager provides telephonic case management to those members with a diagnosis of depression and/or newly started on an antidepressant, who opts into the program. The depression care manager works with the member to coordinate care and appointments when needed, and to serve as an educational resource.
- The depression care management program is reviewed at the depression task force and the behavioral health quality improvement committee.
- The antidepressant medication management measure is reviewed and analyzed at the Behavioral Health Advisory Committee and the Behavioral Health Quality Improvement Committee.

#### **Barriers Identified**

- Lack of coordination between the prescriber and the therapist
- The primary care physician's office cannot make the behavioral health appointment
- Follow up phone calls are not coded
- Physician does not include the depression diagnosis

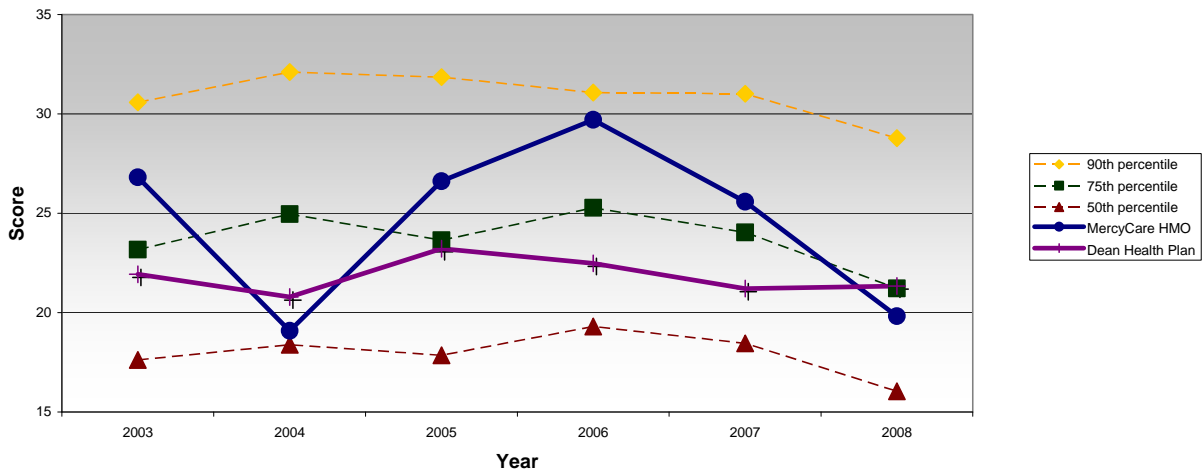
- Co-pays
- Practitioner feels follow up schedule is excessive
- Member declines follow up

### **Interventions for January 2007-September 2008**

- Providers and members will be notified of MercyCare’s 2008 HEDIS® results in their annual notices
- This measure will continue to be reviewed and analyzed at the annual Behavioral Health Advisory Committee
- The Depression care manager will continue to provide educational materials to members and physicians on depression and treatment
- The depression care manager will continue to reinforce the physician treatment plan with members in the care management program
- The depression care manager will continue to work with members in the care management program to assist with facilitating follow up appointments when needed
- MercyCare Health Plans will continue to include this measure in the Depression Guideline
- The depression care manager will continually review her database to ensure she is capturing members newly started on an antidepressant

### **Quantitative Analysis**

**Antidepressant Medication Management -  
Optimal Practitioner Contacts**



- Goal-90<sup>th</sup> percentile  $\geq 28.78\%$
- Dropped from the 75<sup>th</sup> to 90<sup>th</sup> percentile in 2007, to the 50<sup>th</sup> to 75<sup>th</sup> percentile in 2008
- Below State HMO average (19.98)
- 1.52 points below primary regional competitor
- 3-year trend demonstrates a 9.88 point loss

### **Qualitative Analysis**

Although MercyCare has worked to educate members and physicians on the importance of 3 follow-up visits, our percentile ranking has continued to decline. There was much discussion

and analysis on this measure at our behavioral health advisory committee. It continues to be a challenge to get members to return to see a practitioner 3 times in 12 weeks. Members view it as excessive and are protective of their time and resources.

### **Quality Improvement Activities for Acute Phase Treatment**

- The depression care management program is designed and managed by a certified case manager/RN
- The depression care manager provides telephonic case management to those members with a diagnosis of depression and/or newly started on an antidepressant, who opts in. The depression care manager works with members to coordinate care and educate on antidepressant use and length of treatment.
- The depression care management program is reviewed at the depression task force and the behavioral health quality improvement committee.
- The antidepressant medication management measure is reviewed and analyzed at the behavioral health advisory committee and the behavioral health quality improvement committee.

### **Barriers Identified**

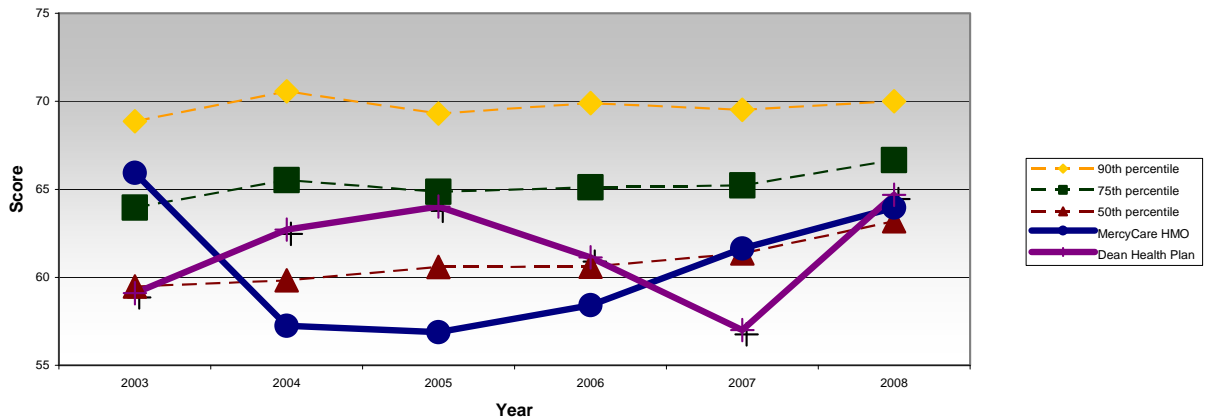
- Need to educate members on their diagnosis (chronic illness)
- Members need more education on antidepressant use (side effects; length of time to be effective)
- Patient self determines discontinuation
- Overuse of antidepressants
- Perceived stigma regarding taking antidepressants

### **Interventions for January 2007-September 2008**

- Providers and members will be notified of MercyCare's 2008 HEDIS® results in their annual notices
- This measure will continue to be reviewed and analyzed at the annual Behavioral Health Advisory Committee
- The Depression care manager will continue to provide educational materials to members and physicians regarding depression and treatment
- The depression care manager will continue to reinforce the physician treatment plan with members in the care management program
- MercyCare Health Plans will continue to include this measure in the Depression Guideline
- The depression care manager will continually review her database to ensure she is capturing members newly started on an antidepressant
- The depression care manager will have more one on one contact with practitioner offices to improve awareness of the program

## Quantitative Analysis

### Antidepressant Medication Management - Effective Acute Phase Treatment



- Goal-90<sup>th</sup> percentile  $\geq 70\%$
- Remained at the 50<sup>th</sup> percentile from 2007 to 2008
- Below the State HMO average (67.66)
- .73 points below primary regional competitor
- 3-year trend demonstrates a 5.54 point gain

## Qualitative Analysis

Although the three-year trend indicates improvement, MercyCare has not been able to move above the 50<sup>th</sup> percentile ranking, indicating that last year's focus on the optimal practitioner contacts as a way to improve this measure was not successful. We are hopeful that by promoting the depression care management program with practitioner groups, our care manager can have an impact on keeping our members on medication for the recommended length of treatment.

## Quality Improvement Activities for Continuation Phase Treatment

- The depression care management program is designed and managed by a certified case manager/RN
- The depression care manager provides telephonic case management to those members with a diagnosis of depression and/or newly started on an antidepressant, who opts in. The depression care manager works with members to coordinate care and educate on antidepressant use and length of treatment.
- The depression care management program is reviewed at the depression task force and the behavioral health quality improvement committee.
- The antidepressant medication management measure is reviewed and analyzed at the behavioral health advisory committee and the behavioral health quality improvement committee.

## **Barriers Identified**

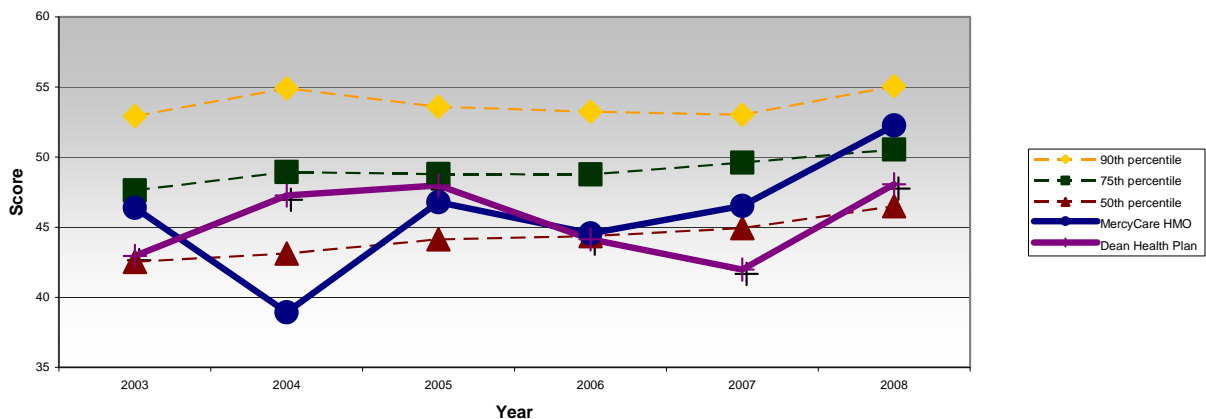
- Members need more education on antidepressant use (side effects; length of time to be effective)
- Cost
- Patient self determines discontinuation

## **Interventions for January 2007-September 2008**

- Providers and members will be notified of MercyCare's 2008 HEDIS® results in their annual notices
- This measure will continue to be reviewed and analyzed at the annual Behavioral Health Advisory Committee
- The Depression care manager will continue to provide educational materials to members and physicians regarding depression and treatment
- The depression care manager will continue to reinforce the physician treatment plan with members in the care management program
- MercyCare Health Plans will continue to include this measure in the Depression Guideline
- The depression care manager will continually review her database to ensure she is capturing members newly started on an antidepressant
- The depression care manager will have more one on one contact with practitioner offices to improve awareness of the program

## **Quantitative Analysis**

**Antidepressant Medication Management -  
Continuation Phase Treatment**



- Goal-90<sup>th</sup> percentile  $\geq 55.07\%$
- Improved from just above the 50<sup>th</sup> percentile in 2007 to between the 75<sup>th</sup> to 90<sup>th</sup> percentile in 2008
- Below State HMO average (50.61)
- 4.14 points above primary regional competitor
- 3-year trend demonstrates a 7.7 point gain

### **Qualitative Analysis**

MercyCare has shown steady improvement over the last three years, indicating that our efforts to educate members about antidepressants could be having an impact. We are hopeful that by promoting the depression care management program with practitioner groups, our care manager can have an impact on keeping our members on medication for the recommended length of treatment; thus, potentially putting MercyCare at our goal of the 90<sup>th</sup> percentile.

### **Appropriate Testing for Children With Pharyngitis (CWP)**

#### **Measure**

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

#### **Quality Improvement Activities**

- Reviewed at the Women's and Children's Health Initiatives Task Force
- Reviewed at the Quality Improvement Task Force

#### **Barriers Identified**

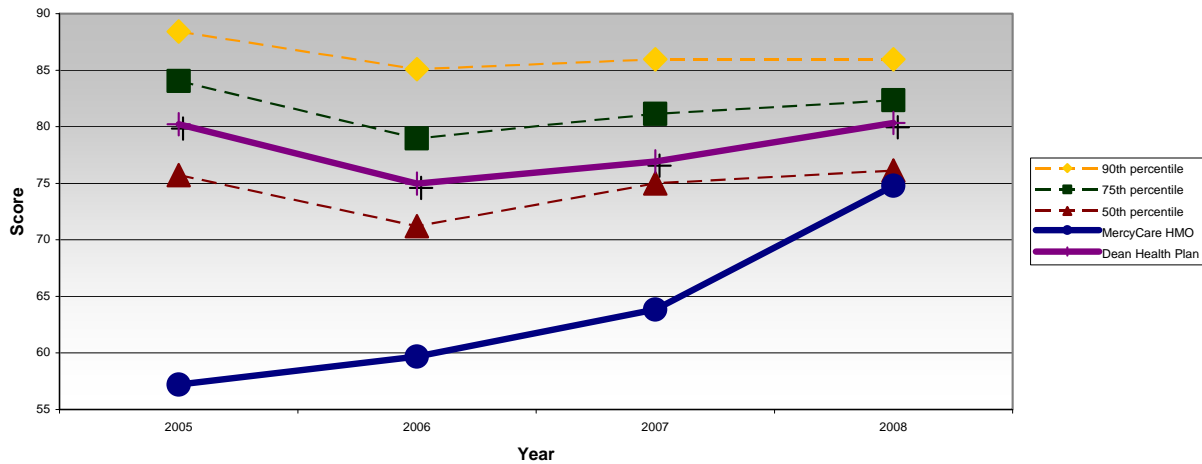
- Labs are not billed by provider sites for strep tests
- Visits are not being coded correctly

#### **Interventions for January 2007-September 2008**

- Reviewed HEDIS® 2008 misses to determine reasons why it was a non-hit
- Reviewed potential misses from January 2008-June 2008
- Identified which clinics are not billing for labs
- Will work with clinics to correct billing
- Will continue to review potential misses on a regular basis
- Performed provider rate comparison of misses
- Will contact physician that contributed to approximately 1/3 of the misses
- Providers and members will be notified of MercyCare's 2008 HEDIS® results in their annual notices

## Quantitative Analysis

### Appropriate Treatment for Children with Pharyngitis



- Goal-90<sup>th</sup> percentile  $\geq$  85.96%
- Remained below 50<sup>th</sup> percentile from 2007 to 2008
- Below State HMO average (79.00)
- 5.56 points below primary regional competitor
- 3-year trend demonstrates a 15.1 point gain

## Qualitative Analysis

MercyCare continues to remain below the 50<sup>th</sup> percentile for this measure, but has demonstrated a significant increase each year. After identifying several billing and coding errors evident in those members that counted as a non-hit for this measure, MercyCare should show a marked increase in percentile rankings and could potentially be at the 90<sup>th</sup> percentile for the 2009 HEDIS® audit.

### Appropriate Treatment for Children With Upper Respiratory Infection (URI)

#### Measure

The percentage of children 3 months–18 years of age who were given a diagnosis of upper respiratory infection (URI) and were not dispensed an antibiotic prescription.

