2011 Healthcare Effectiveness Data and Information Set (HEDIS®)

Health Plan Report Card—Supplement 2

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1100 13th St. N.W., Suite 1000
Washington, DC 20005
NCQA website: ncqa.org

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WHAT IS HEDIS?

The Healthcare Effectiveness Data and Information Set (HEDIS®) is a set of standardized performance measures designed to ensure that the public has the information it needs for reliable comparison of organization performance. HEDIS results are based on statistically valid samples of members. Certified auditors rigorously audit HEDIS results, using a process designed by the National Committee for Quality Assurance (NCQA).

NCQA is a private, not-for-profit organization dedicated to improving health care quality, and is active in quality oversight and improvement initiatives at all levels of the health care system, from evaluating entire systems of care to recognizing individual providers that demonstrate excellence. NCQA firmly believes that health care sectors beyond managed care can significantly benefit from a meaningful performance measurement program that aids quality improvement and provides significant information about health care quality.

HEDIS demonstrates health plan performance from a clinical perspective. The measures evaluate whether the health plan delivers the recommended care based on medical evidence to prevent or manage illness. HEDIS measures health care issues that are meaningful to consumers and purchasers. They measure performance in areas of care where improvements can make a meaningful difference in members' lives while giving health care systems feedback they can use to improve service.

HEDIS is one component of a larger accountability system and complements the NCQA Accreditation Program. When combined, the results of NCQA Accreditation and HEDIS provide the most widely used view of organization quality currently available to purchasers and consumers.

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WHY HEDIS IS USEFUL?

Health care costs have escalated rapidly during the past decades. As costs increase, purchasers of health benefits (large corporations that purchase care on behalf of their employees and the public, and Medicare and Medicaid programs that purchase care on behalf of the senior and low-income populations) have become increasingly concerned that the value of health care has not risen proportionately. As health benefits consume an ever-larger proportion of total expenses, purchasers seek ways to assess the relative value of care offered by organizations. HEDIS offers a means to make an "apples-to-apples" comparison of organizations.

HEDIS provides value on two fronts. First, HEDIS measures give the public an unprecedented ability to understand how well organizations achieve results that matter, by answering questions such as:

- How effective and satisfying is the care and service delivered?
- How accessible is care?
- How well does the organization equip its members to make informed choices about their health?

Second, and just as important, HEDIS measures ensure that results are comparable across all organizations.

An additional use of HEDIS is as a component of a larger system that encourages accountability and quality improvement in health care. Quality professionals within health care strongly believe that managed care can provide better care, and HEDIS can help prove them right.

The HEDIS scores include all the HMO insurers that were available to ETF members in 2010. HEDIS data are collected by each insurer from their entire commercial population and are not reported separately by service area or from state employee and retiree membership. No HEDIS data are available for the State Maintenance Plan, the Standard Plan or WPS Metro Choice. For HMOs such as Humana, Anthem BCBS and United Healthcare, the overall results may not be reflective of the care given in each region of the state that the HMO operates. For example, if scores tend to be lower in the southeastern region than they are in the northeastern region of the state, than the scores presented in the HEDIS report card may be higher than the true scores achieved in the Southeast region and lower than the true scores achieved in the Northeast region.