#### Quality Improvement Activities

- Reviewed at the Quality Utilization Management Committee

#### Barriers Identified

- Barriers not identified

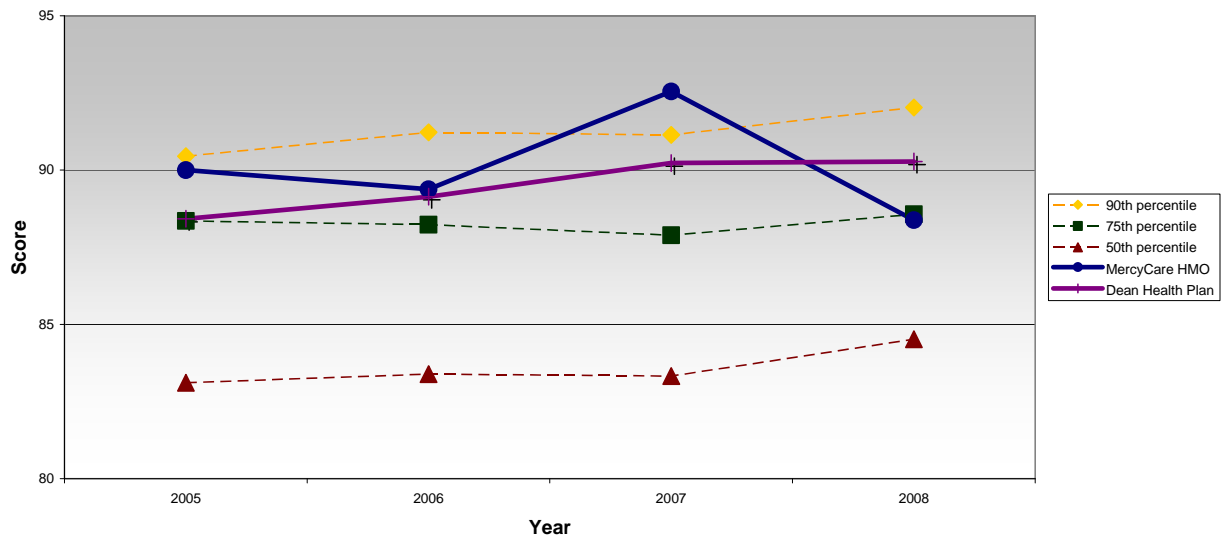
#### Interventions for January 2007-September 2008

- Interventions were not put in place for this measure since 2007 results placed MercyCare above the 90<sup>th</sup> percentile.

- Moving forward, MercyCare plans to send letters to physicians reminding them of this measure
- This measure will be presented at the Quality Utilization Management Committee for review and analysis, where Dr. Mark Goelzer and Dr. Keith Konkol will be present.

### Quantitative Analysis

#### Appropriate Treatment for Children With Upper Respiratory Infections



- Goal-90<sup>th</sup> percentile  $\geq 92.03$
- Dropped from the 90<sup>th</sup> percentile in 2007 to the 75<sup>th</sup> -90<sup>th</sup> percentile in 2008
- Above State HMO average (87.97)
- 1.9 points below primary regional competitor
- 3-year trend demonstrates a 1.0 point loss

### Qualitative Analysis

In past years MercyCare did not have any strong interventions in place for this measure since we were above the 90<sup>th</sup> percentile, evidencing that physicians practices were in line with best practices. This current rate shows a drop in percentiles which could indicate a change in physician practices or practitioner mix. A review of data should give an idea of where the problem lies.

#### Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis

### Measure

The percentage of adults 18–64 years of age with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription. The 2008 measure was inverted and renamed.

### Quality Improvement Activities

- Since the 2008 measure was renamed and inverted, this is considered our baseline.

## **Barriers Identified**

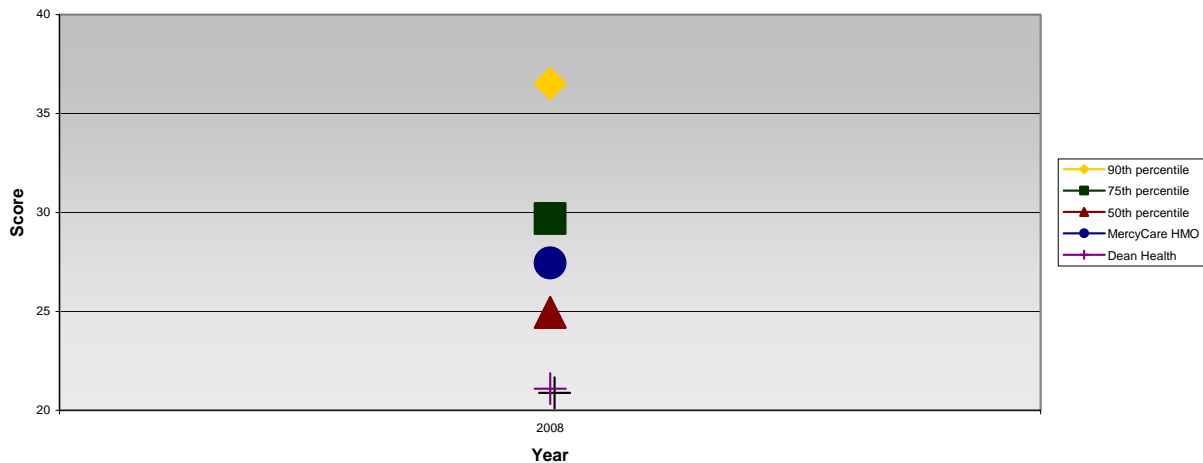
- ✦ N/A-this is baseline

## **Interventions for January 2007-September 2008**

- ✦ Providers and members will be notified of MercyCare's 2008 HEDIS® results in their annual notices
- ✦ Review administrative data for practitioner trends
- ✦ This measure will be presented at the Quality Utilization Management Committee for review and analysis, where Dr. Mark Goelzer and Dr. Keith Konkol will be present.

## **Quantitative Analysis**

### **Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis**



- ✦ Goal-90<sup>th</sup> percentile  $\geq 36.51$
- ✦ In 2008, the specification for this measure changed significantly to invert the rate from the prior year's measure, therefore rates cannot be trended.
- ✦ Below State HMO average (28.02)
- ✦ 6.36 points above primary regional competitor

## **Qualitative Analysis**

Even though there is no current capability of comparing prior years data for this measure, it is evident MercyCare is below where we want to be. Data will need to be reviewed to identify how to proceed and improve results for this measure.

## **Breast Cancer Screening (BCS)**

### **Measure**

The percentage of women 40–69 years of age who had a mammogram to screen for breast cancer. Only two years worth of data is shown in the graph below since the methodology changed in 2006 to include women ages 40 and up instead of 50 and up

## Quality Improvement Activities

- Reviewed at the Quality Improvement Task Force
- Reviewed at the Women's and Children's Health Initiatives Task Force

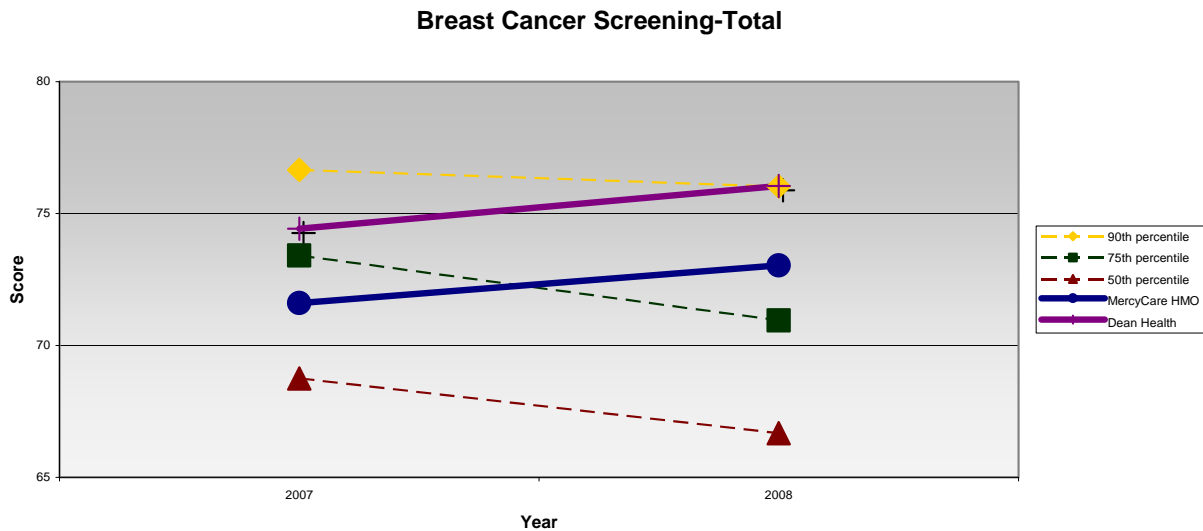
## Barriers Identified

- Women not scheduling mammograms
- Higher Co-pays are impacting screening rates. This has been demonstrated in recent studies.

## Interventions for January 2007-September 2008

- Sent letters to member's age 40-70 who had not had a screening mammogram in the past 2 years (women who had had a mastectomy were excluded)
- Sent educational information to the same members about breast cancer and screening, along with a listing of mammography sites

## Quantitative Analysis



- Goal-90<sup>th</sup> percentile  $\geq$  76.03
- Remained between the 75<sup>th</sup> to 90<sup>th</sup> percentile from 2007 to 2008
- Below the State HMO average (76.08)
- 3.01 points below primary regional competitor
- 1.43 increase from 2007 data to 2008 data. 3 year trend cannot be done since the methodology changed in 2006 to include women ages 40 and up instead of 50 and up

## Qualitative Analysis

Even though the national percentiles have shown a decline, MercyCare has shown some improvement between 2007 and 2008. MercyCare will continue to send reminder letters to members who have not had their mammogram along with educational inserts to continue to measure the effect.

## Cervical Cancer Screening (CCS)

### Measure

The percentage of women 21–64 years of age who received one or more Pap tests to screen for cervical cancer. Only one year of data is shown below since the lower age band was raised to 21 in 2007.

### Quality Improvement Activities

- Reviewed at the Quality Improvement Task Force
- Reviewed at the Women's and Children's Health initiatives Task Force
- MercyCare's medical director reviewed and discussed this measure with Mercy OB/GYN

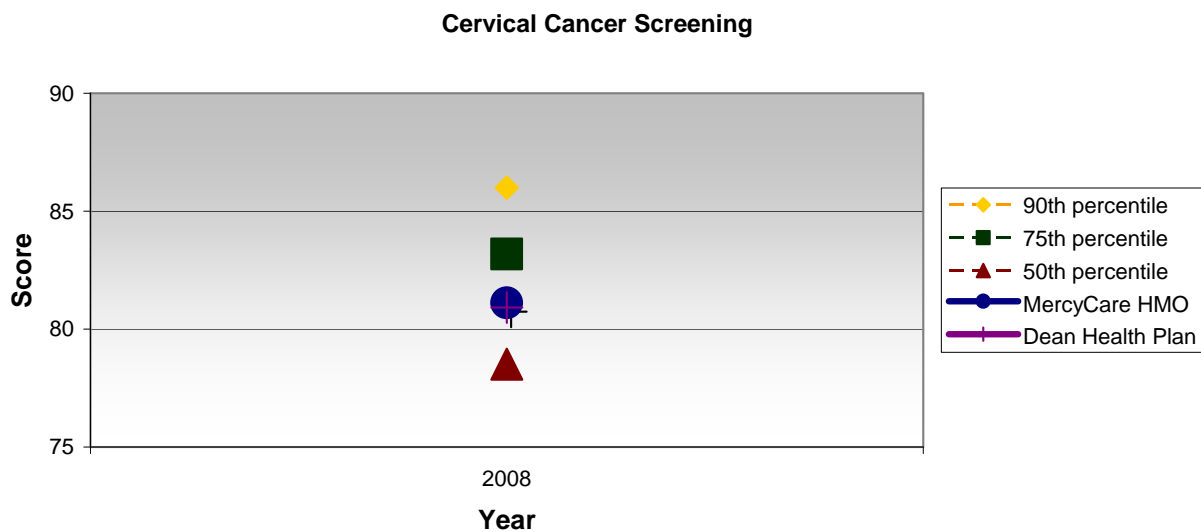
### Barriers Identified

- Women are not scheduling appointments for their exams
- New guidelines from the American College of Gynecology allows more infrequent testing if viral serologies are done for HPV

### Interventions for January 2007-September 2008

- Letters sent to members who had not had a pap test to encourage them to obtain one
- Educational inserts on cervical cancer sent to members who had not had a pap test

### Quantitative Analysis



- Goal-90<sup>th</sup> percentile  $\geq 86\%$
- Cannot compare data from 2007 since the lower age band was raised to 21
- Below State HMO average (84.03)
- .19 points above primary regional competitor
- Unable to produce a 3 year trend since the lower age band was raised to 21 in 2007

## **Qualitative Analysis**

MercyCare is below the goal of the 90<sup>th</sup> percentile. Difficulties remain in achieving significant increases in percentile ranking since most of our network OB/GYN follow ACOG guidelines which are different than HEDIS® specifications.

## **Childhood Immunizations Status Combo-2**

### **Measure**

The percentage of children two years of age who had four diphtheria, tetanus and acellular pertussis (DTaP), three polio (IPV), one measles, mumps and rubella (MMR), three H influenza type B (HiB), three hepatitis B, one chicken pox (VZV) and four pneumococcal conjugate vaccines by their second birthday. The measure calculates a rate for each vaccine and two separate combination rates.

### **Quality Improvement Activities**

- Reviewed at the Women's and Children's Health Initiatives Task Force
- Quarterly identifies children at 9 and 18 months to determine whether or not they are current with their immunizations
- Case manages those at risk children that are identified in the quarterly review
- Monitors rates of newly recommended immunizations such as Hep. A, Influenza, and Rotavirus

### **Barriers Identified**

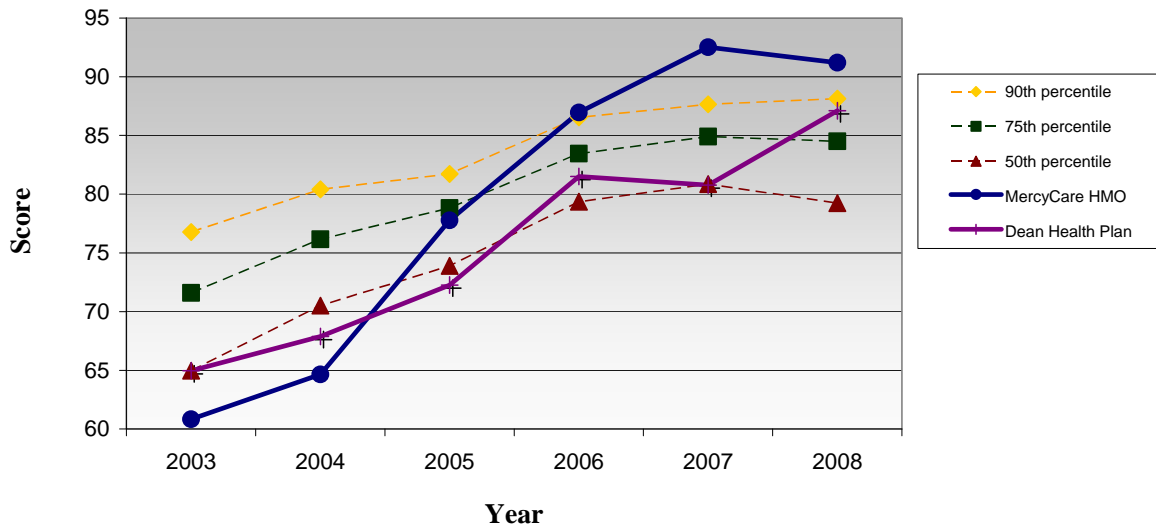
- Children are missing their 18-month well child visit
- Parental refusals to vaccinate are increasing due to continued coverage by national media of possible risks despite the fact that numerous scientific studies have found no evidence of such risks.
- Providers are not proactively catching up on prevnar vaccinations with past shortages
- Providers are slow to adopt new recommendations
- Billing errors occur that effect the integrity of WIR database
- Main delivering hospital has not begun entering newborn hepatitis B into WIR

### **Interventions for January 2007-September 2008**

- Case management process
- Continued Parental education through our healthy living magazine
- Provider and parent education in provider and member newsletters
- One on one telephonic communication with provider and member
- Collaboration with the Wisconsin Immunization Registry (WIR)
- Assure newly recommended vaccines are covered in the benefit plan by reviewing at the Benefits Interpretation Committee (BIC)
- Identified billing errors and worked with provider billers to ensure accurate coding and placed age appropriate claim denials for certain immunizations to force providers to bill correctly

**Quantitative Analysis**

**Childhood Immunization Status - Combo 2**



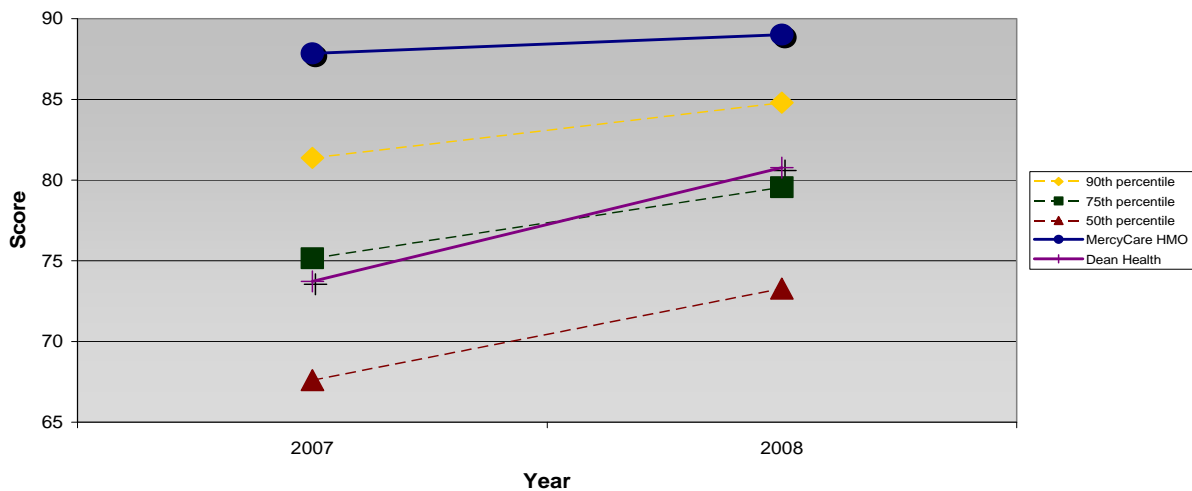
- Goal-90<sup>th</sup> percentile  $\geq 88.14\%$
- Remained above the 90<sup>th</sup> percentile from 2007 to 2008
- Above the State HMO average (86.74)
- 5.5 points above primary regional competitor
- 3-year trend demonstrates a 4.25 point gain

**Qualitative Analysis**

The three-year trend continues to show improvement in the number of children obtaining their vaccinations indicating that our interventions have been successful. The interventions appear to have increased member and provider awareness of not only the importance of vaccinations, but also the ability to keep current with which vaccinations are needed and when.

**Quantitative Analysis**

**Childhood Immunization Status Combo 3**



- Goal-90<sup>th</sup> percentile  $\geq$  84.8%
- Remained above the 90<sup>th</sup> percentile from 2007 to 2008
- Above State HMO average (83.39)
- 8.23 points above primary regional competitor

### **Qualitative Analysis**

We continue to remain above the 90<sup>th</sup> percentile in this measure and did show improvement between 2007 and 2008. It is evident that our current interventions are successful.

## **Cholesterol Management for Patients with Cardiovascular Disease (LDL-C Screening Performed)**

### **Measure**

The percentage of members 18–75 years of age who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous transluminal coronary angioplasty (PTCA) from January 1–November 1 of the year prior to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to measurement year, who had LDL-C screening performed. Only two years worth of data is shown below since data is only available beginning in 2007.

### **Quality Improvement Activities**

- Developed a healthy heart case management program for cardiovascular health

### **Barriers Identified**

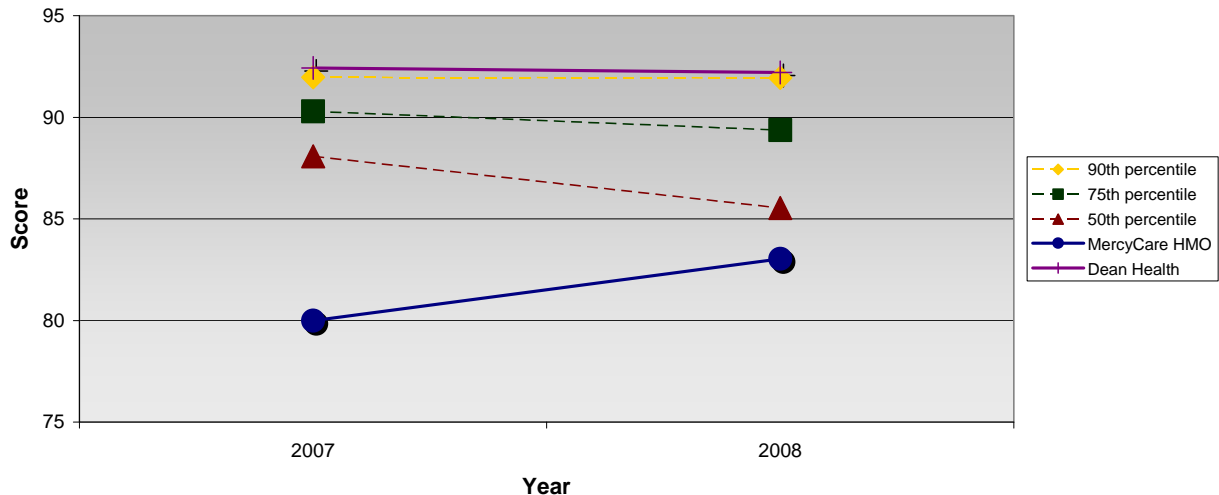
- Member does not understand risk factors
- Members has difficulty modifying their lifestyle
- Tobacco use

### **Interventions for January 2007-September 2008**

- Information to members on what their numbers mean
- Selected members who meet criteria are in telephonic case management
- Helps members determine what changes they are ready to make
- Moving forward, case management will send letters to members notifying them that seeing a nutritionist is part of their benefit package

## Quantitative Analysis

### Cholesterol Management for Patients with Cardiovascular Conditions (LDL-C Screening Performed)



- Goal-90<sup>th</sup> percentile  $\geq 91.94$
- Remained below the 50<sup>th</sup> percentile from 2007 to 2008
- Below State HMO average (91.51)
- 9.17 points below national regional competitor
- Unable to produce a three year trend since the data only goes back to 2007

## Qualitative Analysis

Although MercyCare increased a few percentage points from 2007 to 2008, we continue to remain below the 50<sup>th</sup> percentile. The Heart Healthy Case management program should positively impact these numbers moving forward.

## Comprehensive Diabetes Care

### Measure

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

- Hemoglobin A1c (HbA1c) testing
- HbA1c poor control (>9.0%)
- LDL-C screening (only two years of data is shown in the chart below since the methodology changed in 2007)
- Medical attention for nephropathy (only two years of data is shown in the chart below since the methodology changed in 2007)

## Hemoglobin A1c (HbA1c) Testing

### Quality Improvement Activities

- Participation in the Diabetes Advisory Group (statewide group working to improve care for patients with diabetes; reviews and updates the Wisconsin Essential Diabetes Mellitus Care Guidelines) updated in 2008.
- Participation in the Wisconsin Collaborative Diabetes Quality Improvement Project (HMO's work with the State Diabetes Prevention and Control Project to improve diabetes care state-wide)
- Process and program continually reviewed and updated in the Diabetes Health Management Task Force, Tim Reid, MD, physician advisor and Steven Bartz, MD, physician advisor.
- Diabetes Clinical Practice Guidelines are reviewed and distributed at least every two years, or sooner if new scientific or national standards are published prior to the 2 year review date
- Diabetes Clinical Practice Guidelines are posted on the MercyCare Health Plans website
- Educational articles are published in member and provider newsletters

### Barriers Identified

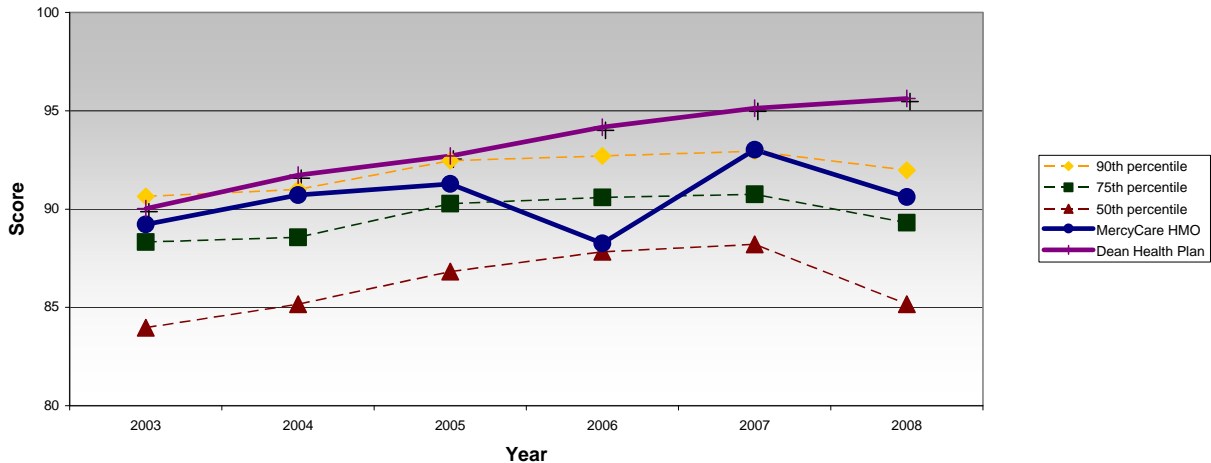
- Member timeliness of obtaining lab work
- Economic factors may be decreasing screening frequency

### Interventions

- Telephonic diabetic case management program managed by a certified case manager, RN, and certified diabetic educator
- Annual physician performance comparative profiles
- Physician and member notification mailings
- Targeted educational member mailings
- Quarterly query for members who have not had an A1c, eye exam, or LDL test in the last 9 months
- Letters sent to those identified in the above query
- Modified and expanded the verbiage in the letters to include LDL and nephropathy

## Quantitative Analysis

### Comprehensive Diabetes Care HbA1c Testing



- Goal-90<sup>th</sup> percentile  $\geq 91.97$
- Dropped from the 90<sup>th</sup> percentile in 2007 to just below the 90<sup>th</sup> percentile in 2008
- Below State HMO average (93.27)
- 5.01 points below primary regional competitor
- 3-year trend demonstrates a 2.36 point increase

## Qualitative Analysis

It is evident that case management continues to have a great impact on this measure and the healthcare received by our members. Although the three-year trend continues to demonstrate improvement, we did show a slight decrease in our percentile ranking from 2007. However, national rankings also showed a dip from 2007 to 2008.

### HbA1c Poor Control (>9.0%)

#### Quality Improvement Activities

- Participation in the Diabetes Advisory Group (statewide group working to improve care for patients with diabetes; reviews and updates the Wisconsin Essential Diabetes Mellitus Care Guidelines updated 2008)
- Participation in the Wisconsin Collaborative Diabetes Quality Improvement Project (HMO's work with the State Diabetes Prevention and Control Project to improve diabetes measures)
- Process and program continually reviewed and updated in the Diabetes Health Management Task Force, Tim Reid, MD, physician advisor, and Steven Bartz, MD, physician advisor
- Diabetes Clinical Practice Guidelines are reviewed and distributed at least every two years, or sooner if new scientific or national standards are published prior to the 2 year review date
- Diabetes Clinical Practice Guidelines are posted on the MercyCare Health Plans website
- Educational articles are published in member and provider newsletters

## Barriers Identified

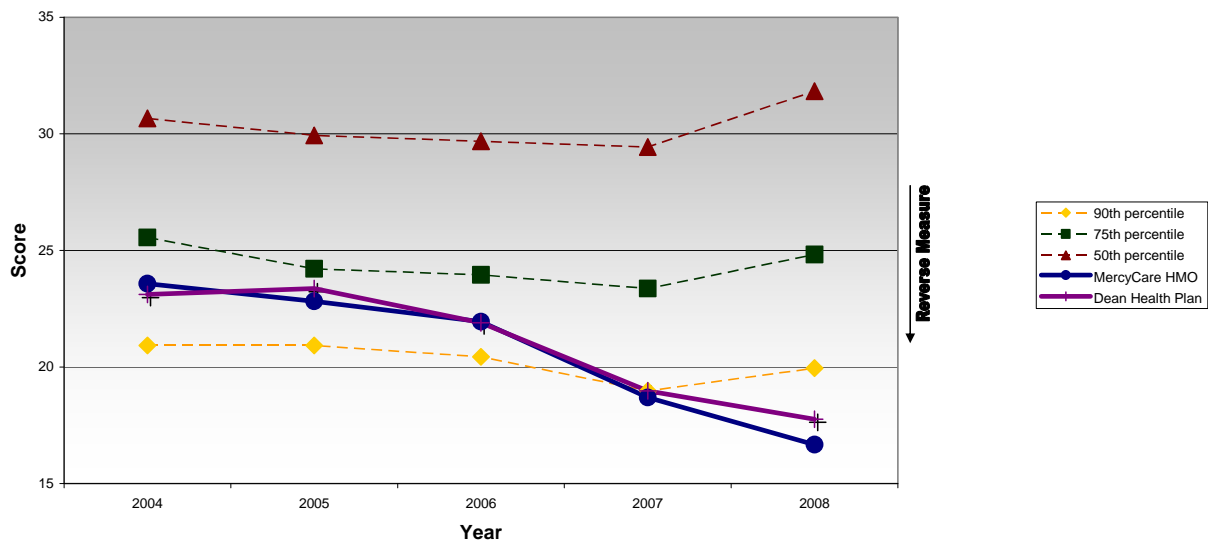
- ✦ None

## Interventions for January 2007-September 2008

- ✦ Telephonic case management program managed by a certified case manager, RN, and certified diabetic educator
- ✦ Annual physician performance comparative profiles
- ✦ Physician and member notification mailings for those members who have not had an A1c in the last 9 months
- ✦ Telephonic case management goal increased to calls every 2 months for all members with a HbA1c  $\geq 8.5$
- ✦ Targeted educational member mailings for those members that were unreachable by phone
- ✦ Changed the working hours of the diabetic case manager to allow more evening phone calls to members
- ✦ If members receive an unable to reach letter twice, then they move to a new level where they receive educational mailings only

## Quantitative Analysis

**Comprehensive Diabetes Care - HbA1c - Poor Control(>9%)**



- ✦ Goal-90<sup>th</sup> percentile  $\geq 19.95$
- ✦ Remained above the 90<sup>th</sup> percentile
- ✦ Above the State HMO average (18.67)
- ✦ 1.09 points above primary regional competitor
- ✦ 3-year trend demonstrates a 5.28 increase

### **Qualitative Analysis**

Interventions have shown to be successful, and continue to demonstrate the effectiveness of case management for this population. MercyCare has been able to demonstrate improvement in this measure consistently since 2004.