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EFFECTIVENESS OF CARE

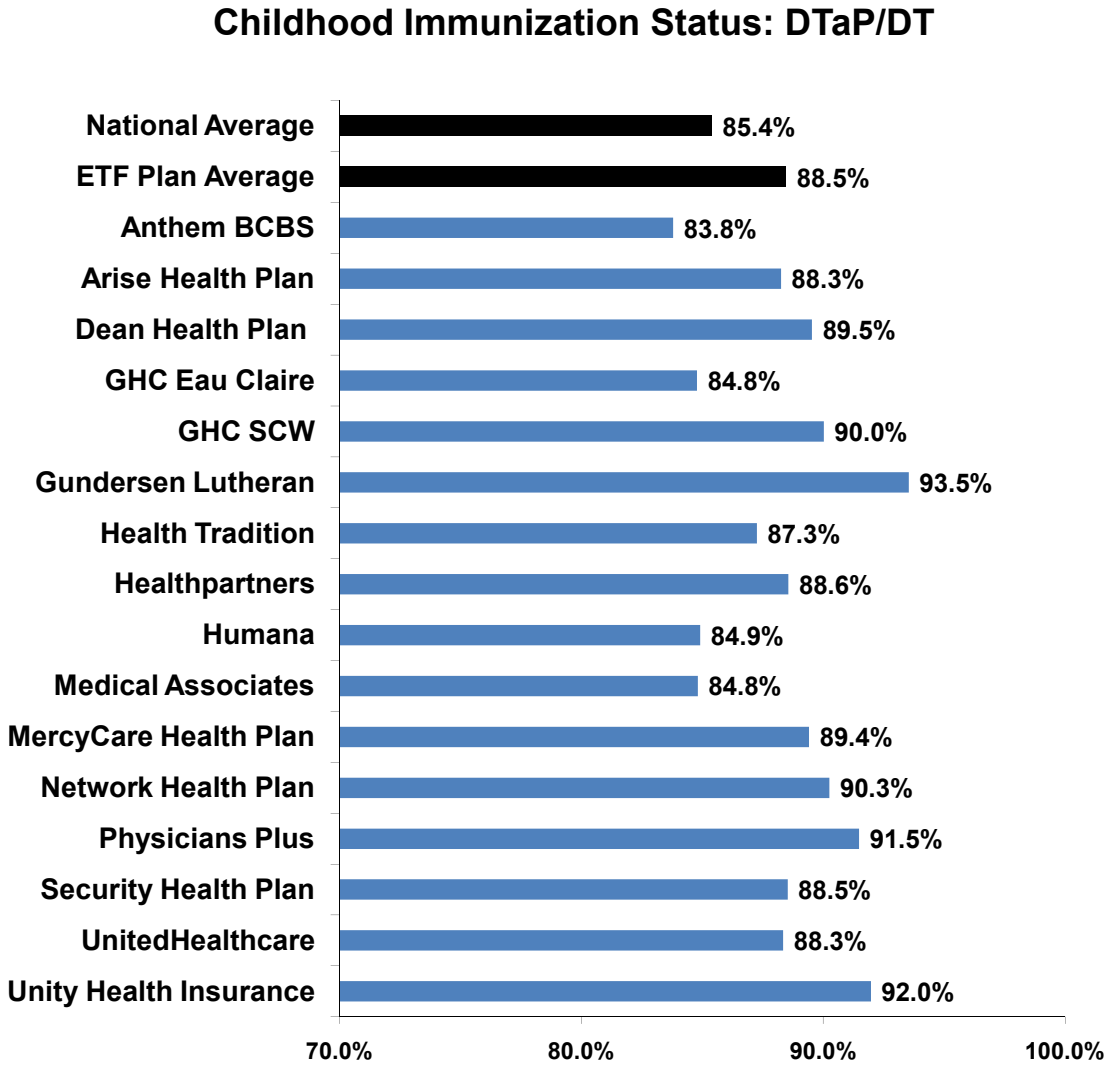
Prevention

A basic method for prevention of illness is immunization. Childhood immunizations help prevent serious illnesses such as polio, tetanus and hepatitis. Vaccines are a proven way to help a child stay healthy, and avoid potentially harmful effects of childhood diseases like mumps and measles. Even preventing "mild" diseases saves hundreds of lost school and work days, and millions of dollars.

The measures in questions 1-9 assess the percentage of children who became 2 years old during the measurement year and who had received these vaccinations on or before 2 years of age: four doses of DTaP (diphtheria-tetanus-acellular pertussis) – question 1; three doses of IPV (polio) – question 2; one dose of MMR (measles, mumps, rubella) – question 3; three doses of Hib (homophiles influenza type b) – question 4; three doses of hepatitis B – question 5; one dose of VZV (chickenpox) – question 6; four doses of pneumococcal conjugate – question 7. Immunizations that were a combination of the vaccinations listed above are the measures in question 8 and question 9.

Note: Due to the Hib shortage, only two of the three doses are required for HEDIS 2010.