### **LDL-C Screening Performed**

#### **Quality Improvement Activities**

- Participation in the Diabetes Advisory Group (statewide group working to improve care for patients with diabetes; reviews and updates the Wisconsin Essential Diabetes Mellitus Care Guidelines updated in 2008)
- Participation in the Wisconsin Collaborative Diabetes Quality Improvement Project (HMO's work with the State Diabetes Prevention and Control Project to improve diabetes measures)
- Process and program continually reviewed and updated in the Diabetes Health Management Task Force, Tim Reid, MD, physician advisor, and Steven Bartz, MD, physician advisor
- Diabetes Clinical Practice Guidelines are reviewed and distributed at least every two years, or sooner if new scientific or national standards are published prior to the 2 year review date
- Diabetes Clinical Practice Guidelines are posted on the MercyCare Health Plans website
- Educational articles are published in member and provider newsletters

#### **Barriers Identified**

- Timeliness of member's obtaining lab work
- Economic factors may be decreasing screening frequency

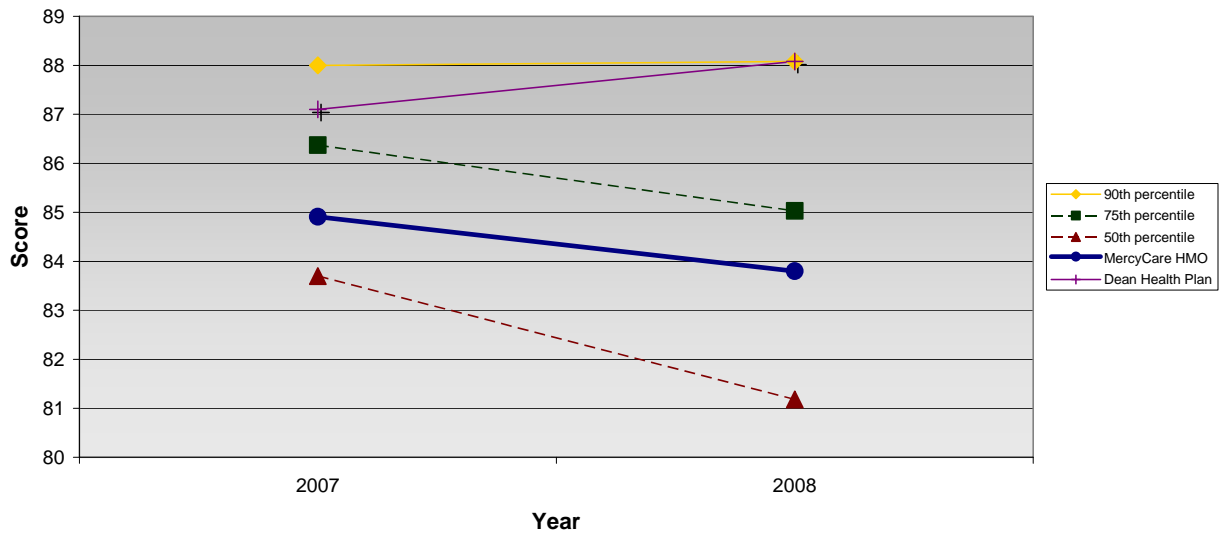
#### **Interventions for January 2007-September 2008**

- Telephonic case management program managed by a certified case manager, RN, and certified diabetic educator
- Annual physician performance comparative profiles
- Quarterly physician and member notification mailings of members who have not had their screening in the last 9 months
- Targeted member mailings

### **Quantitative Analysis**

*\*Methodology changed for LDL screening and control criteria to require testing during the measurement year. May affect data trending.*

## Comprehensive Diabetes Care-(LDL Screening Performed)



- Goal-90<sup>th</sup> percentile  $\geq 88.08$
- Remained between the 50<sup>th</sup> and 75<sup>th</sup> percentile from 2007 to 2008
- Below State HMO average (91.51)
- 4.28 points below primary regional competitor
- Unable to produce a three year trend since the methodology for this data was changed in 2007

### Qualitative Analysis

New methodology is stricter and has resulted in a marked drop in national benchmarks. Our results are still above the 50<sup>th</sup> percentile.

### Medical Attention for Nephropathy

#### Quality Improvement Activities

- Participation in the Diabetes Advisory Group (statewide group working to improve care for patients with diabetes; reviews and updates the Wisconsin Essential Diabetes Mellitus Care Guidelines updated in 2008)
- Participation in the Wisconsin Collaborative Diabetes Quality Improvement Project (HMO's work with the State Diabetes Prevention and Control Project to improve diabetes measures)
- Process and program continually reviewed and updated in the Diabetes Health Management Task Force, Tim Reid, MD, physician advisor, and Steven Bartz, MD, physician advisor
- Diabetes Clinical Practice Guidelines are reviewed and distributed at least every two years, or sooner if new scientific or national standards are published prior to the 2 year review date
- Diabetes Clinical Practice Guidelines are posted on the MercyCare Health Plans website
- Educational articles are published in member and provider newsletters

#### Barriers Identified

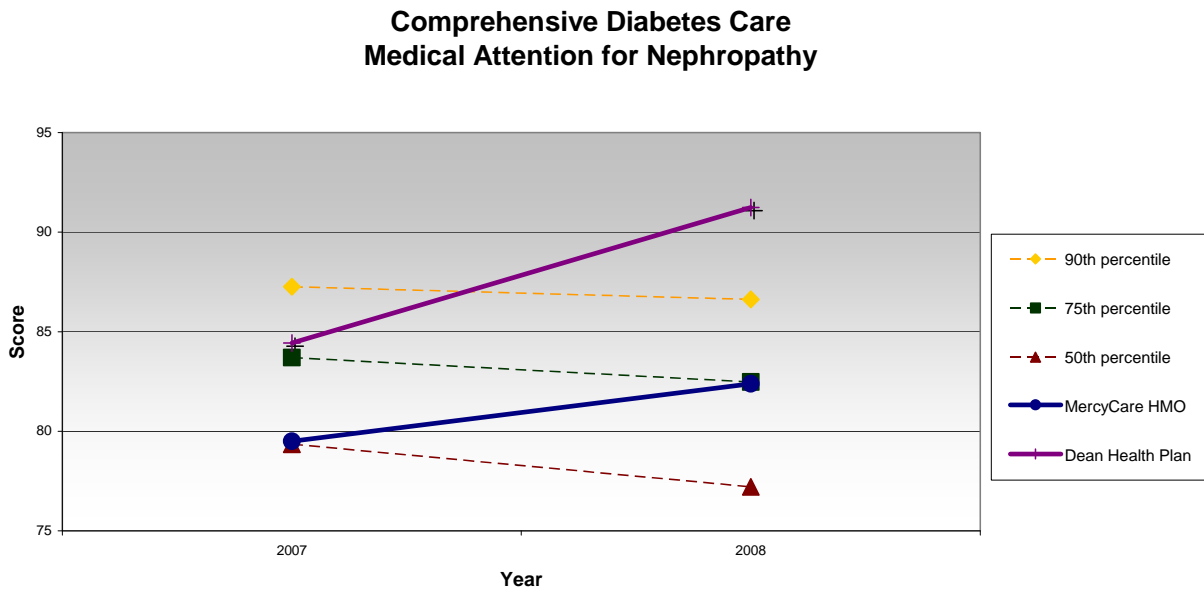
- Timeliness of member's obtaining lab work

### **Interventions for January 2007-September 2008**

- Telephonic case management program managed by a certified case manager, RN, certified diabetic educator
- Annual physician performance comparative profiles using HEDIS® data
- Urine for micro album added to missing lab work
- Quarterly mailings sent to members who haven't had LDL or A1c in the last 12 months
- Sent letters to physicians if the member's eGFR is less than 60 and they are not on an ACE or an ARB

### **Quantitative Analysis**

*Measure specifications were changed in 2007; therefore data cannot be compared to prior year's data*



- Goal-90<sup>th</sup> percentile  $\geq 86.62$
- Improved from the 50<sup>th</sup> percentile in 2007 to the 75<sup>th</sup> percentile in 2008
- Below State HMO average (86.52)
- 8.85 points below primary regional competitor
- Since measure specifications changed in 2007, a 3 year trend cannot be performed

### **Qualitative Analysis**

The intervention in 2007 to send letters to physicians if the patient's eGFR is less than 60, and they are not on an ACE or ARB clearly had an impact. The national trend showed a decline, whereas MercyCare was able to demonstrate improvement.

## Controlling High Blood Pressure (CBP)

### Measure

The percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90) during the measurement year. Only two years worth of data is shown below since the measure specifications changed in 2007.

### Quality Improvement Activities

- Annual work place screening and education for major employer groups
- Developed a heart healthy case management program for select patients that meet specific criteria

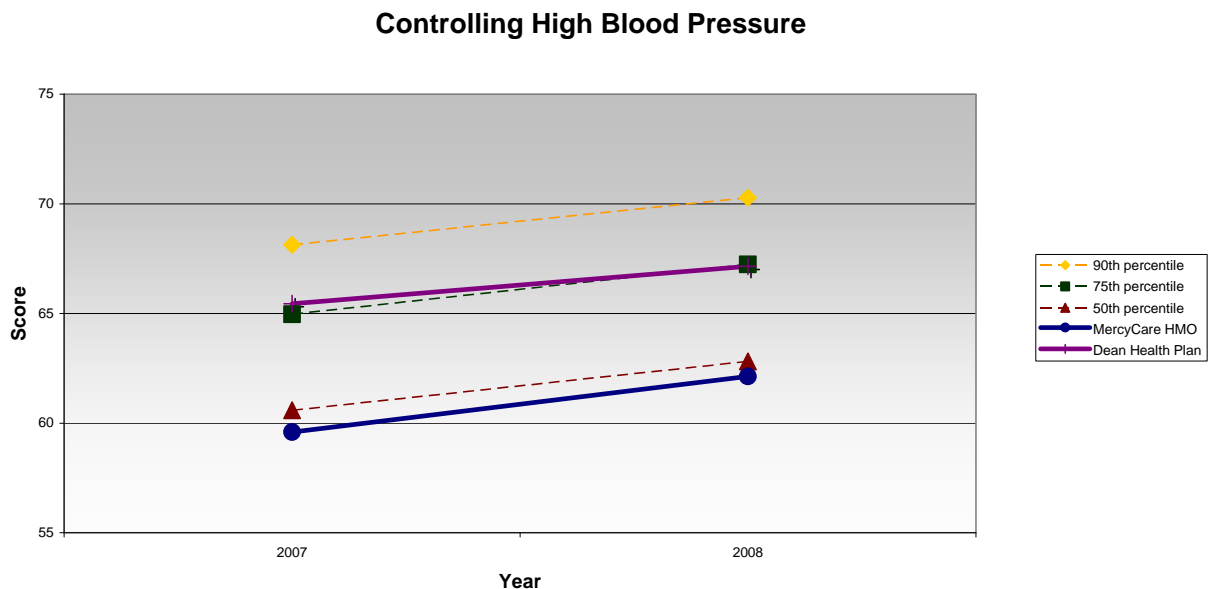
### Barriers Identified

- Physician variation on treatment, monitoring, and diagnosis
- Resource availability for chart review activities to determine control
- Access to employee demographic information for case management follow up activities
- Identified incorrectly into measure
- Patient resistance to treatment

### Interventions for January 2007-September 2008

- Work site screenings that include blood pressure screenings and education
- Telephonic case management to those that are in the heart healthy case management program
- Targeted mailings to members
- Communication to physicians reminding them of nationally recognized treatment goals

### Quantitative Analysis



- Goal-90<sup>th</sup> percentile  $\geq 70.28\%$

- Remained below the 50<sup>th</sup> percentile from 2007 to 2008
- Below the State HMO average (66.62)
- 5.02 points below primary regional competitor
- Since measure specifications changed in 2007, a 3 year trend cannot be performed

### **Qualitative Analysis**

There was some improvement in MercyCare's score, although the same trend was seen nationally. The score should continue to improve with the implementation of the case management program.

## **Seven Day Follow-Up After Hospitalization for Mental Illness**

### **Measure**

The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported.

1. The percentage of members who received follow-up within 30 days of discharge (This graph is not in this report. MercyCare focusing on the 7 day follow-up. MercyCare is above the 90<sup>th</sup> percentile for this measure)
2. The percentage of members who received follow-up within 7 days of discharge

### **Quality Improvement Activities**

- This measure is reviewed and analyzed in the Behavioral Health Advisory Committee and in the Behavioral Health Quality Improvement Committee.
- Depression case manager who is an RN and certified case manager facilitates follow up appointment with the outpatient provider if the inpatient provider cannot obtain an appointment for the member
- This measure is addressed in quality meetings with Mercy Hospital and Rogers Hospital
- Utilization review nurses request that the discharge appointment be made and indicated on the utilization form prior to discharge
- Reminder letters are sent to members when they are admitted to the hospital reminding them to follow up with an outpatient provider within seven days of discharge.

### **Barriers Identified**

- Inpatient providers do not set up a follow up appointment prior to discharge
- Patient reschedules appointment outside of the timeframe
- Outpatient provider does not schedule appointment within 7 days
- The member refuses follow up

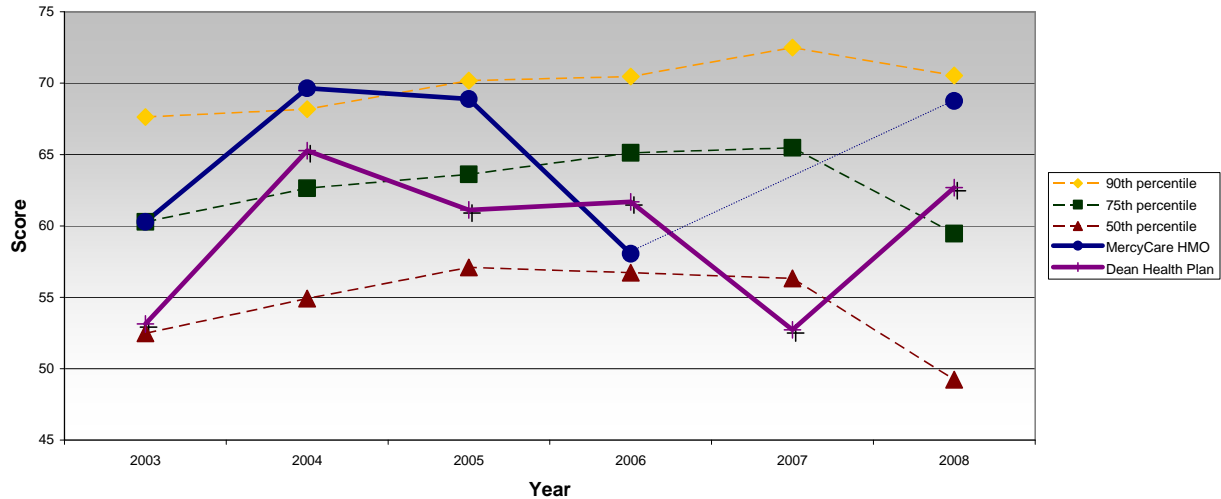
### **Interventions for January 2007-September 2008**

- Utilization review paperwork includes a section a request for the follow up appointment date and practitioner name prior to discharge
- MercyCare meets with inpatient providers to address quality projects

- Providers and members will be notified of MercyCare's 2008 HEDIS® results in their annual notices

## Quantitative Analysis

### FU After Hospitalization For Mental Illness 7 Days



- Goal-90<sup>th</sup> percentile  $\geq 70.53\%$
- Cannot compare to last years data since the sample size was too small for 2007
- Above State HMO Average (55.41)
- 6.07 points above primary regional competitor
- 3 year trend is unavailable since there was not any data for 2007

## Qualitative Analysis

Interventions put in place have been successful. A large contribution to improvement on this measure is due to the support of the Mercy Options VP. MercyCare was able to climb from just above the 50<sup>th</sup> percentile in 2006 to just below the 90<sup>th</sup> percentile in 2008.

## Prenatal and Postpartum Care (PPC)

### Measure

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

- Timeliness of Prenatal Care. The percentage of deliveries that received a prenatal care visit as a member of the organization 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.

## Quality Improvement Activities (Prenatal Care)

- Reviewed at the Women's and Children's Health Task Force

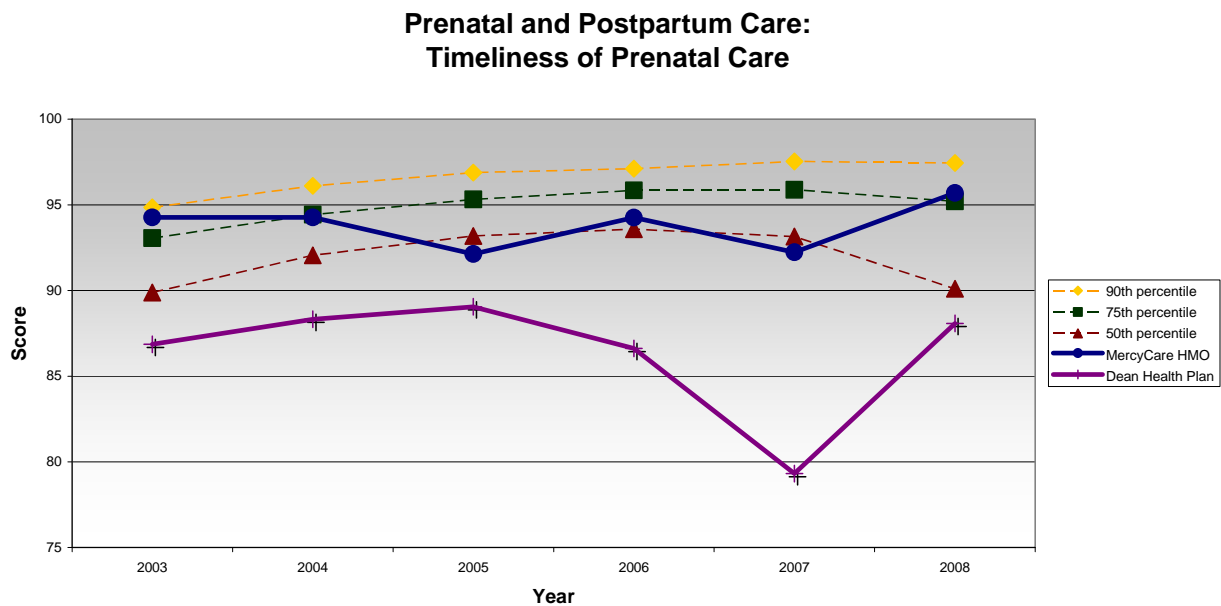
## Barriers Identified

- Appointment accessibility

## Interventions for January 2007-September 2008

- Main provider re-structured their scheduling system to allow more time slots for prenatal appointments
- Main provider changed appointment process to transfer from reception to the physicians' nurse if an appointment is not available
- Main provider simplified their scheduling process
- Addition of OB/GYN

## Quantitative Analysis



- Goal-90<sup>th</sup> percentile  $\geq 97.44\%$
- Improved from below the 50<sup>th</sup> in 2007 to above the 75<sup>th</sup> in 2008
- Above State HMO average (94.12)
- 3.46 points above primary regional competitor
- 3-year trend demonstrates a 1.44 increase

## Qualitative Analysis

With the help of interventions put into place at our main provider site, MercyCare was able to improve from below the 50<sup>th</sup> to above the 75<sup>th</sup> percentile. Hopefully these improvements and addition of practitioners will continue to improve the score of this measure.

### Quality Improvement Activities (Postpartum Care)

- Reviewed at the Women’s and Children’s Health Task Force
- Involved main provider in the improvement process

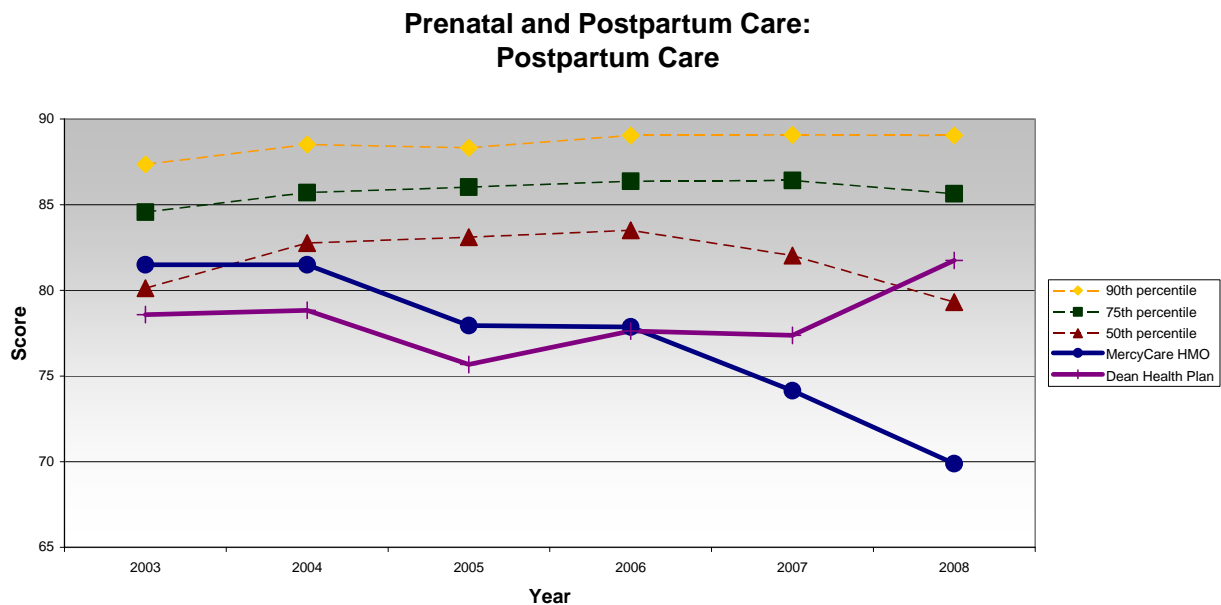
### Barriers Identified

- Members were not attending their follow up appointments
- Members do not schedule follow up appointments
- Members who delivered by c-section had their follow up appointment too soon.

### Interventions for January 2007-September 2008

- Letters sent to members after delivery reminding members to schedule their follow up appointment within 21-56 days of delivery
- Main hospital’s discharge instruction sheet has a section to record their follow up appointment
- Main hospital calls members within 72 hours of delivery and verifies whether or not they have scheduled their 6-week postpartum visit
- Met with director of main practice site to implement an itinerary system that schedules the members follow up appointment during a routine prenatal appointment; the appointment date is then sent to the hospital to be recorded on the member’s discharge paperwork
  - Worked with main practice site to change the 2 week postpartum visit for c-sections to 2 week post-op visit for less confusion
  - Follow up appointments for scheduled c-sections and inductions are made at the time the clinic is scheduling their procedure
  - Reviewed HEDIS ® misses to identify practitioner trends
  - Sent letters to physicians comparing their individual results to their peers

### Quantitative Analysis



- Goal-90<sup>th</sup> percentile  $\geq 89.04$
- Remained below the 50<sup>th</sup> percentile from 2007 to 2008

- Below the State HMO average (84.07)
- 11.86 points below primary regional competitor
- 3-year trend demonstrates a 7.98 point decrease

### **Qualitative Analysis**

MercyCare has shown a continual decline in the last three years. MercyCare has put several new interventions in place. We are hopeful that these changes will result in drastic improvement.

## **Use of Appropriate Medications for People With Asthma (ASM)**

### **Measure**

The percentage of members 5–56 years of age during the measurement year who were identified as having persistent asthma and who were appropriately prescribed medication during the measurement year.

This measure is measured in the following age categories:

- 5-9-There is no data trending for this measure since the sample size is too small, therefore it is ineligible.
- 10-17 -There is no data trending for this measure since the sample size is too small, therefore it is ineligible.
- 18-56 (Only two years worth of data is compared in the graphs below since were changes in the 2006 specifications)
- Combined Rate (Only two years worth of data is compared in the graphs below since were changes in the 2006 specifications)

### **Quality Improvement Activities**

- Addressed in the MCHP Asthma Health Management Task Force Committee. Physician advisors include Ronald Rogatzy, MD, and Janet Fechter, MD
- Affiliated with the Wisconsin Asthma Coalition
- Regular asthma educational publications in member newsletters
- Acquired practitioner that is a certified asthma nurse educator

### **Barriers Identified**

- Best practice compliancy with prescribing controller medication
- Treatment adherence to medication regimen
- Adequate member education on medication and the disease process
- Tobacco use
- Complacency

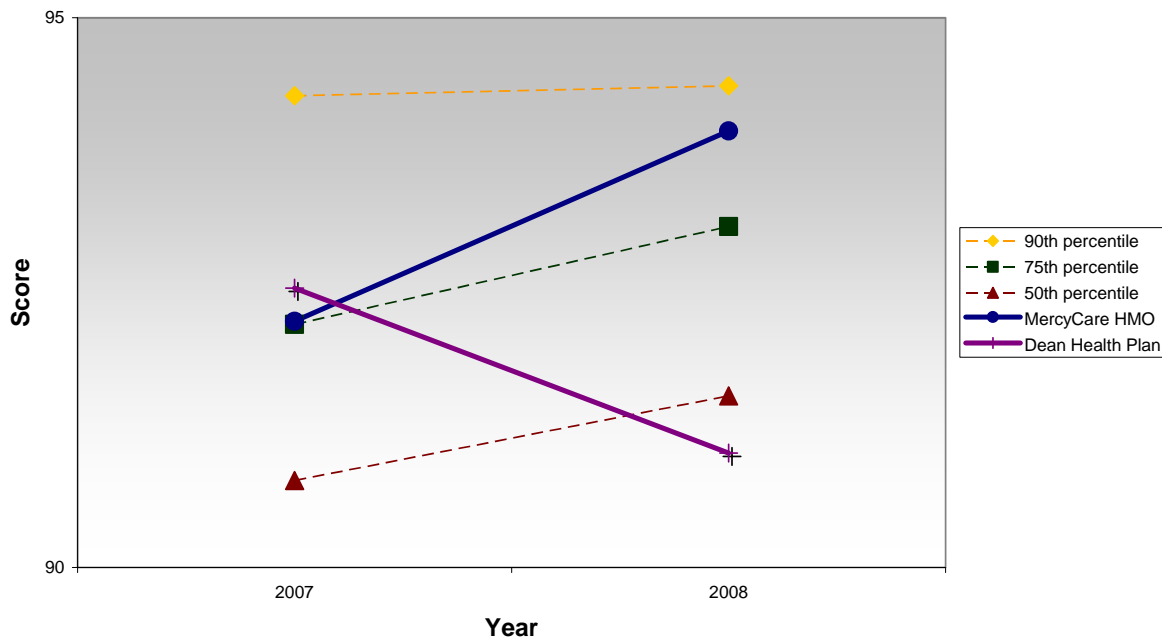
### **Interventions for January 2007-September 2008**

- Telephonic case management program managed by a RN case manager, for those that have had inpatient, urgent, or emergency room care
- Enhanced reporting to practitioners to include a case management format that would help identify barriers and concerns
- Refer to a practitioner that is a certified asthma nurse educator
- Moved rescue inhalers asmanex and qvar to tier 1 to reduce co-pays for our members

- Moved all rescue inhalers to tier 2 to discourage overutilization
- Put quantity limits on rescue inhalers to discourage overutilization
- Reports are done for case management to identify members that are on too many rescue inhalers
- Asthma action plan and control tests were sent to members and encouraged to schedule an appointment with their physician every three months

### Quantitative Analysis

#### Use of Appropriate Medications for People with Asthma -18-56



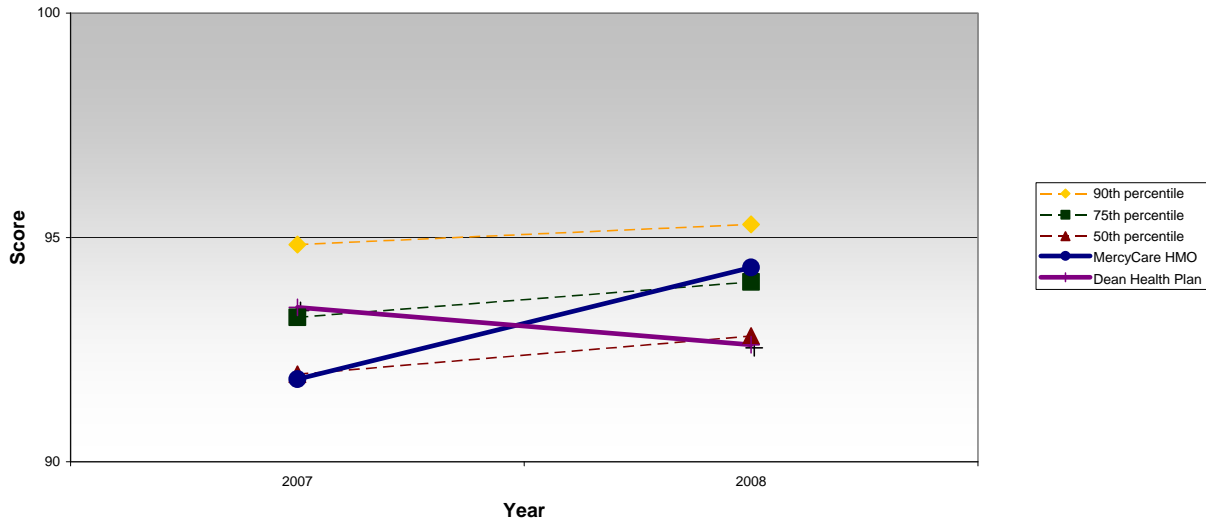
- Goal-90<sup>th</sup> percentile  $\geq 94.38$
- Improved from the 75<sup>th</sup> percentile in 2007 to just below the 90<sup>th</sup> percentile in 2008
- Above State HMO average (92.46)
- 2.93 points above primary regional competitor
- 3-year trend cannot be completed since there were changes in 2006 HEDIS® specifications

### Qualitative Analysis

Improvements were made in MercyCare's percentile ranking from 2007 to 2008. The percentage points between percentiles is very close. Case management will continue to support member compliance in hopes to improve treatment plan adherence.

## Quantitative Analysis

### Use of Appropriate Medications for People with Asthma -Combo



- Goal-90<sup>th</sup> percentile  $\geq 95.29$
- Improved from the 50<sup>th</sup> percentile in 2007 to just above the 75<sup>th</sup> percentile in 2008
- Above State HMO average (93.51)
- 1.72 points above primary regional competitor
- 3-year trend cannot be completed since there were changes in 2006 HEDIS® specifications

## Qualitative Analysis

Interventions have shown a substantial increase bringing rates from the 50<sup>th</sup> to above the 75<sup>th</sup> percentile. Case management will continue to support member compliance in hopes to improve treatment plan adherence.

### Medical Assistance with Smoking Cessation (Advising Members to Quit)

#### Measure

A rolling average represents the percentage of members 18 years of age and older who are current smokers, who were seen by a practitioner during the measurement year and who received advice to quit smoking.