Question 1: What percentage of children received four doses of DTaP (diphtheria, tetanus and acellular pertussis) vaccine before their second birthday?



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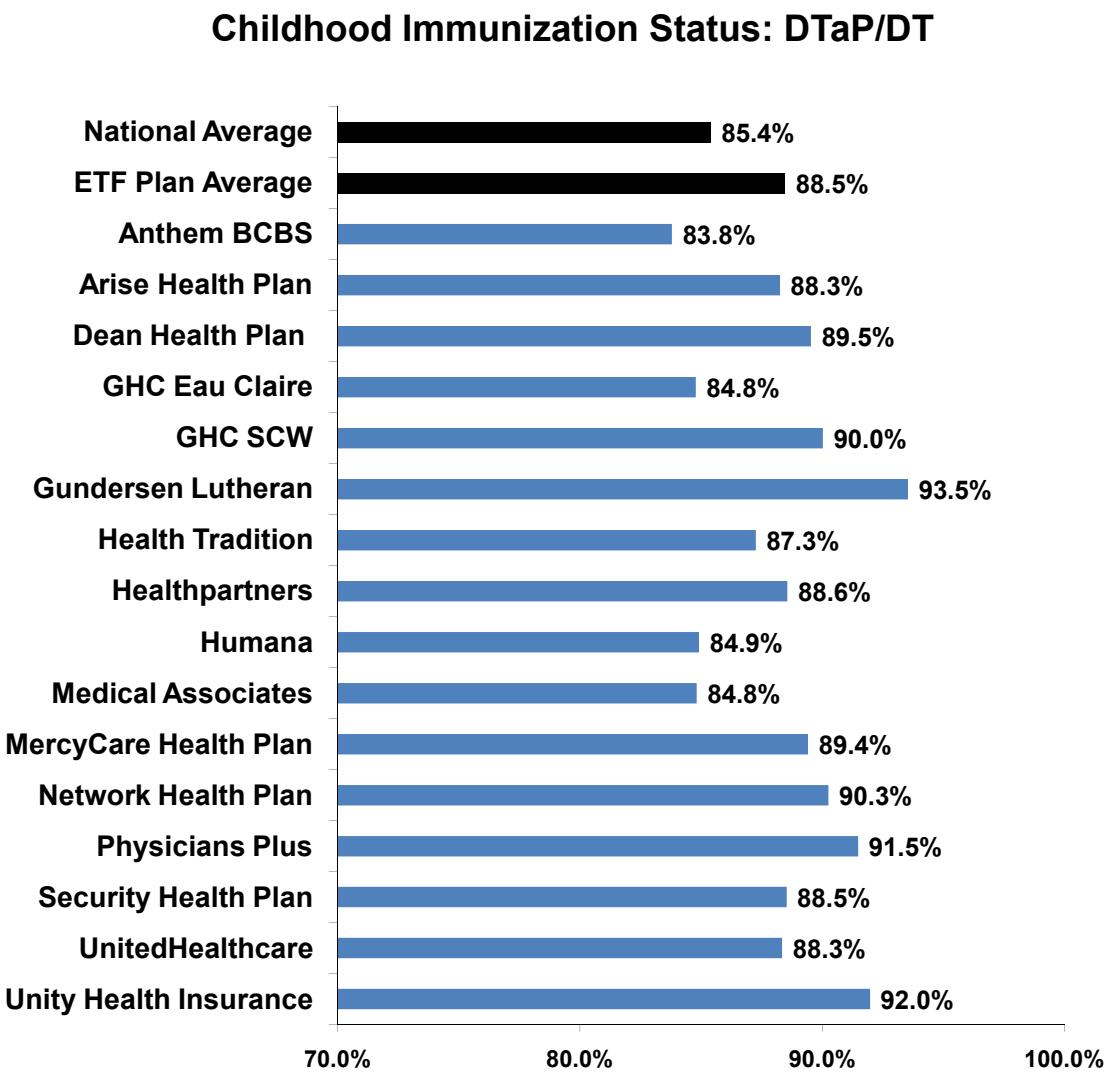
Question 2: What percentage of children received at least three doses IPV (polio) vaccine before their second birthday?



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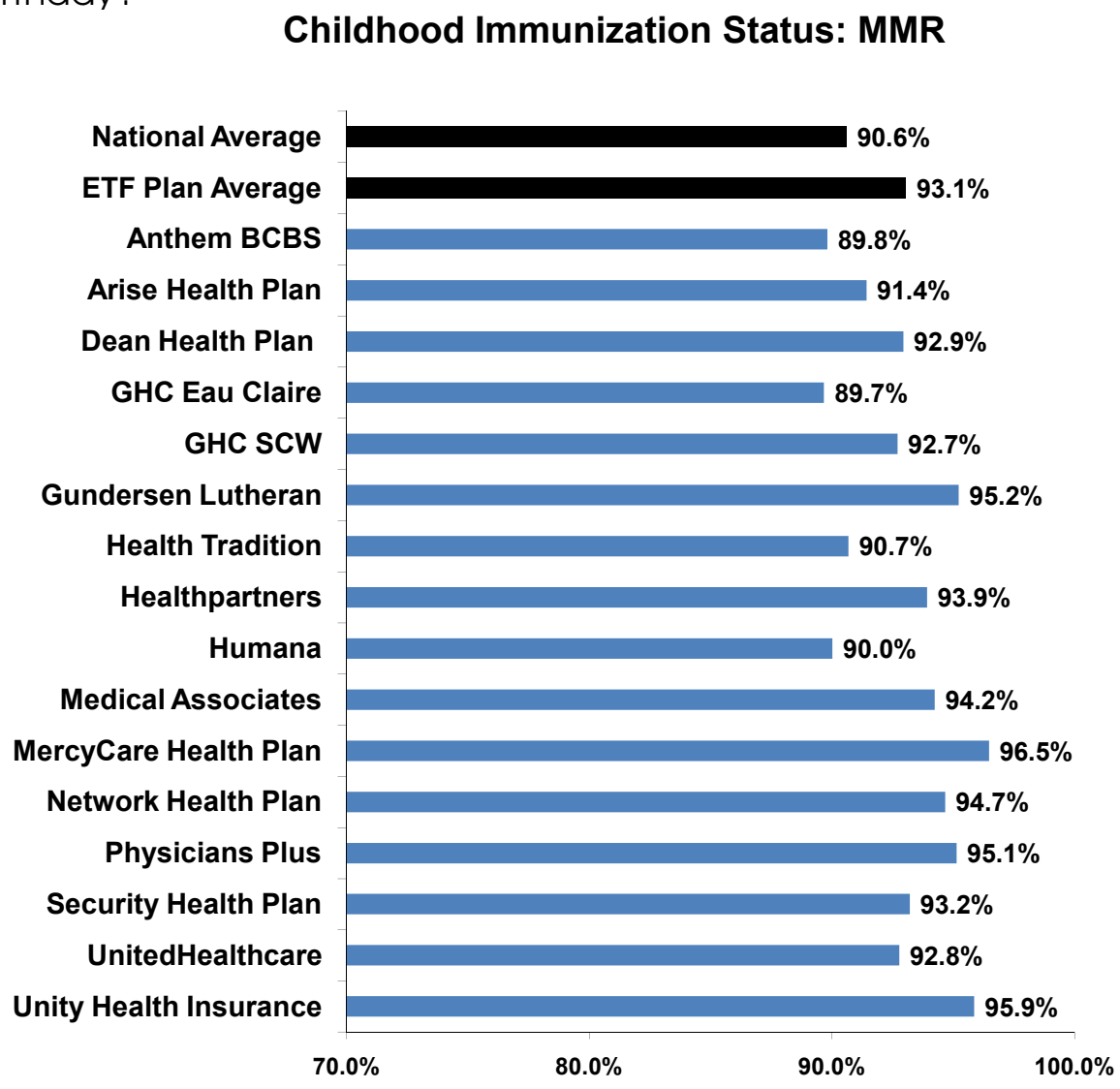
Question 3: What percentage of children received one dose of MMR (measles, mumps, and rubella) vaccine before their second birthday?