#### Quality Improvement Activities

- No QI activities specific to this measure

#### Barriers Identified

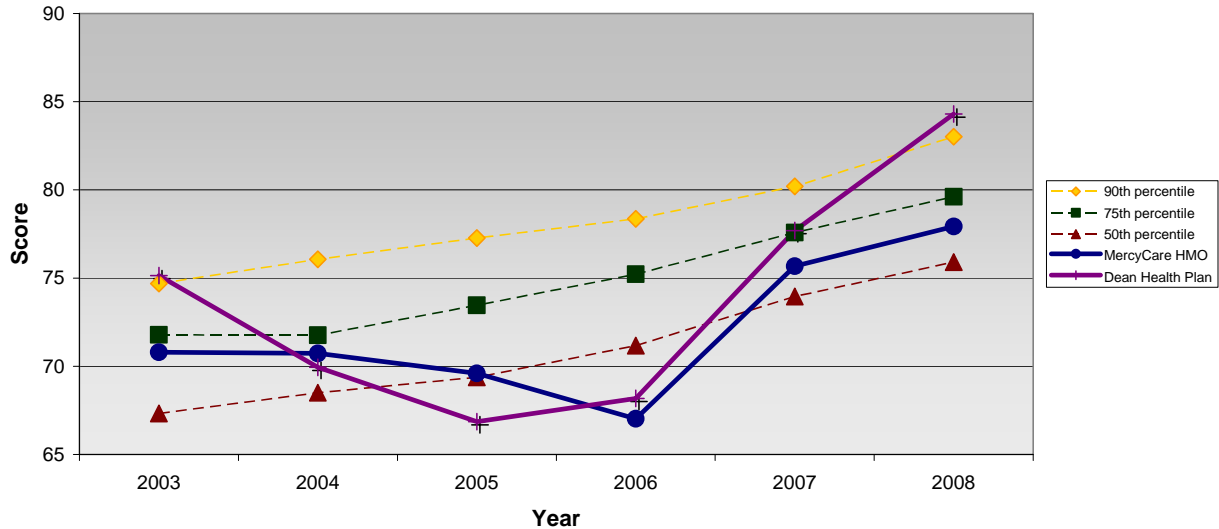
- Physicians feel time pressure
- Physicians “give up” on telling smokers to quit
- Physicians are concerned that “nagging” smokers may affect their patient satisfaction scores

## Interventions for January 2007-September 2008

✦ None

## Quantitative Analysis

### Medical Assistance with Smoking Cessation (Advising Smokers to Quit)



- ✦ Goal-90<sup>th</sup> percentile  $\geq$  83.02%
- ✦ Remained between the 50<sup>th</sup> to 75<sup>th</sup> percentile from 2007 to 2008
- ✦ Below State HMO average (81.84)
- ✦ 6.37 points below primary regional competitor
- ✦ 3-year trend demonstrates a 10.9 point increase

## Qualitative Analysis

Although MercyCare has been able to show improvement over the last three years, we still are below our goal of 83.02%.

## **Use of Imaging Studies for Low Back Pain**

### Measure

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

### Quality Improvement Activities

✦ Through utilization review activities it was identified that there was a large increase in orders for MRI's during late 2006 and yearly 2007 and a prior authorization program was started for MRI requests in the third quarter of 2007. Data from our principal provider, the Mercy Health System shows that MRI requests have dropped dramatically in response to this requirement though few denials have been issued.

### Barriers Identified

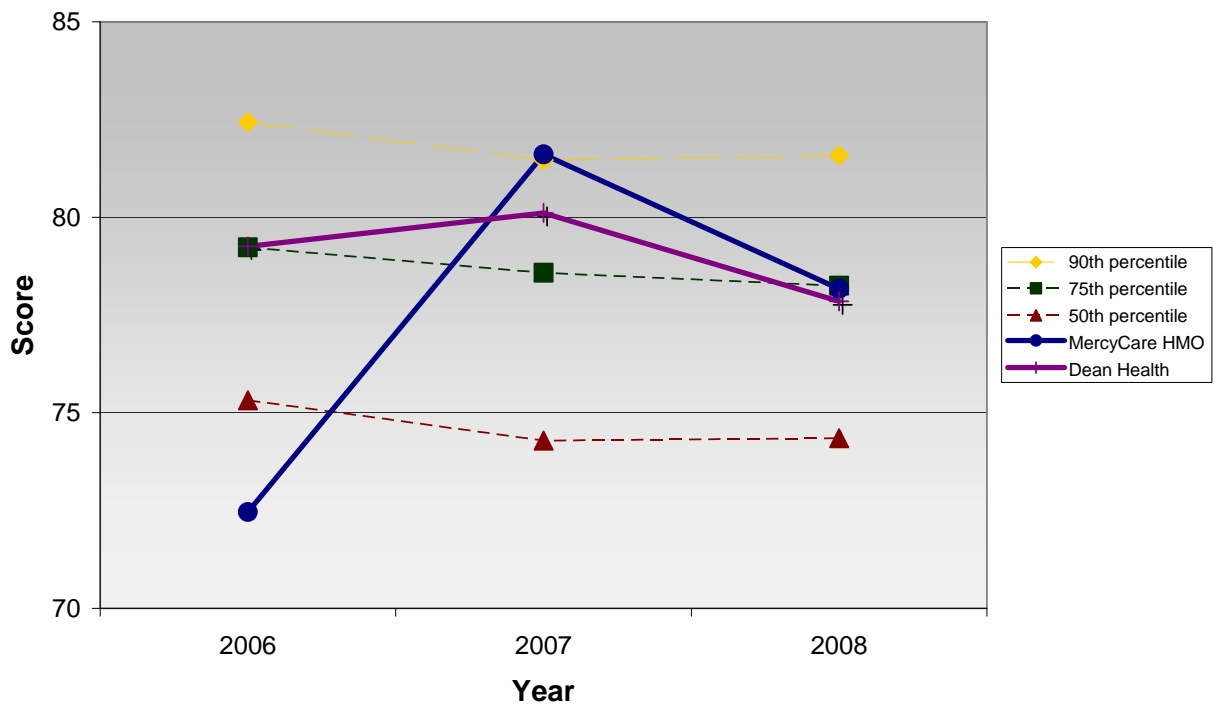
- Patient requests scan
- PCPs request early scanning for diagnostic reasons when evidence based guidelines recommend conservative care before scanning.

### Interventions for January 2007-September 2008

- Prior authorization requirement
- Medical Director communication to network physicians

### Quantitative Analysis

#### Use of Imaging Studies for Low Back Pain



- Goal-90<sup>th</sup> percentile  $\geq 81.58\%$
- Declined from the 90<sup>th</sup> percentile in 2007 to the 75<sup>th</sup> percentile in 2008
- Above State HMO average (75.86)
- .32 points above primary regional competitor
- 3-year trend demonstrates a 5.71 point increase

### Qualitative Analysis

Even though MercyCare has demonstrated an increase in the 3 year trend, we dropped from our goal of the 90<sup>th</sup> percentile to the 75<sup>th</sup> percentile.

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## Report and Analysis

The following report and analysis reviews individual CAHPS® 4.0H 2008 scores. Since this is a patient survey and statistical analysis provided by our contracted surveyor shows strong correlations between many questions and composite scores, interventions for all survey questions will be included at the end.

### Claims Processing Composite

#### CAHPS® Questions

**Question #40**-In the last 12 months, how often did your health plan handle your claims quickly?

**Question #41**-In the last 12 months, how often did your health plan handle your claims correctly?

#### Quality Improvement Activities

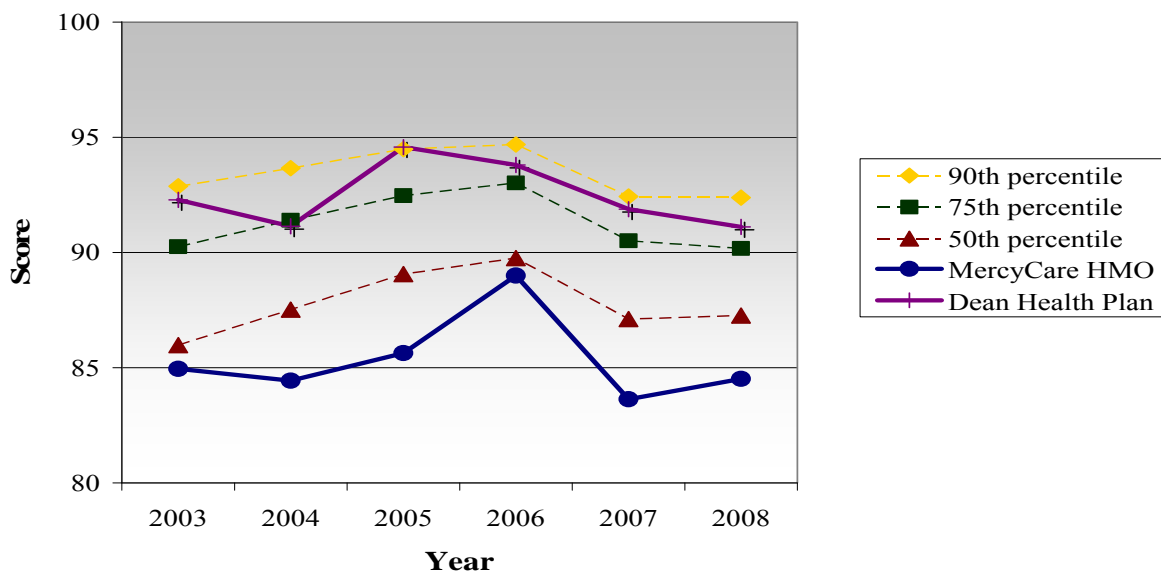
- ✦ Reviewed at the Director's Meeting

#### Barriers Identified

- ✦ Training and turnover challenges
- ✦ Electronic processing
- ✦ System set up errors
- ✦ Entry errors
- ✦ Member perception

#### Quantitative Analysis

##### Claims Processing Composite



- Goal-75<sup>th</sup> percentile  $\geq$  90.18
- Remained below 50<sup>th</sup> percentile from 2007 to 2008
- Below the State HMO average (90.04)
- 6.59 points below primary regional competitor
- 3-year trend demonstrates a 4.48 point loss

### **Qualitative Analysis**

MercyCare has put process improvements in place in prior years, but unfortunately has not been able to improve the member's perception of how quickly or accurately their claims have been handled. Results continue to stagger. The national three year trend also shows a continual decrease. We are hopeful that by beginning to publish the percentage of claims that are processed quickly in member newsletters, on our website, and in annual notices to members, we can improve member perception.

## **Customer Service Composite**

### **CAHPS® Questions**

**Question #35**-In the last 12 months, how often did your health plan's customer service give you the information or help you needed?

**Question #36**-In the last 12 months, how often did your health plan's customer service staff treat you with courtesy and respect?

### **Quality Improvement Activities**

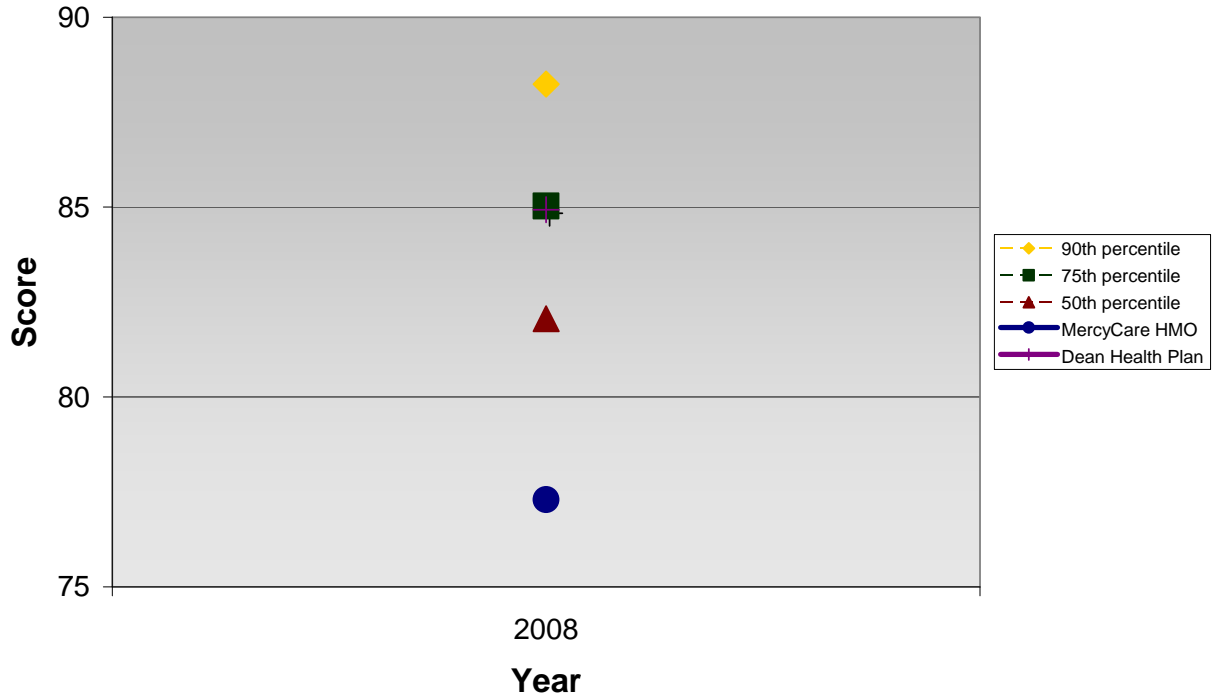
- Reviewed at the Director's Meetings

### **Barriers Identified**

- Small department
- Newer staff's lack of experience
- Procedures implemented by other departments that increases limited staff workload
- Uneven distribution of work load
- Large number of provider calls vs. member calls

## Quantitative Analysis

### Customer Service Composite



- Goal-75<sup>th</sup> percentile  $\geq 85.03$
- Cannot compare to 2007 since results for this measure were not reported
- Below state HMO average (85.53)
- 7.63 points below primary regional competitor
- Cannot demonstrate a 3 year trend since data is not available from 2007

## Qualitative Analysis

Staff turnover continues to have an impact on improving this measure. MercyCare is hopeful that if web access it could greatly influence the results of this composite. Web access could reduce provider calls by as much as 50% leaving more time for customer service representatives to devote to members.

### Getting Care Quickly

#### CAHPS® Questions

**Question #4**-In the last 12 months, when you needed care right away, how often did you get care as soon as you thought you needed?

**Question #6**-In the last 12 months, not counting the times you needed health care right away, how often did you get an appointment for your health care at a doctor's office or clinic as soon as you thought you needed?

### Quality Improvement Activities

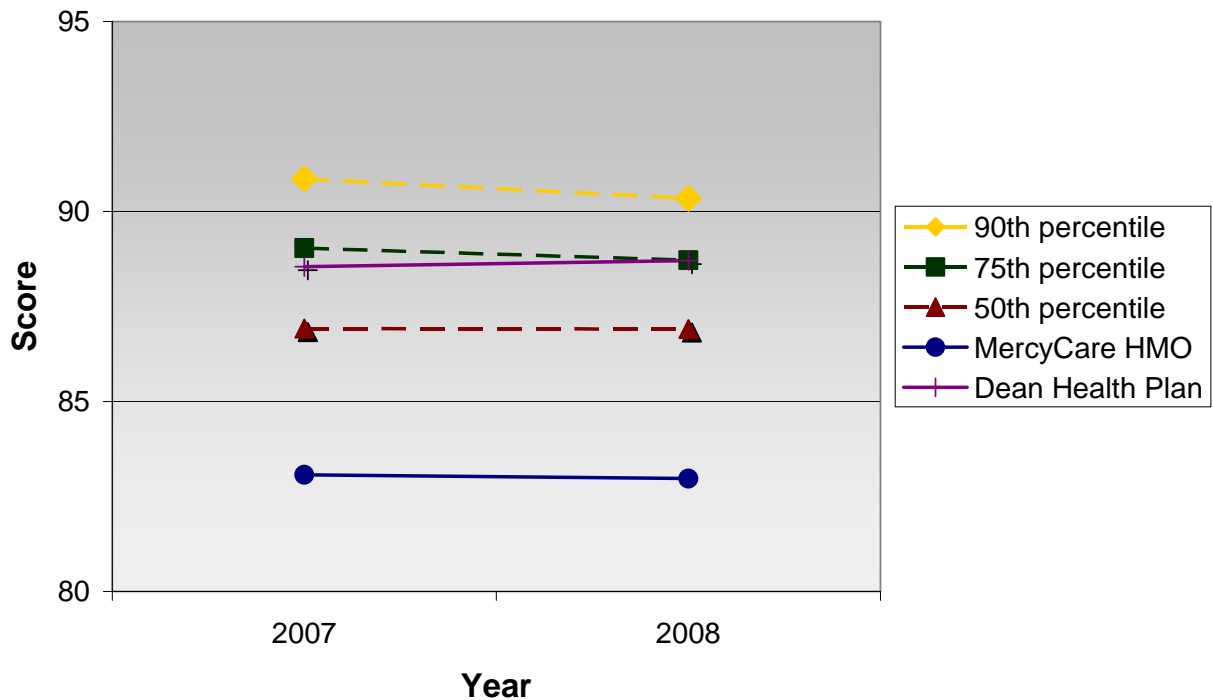
- Reviewed at the Directors Meeting

### Barriers Identified

- Perception of the referral process
- Perception of accessibility

### Quantitative Analysis

#### Getting Care Quickly Composite



- Goal-75<sup>th</sup> percentile  $\geq 88.72$
- Remained below the 50<sup>th</sup> percentile from 2007 to 2008
- Below the State HMO average (86.91)
- 5.74 points below primary regional competitor
- Cannot demonstrate a 3 year trend since data is not available prior to 2007

### Qualitative Analysis

Although MercyCare continues to fall below the 50<sup>th</sup> percentile, annual accessibility audits have demonstrated very high compliance results. MercyCare will try to raise member awareness as to what national standards are and how we compare to improve member perception in the member newsletter, on our website, and in annual notices to members.

## Getting Needed Care

### CAHPS® Questions

**Question #23**-In the last 12 months, how often was it easy to get appointments with specialists?

**Question #27**-In the last 12 months, how often was it easy to get the care, tests or treatment you thought you needed through your health plan?

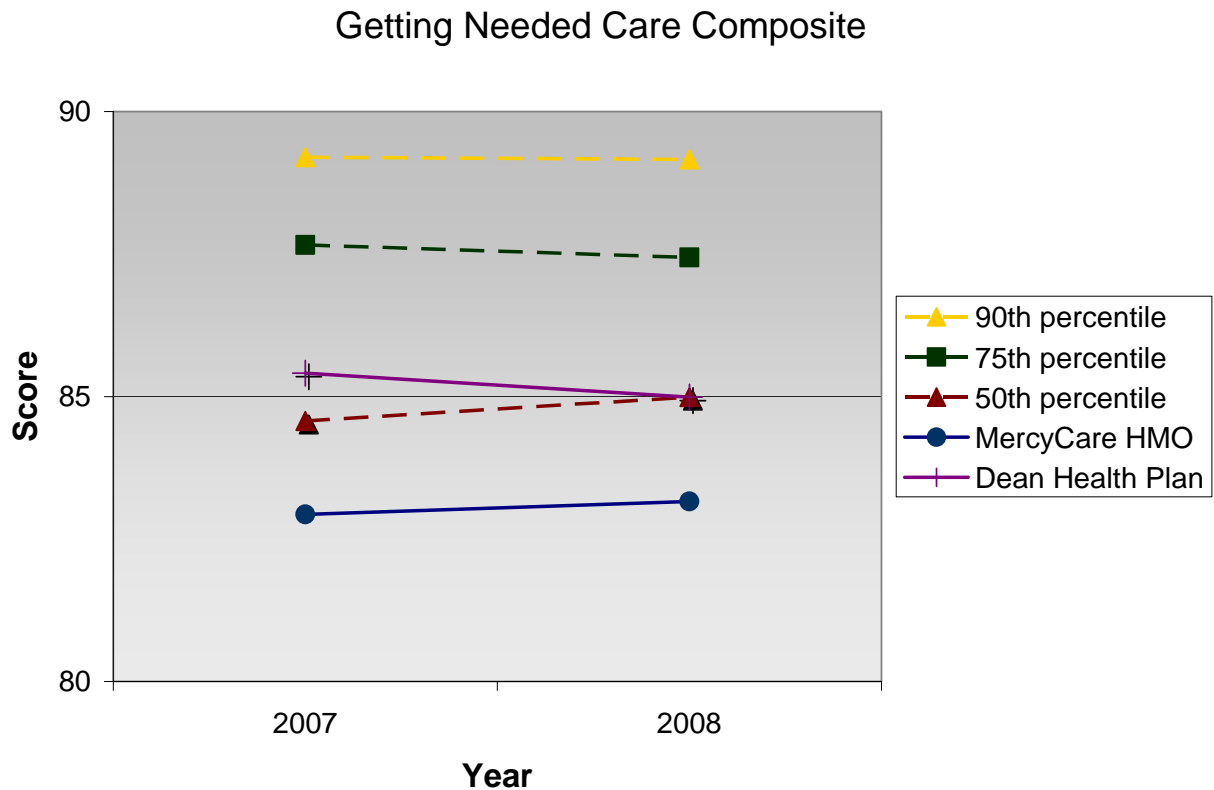
### Quality Improvement Activities

- Reviewed at the Directors Meeting

### Barriers Identified

- Member perception

### Quantitative Analysis



- Goal-75<sup>th</sup> percentile  $\geq$  87.44
- Remained below the 50<sup>th</sup> percentile from 2007 to 2008

- Below State HMO average (85.49)
- 1.83 points below primary regional competitor
- Cannot demonstrate a 3 year trend since data is not available prior to 2007

### **Qualitative Analysis**

It is difficult to determine why MercyCare continues to score so poorly on this CAHPS® composite, since there are so few denials for referrals to services within the plan. Our customer service department reported that only approximately 1 in 10, 000 referrals within the plan are denied. In prior years, surveys were sent to members within 12 hours of patient care with a specialist or primary care physician incorporating a rapid intervention approach. This process was discontinued since results indicated satisfaction. We are hopeful our quest to improve member perception through providing members with information in member newsletters, on our website, and annual notices to members, will indicate improved results.

## **How Well Doctors Communicate**

### **CAHPS® Questions**

**Question #15**-In the last 12 months, how often did your personal doctor explain things in a way that was easy to understand?

**Question #16**-In the last 12 months, how often did your personal doctor listen carefully to you?

**Question #17**-In the last 12 months, how often did your personal doctor show respect for what you had to say?

**Question #18**-In the last 12 months, how often did your personal doctor spend enough time with you?

### **Quality Improvement Activities**

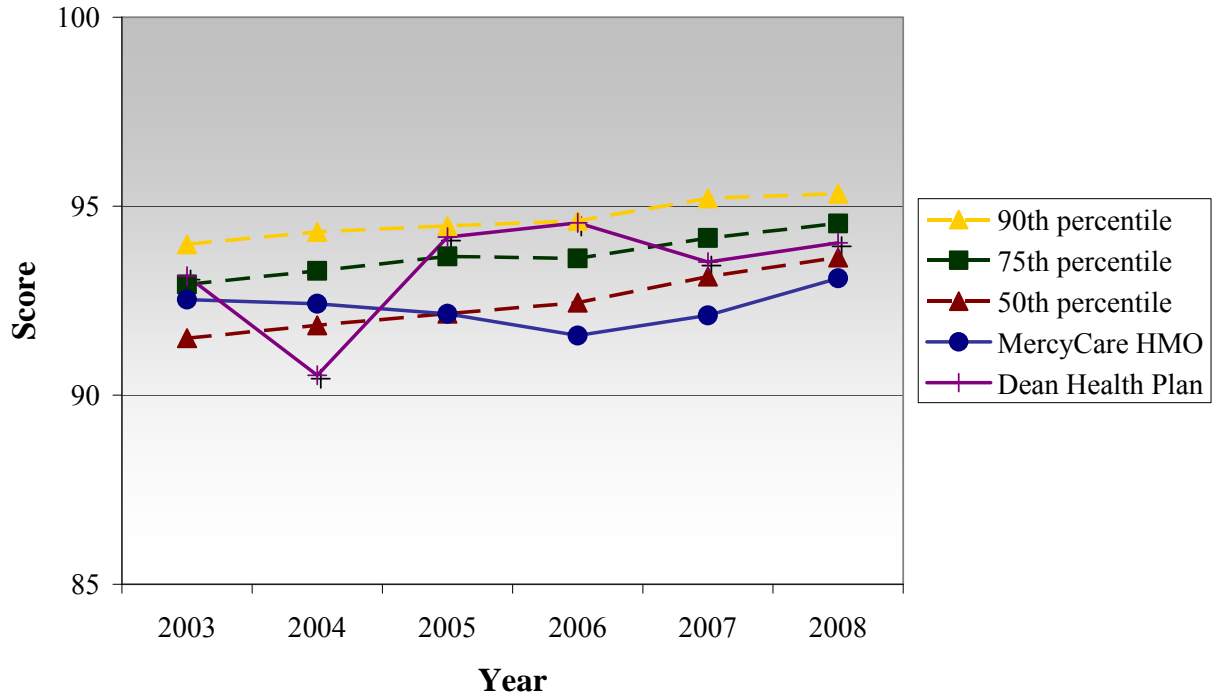
- Reviewed at the Directors Meeting

### **Barriers Identified**

- none

## Quantitative Analysis

### How Well Doctors Communicate Composite



- Goal-75<sup>th</sup> percentile  $\geq$  94.54%
- Remained below the 50th percentile from 2007 to 2008
- Below the State HMO average (94.46)
- .94 points below primary regional competitor
- 3-year trend demonstrates a 1.51-point gain

## Qualitative Analysis

Our 3-year trend does show slight improvement. MercyCare will continue to promote the Ask Me 3 on our website as a resource for our members.

### Rating of All Health Care

#### CAHPS® Question

**Question #12**-Using any number from 0 to 10, where 0 is the worst health care possible and 1 is the best health care possible, what number would you use to rate all your health care in the last 12 months?

## Quality Improvement Activities

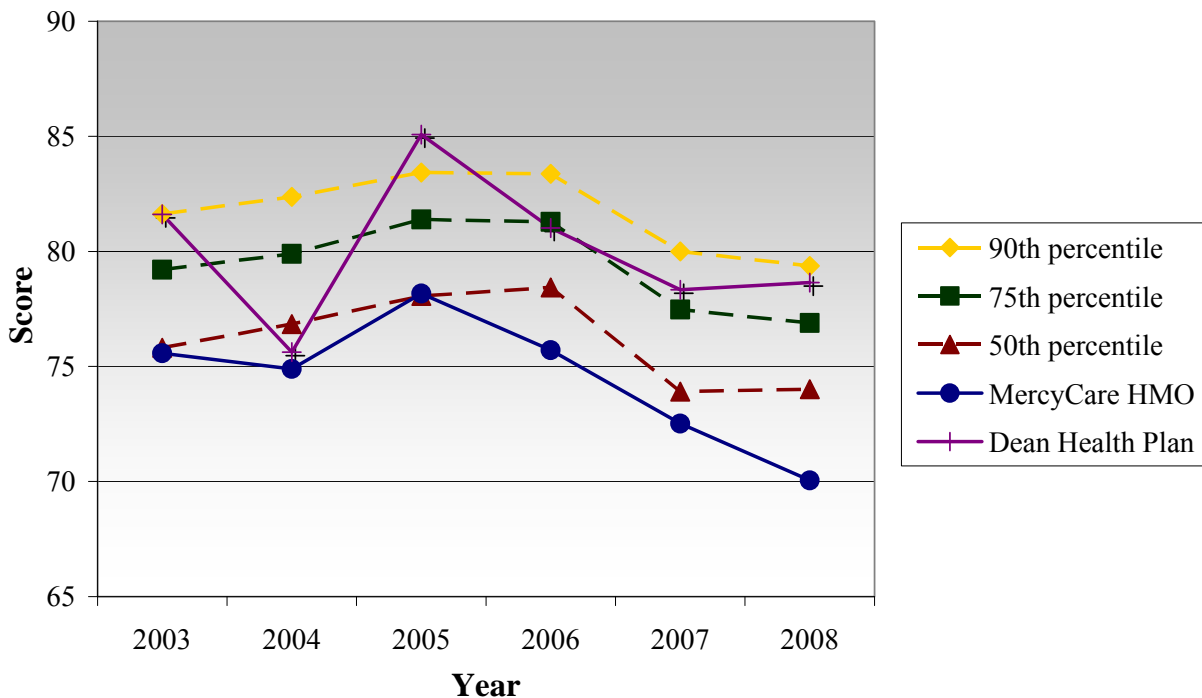
- ✦ Reviewed at the Directors Meeting

## Barriers Identified

- ✦ Barriers for the composite scores impact this item

## Quantitative Analysis

### Rating of all Health Care (8+9+10)



- ✦ Goal-75<sup>th</sup> percentile  $\geq$  76.89
- ✦ Remained below 50<sup>th</sup> percentile ranking from 2007 to 2008
- ✦ Below the State HMO average (76.95)
- ✦ 8.59 points below primary regional competitor
- ✦ 3-year trend demonstrates a 5.66 point loss

## Qualitative Analysis

Our three year trend indicates a significant decline, and is similar to that seen nationally. Informing members on data specific to MercyCare compared with national standards through member newsletters, the website, and annual notices to members should improve scores.

## Rating of Health Plan

### CAHPS® Question

**Question #42**-Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your health plan?

### Quality Improvement Activities

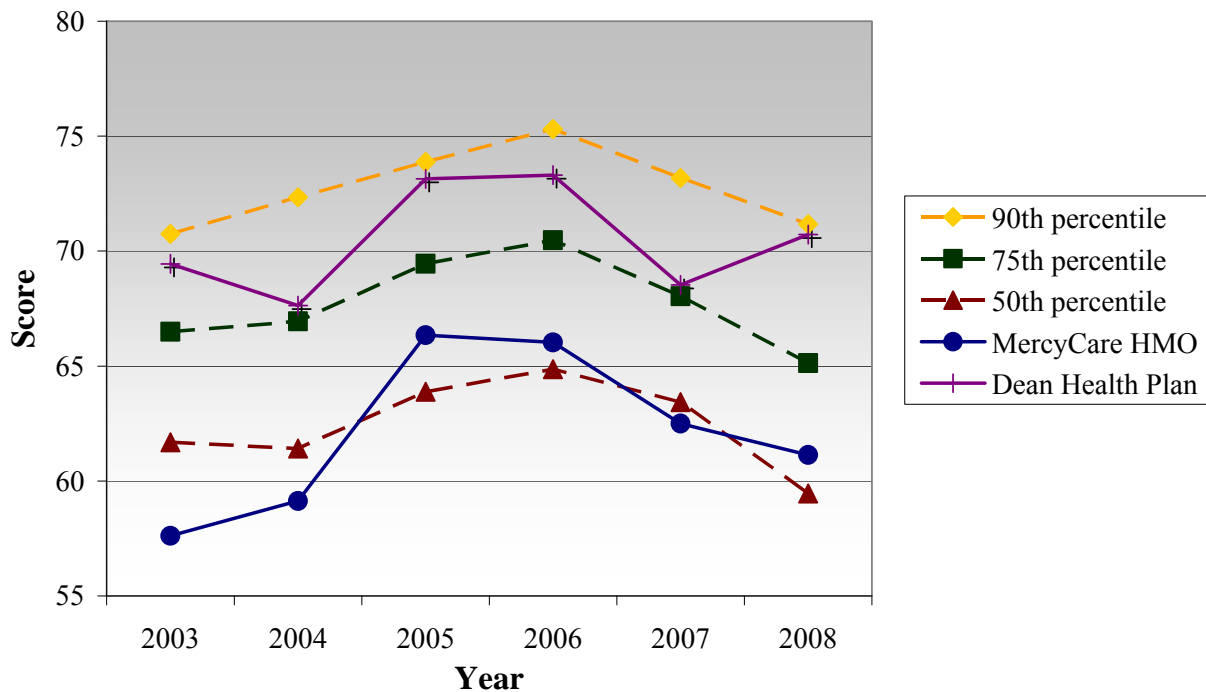
- Reviewed at the Directors Meeting

### Barriers Identified

- Barriers for the composite scores impact this item

### Quantitative Analysis

Rating of Health Plan (8+9+10)



- Goal-75<sup>th</sup> percentile  $\geq 65.13$
- Improved from below the 50<sup>th</sup> percentile to between the 50 and 75<sup>th</sup> percentile
- Below the State HMO average (76.95)
- 10.59 points below primary regional competitor
- 3-year trend demonstrates a 4.09 point loss

### Qualitative Analysis

Our three year trend indicates a significant decline. MercyCare believes that the results of the composite scores greatly impact the results of this measure. Informing members on data specific

to MercyCare compared with national standards through member newsletters, the website, and annual notices to members should improve scores.

## Rating of Personal Doctor

### CAHPS® Question

**Question #21**-Using any number from 0 to 10, where 0 is the worst possible doctor ever and a 10 is the best personal doctor possible, what number would you use to rate your personal doctor?

### Quality Improvement Activities

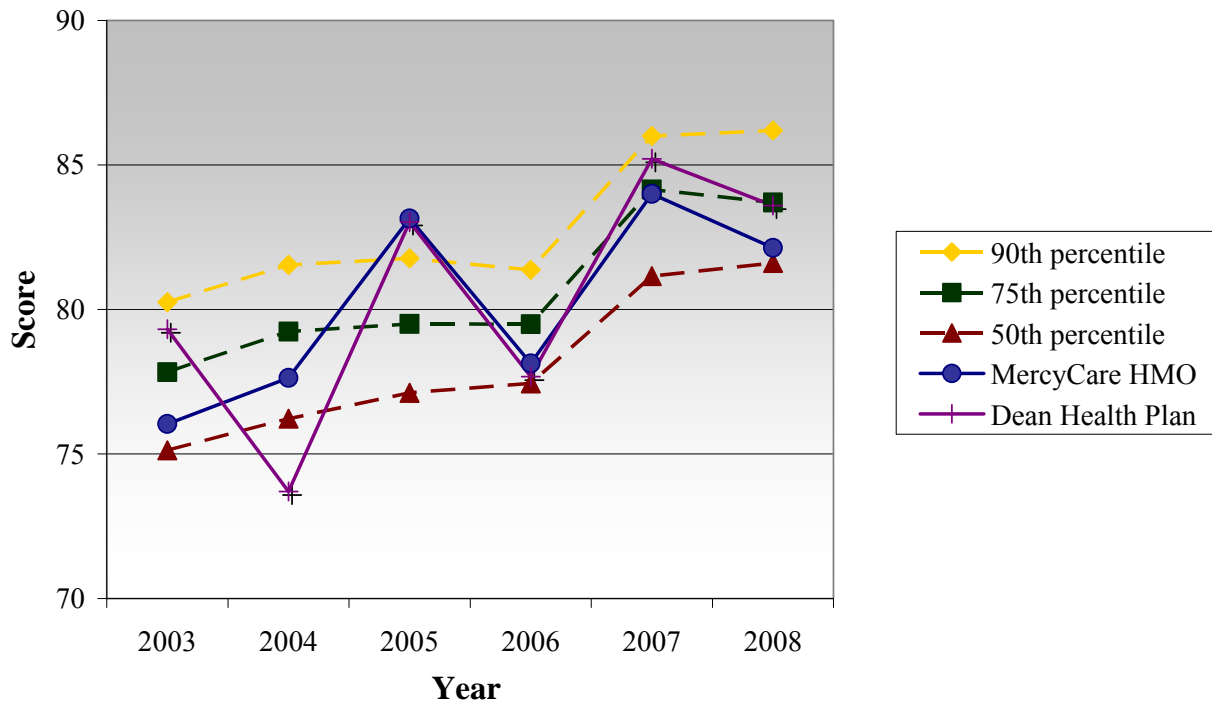
- Reviewed at the Directors Meeting
- Review and analyze with physicians at the Quality Utilization Management Committee

### Barriers Identified

- Barriers for the composite scores impact this item

### Quantitative Analysis

#### Rating of Personal Doctor (8+9+10)



- Goal-75<sup>th</sup> percentile  $\geq$  83.10
- Remained between the 50<sup>th</sup> and 75<sup>th</sup> percentile from 2007 to 2008
- Below the State HMO average (83.92)

- 1.47 points below primary regional competitor
- 3-year trend demonstrates a 4 point gain

### **Qualitative Analysis**

Although the three year trend indicates a 4 point gain, much improvement is still needed to satisfy our members' needs.

## **Rating of Specialist Seen Most Often**

### **CAHPS® Question**

**Question #25-**We want to know the rating of the specialist you saw most often in the last 12 months. Using any number from 0 to 10, where 0 is the worst specialist possible and 10 is the best specialist possible, what number would you use to rate that specialist?

### **Quality Improvement Activities**

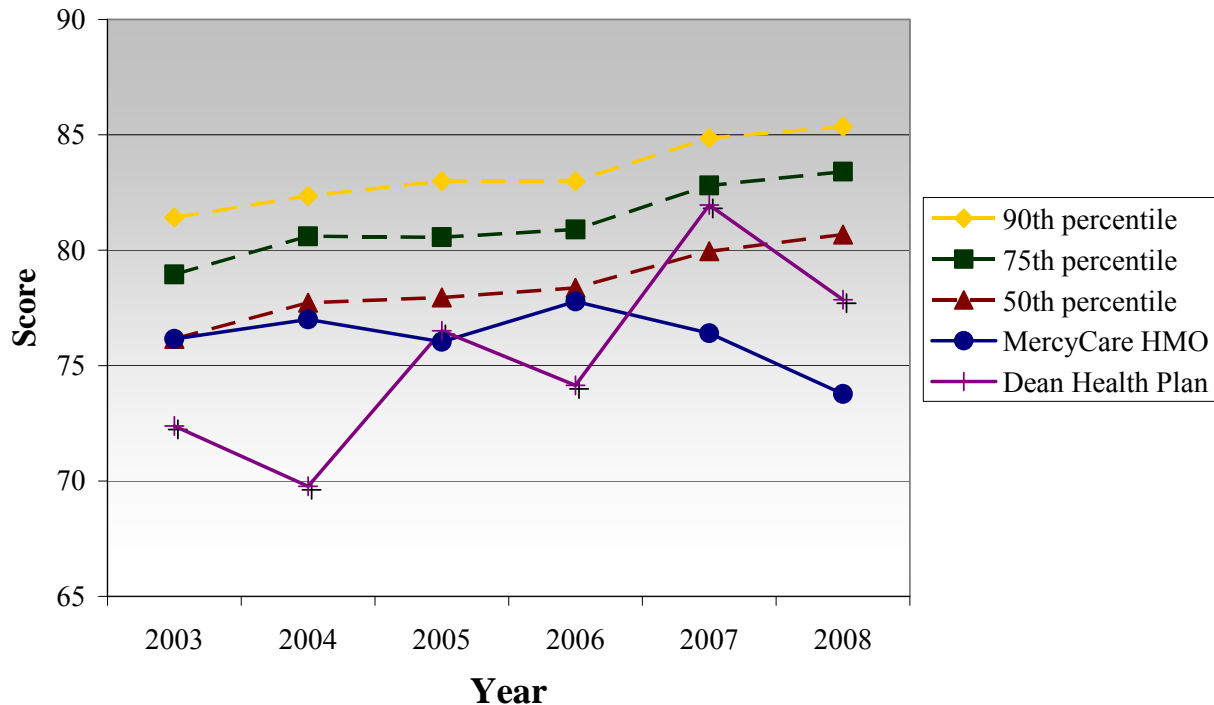
- Reviewed at the Directors Meeting
- Review and analyze with physicians at the Quality Utilization Management Committee

### **Barriers Identified**

- Barriers for the composite scores impact this item
- Members influenced by the length of time it takes to see a specialist versus a primary care physician
- Number of locums used in specialty areas

## Quantitative Analysis

### Rating of Specialist Seen Most Often (8+9+10)



- Goal-75<sup>th</sup> percentile  $\geq$  83.41
- Remained below the 50<sup>th</sup> percentile from 2007 to 2008
- Below the State HMO average (79.95)
- 4.09 points below primary regional competitor
- 3-year trend demonstrates a 4.01 point loss

## Qualitative Analysis

Member's perception of the specialist they see continues to decline, even though the national trend has shown a steady increase. Our primary regional competitor has also shown a sharp decrease from 2007 which could be evidencing a local trend. MercyCare will work with our Quality utilization Management Committee to improve this item.

## Interventions for all the above CAHPS® 4.0H Measures January 2007-September 2008

- Claims department is developing an action plan as a team to determine why errors are occurring and set up improvements
- Complaints related to claims processing are tracked and reviewed
- Claims and customer service have had CAHPS specific questions added to the quality portion of their performance evaluation
- Continually works to improve interdepartmental cooperation

- Customer service representatives are given one day off of the phones per week to work on their gits reports
  - Evaluating the feasibility of a web based functionality that would give members and providers the ability to review benefit information thereby reducing the call load in member services
- 

### **Monitoring Safety**

The safety of our members is of the utmost importance. MercyCare is committed to ensuring safety is addressed for our members. MercyCare focuses on safety in the following ways:

- Educational information to members
- Monitors adverse events
- Medical record audits
- Site visits
- Member complaint resolution process
- Pharmacy management
- Continuity and coordination of care projects
- Clinical practice guidelines
- Electronic medical records

### **Education to Members**

MercyCare has added a page to our website that offers safety information to our members. This page on safety includes

- how to access CheckPoint, and what type of information about our network hospitals can be found there
- educates members on the importance of communication with their providers and links them to the Ask Me 3 website
- discusses electronic medical records and Mercy's commitment to implementation
- notifies members of their rights and responsibilities
- gives additional quality and safety resources

### **Adverse Events**

MCHP monitors adverse events through identifying possible quality issues during all of its other health plan activities, i.e., customer service complaints, inpatient reviews, case management and

possible quality issues are referred to a peer review process if chart review confirms a possible quality issue.

**Medical Record Audit**

In 2008, MCHP performed a medical record audit for the purpose of:

- Assessing medical record keeping documentation practices against organizational standards
- Monitor coordination of care with specialty consultants
- Monitoring medical and behavioral health continuity and coordination of care, and
- Quantifying the quality of medical record keeping in comparison with expected performance goals

**Site Visits**

Prior to a provider site being credentialed, MercyCare reviews that site to ensure it is in compliance with our site requirements. The site visit tool addresses safety by reviewing medical records accessibility and confidentiality, and physical accessibility and appearance. There were not any initial site visits done in 2007. There were 50 routine site visits done in 2007. No deficiencies were detected.

**Member Complaint Review (Get info from Rebekah)[how were these resolved?]**

Member complaint reports are generated routinely to identify member complaints related to accessibility to behavioral health appointments (routine, urgent, and emergent), medical appointment accessibility, availability of behavioral health and medical practitioners, specifically identifying those related to cultural or special needs, and quality of care. All complaints are reviewed and followed up on until fully resolved. For the above categories, the following complaints were reported in 2007:

Accessibility of Medical Appointment	Quality of Medical Care	Attitude of Provider or Office Personnel	Accessibility of a Routine Behavioral Health Appointment
0	1	0	0

The one complaint was about an admission at a non-Mercy behavioral health facility regarding discharge planning and communication with parent. Complaint was communicated and resolved by that facility.

**Pharmacy Management**

MercyCare works to improve safety through pharmacy by implementing prior authorizations and quantity limits. These limits and prior authorizations are put in place specifically to:

- Prevent over-utilization
- Ensure appropriate use of medications
- Identify poly-pharmacy issues
- Identify abuse or diversion in the case of narcotics
- Reduce exposure of members to new medications with uncertain side-effects

### **Continuity and Coordination of Care**

MercyCare strongly supports continuity and coordination of care between behavioral health and primary care physicians. MercyCare reviews inpatient psychiatric admissions to network providers to verify whether or not the psychiatric discharge summary has been sent to the primary care physician. The psychiatric discharge summary is a key piece of correspondence since it includes the member's diagnosis, medications that the member was discharged on, and follow-up recommendations.

### **Clinical Practice Guidelines**

MercyCare routinely notifies providers of clinical practice guidelines in place as a resource to assist in evaluation, treatment, and follow-up for chronic medical conditions. The following guidelines are available on our website:

- Detection, Evaluation , and Treatment of High Blood Cholesterol
- Major Depression Treatment
- Wisconsin Essential Diabetes Mellitus Guideline
- Practice Guide for the Diagnosis and Management of Asthma
- Pharmacological Management of Alcohol Withdrawal
- Clinical Preventive Services for Normal Risk Adults & Child Preventive Care Timeline
- Attention Deficit and Hyperactivity Disorder Treatment Guideline for Primary Care

The case managers also incorporate these guidelines into their disease and case management programs to make certain the care the members are receiving is in keeping with the latest standards.

### **Electronic Medical Records**

MercyCare Health System has a timeline in place to implement electronic medical records at all sites. This will allow practitioners to more efficiently share patient medical information and reduce the number of medical errors that are caused by handwritten abbreviations. It will also be an additional safety mechanism for those patients who receive care in multiple medical settings.

**Summary**

In summary, MercyCare has implemented several activities to improve patient safety, and will continue to monitor and improve these activities. Moving forward, MercyCare will organize a safety committee that will review provider safety data available from CheckPoint, and make this information available to our members.

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## **Overall Summary**

MercyCare continues to exhibit progress amongst quality measures and improvement projects. We will continue to maintain our current quality task forces to serve as improvement forums to identify barriers and implement specific interventions. Our ultimate goal is to have all of the key measures at or above the 75th percentile. As a first step to get to that goal, MercyCare is focusing on those measures that have fallen below the 50th percentile. Stronger interventions have been put into place for appropriate testing for children with pharyngitis and timeliness of postpartum care. Our expectation is that these two measures will be above the 50th percentile in next year's HEDIS report. We are currently ramping up a new "Healthy Heart" disease management program to impact Cholesterol Management for Patients with Cardiovascular Disease and Controlling High Blood Pressure scores. We will also undertake a retrospective review of cases that did not pass the HEDIS measure. We have not previously had an intervention for the other measure now falling below the 50th percentile, "Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis." Our Medical Director will be sending out a letter to our physicians reminding them to refrain from using antibiotics in adults with acute bronchitis without co-morbid conditions with accompanying references. We will also be analyzing our results by physician to reveal any pattern that would be amenable to a stronger intervention.

Our CAHPS scores continue to challenge us to change the perception that our members have of the health plan and services, since our scores continue to remain well below our goal. Most of our scores remained below the 50th percentile band despite significant efforts last year to better understand our customer's needs. In fact, there appears to be a disconnect between the internal survey process, which occurred immediately following a members visit to one of our providers and this annual survey. It does appear that there is a direct correlation between the benefit plan offered by the employer and the member satisfaction. Given that more and more employers in our service area are choosing HMO plans with higher deductibles and co-pays seems to have hurt our relative performance. This year the score for Rating of Health Plan did move up from below the 50th percentile to between the 50th and 75th percentile. When comparing MercyCare results to national percentages, and to those of our primary regional competitor, it is evident that the trending is equivalent. Moving forward, we need to work to improve our member's perception of our health plan by increasing direct communications with our membership to promote, the positive aspects of our plan, including MercyCare accessibility standards, our commitment to quality and our commitment to getting the care that they need, and their questions answered promptly.

MercyCare has improved the types of educational information members have access to regarding aspects of safety this year. MercyCare will expand this effort by organizing a Safety Committee that monitors and analyzes the data on WI CheckPoint. We will interact with our hospitals to encourage appropriate quality improvement efforts. Members will be notified of the availability of comparative results.

Approvals

\_\_\_\_\_  
Philip Bedrossian, MD  
Medical Director

\_\_\_\_\_  
Date

\_\_\_\_\_  
Joseph Nemeth  
Vice President/Chief Operating Officer

\_\_\_\_\_  
Date

\_\_\_\_\_  
Stephen VanGalder  
Board of Directors, Chair

\_\_\_\_\_  
Date of Board Approval