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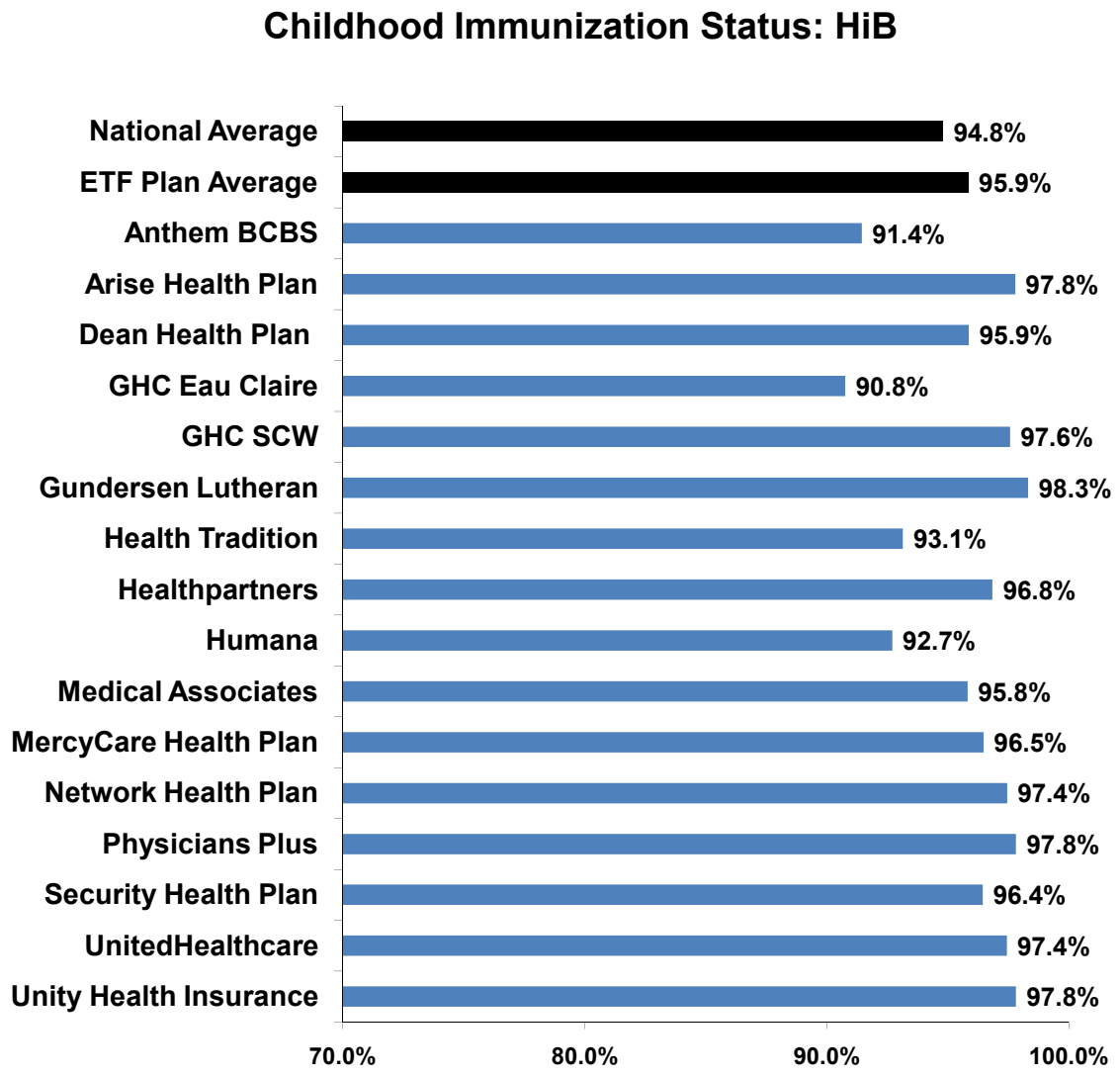
Question 4: What percentage of children received two H influenza type B (Hib) vaccines before their second birthday?



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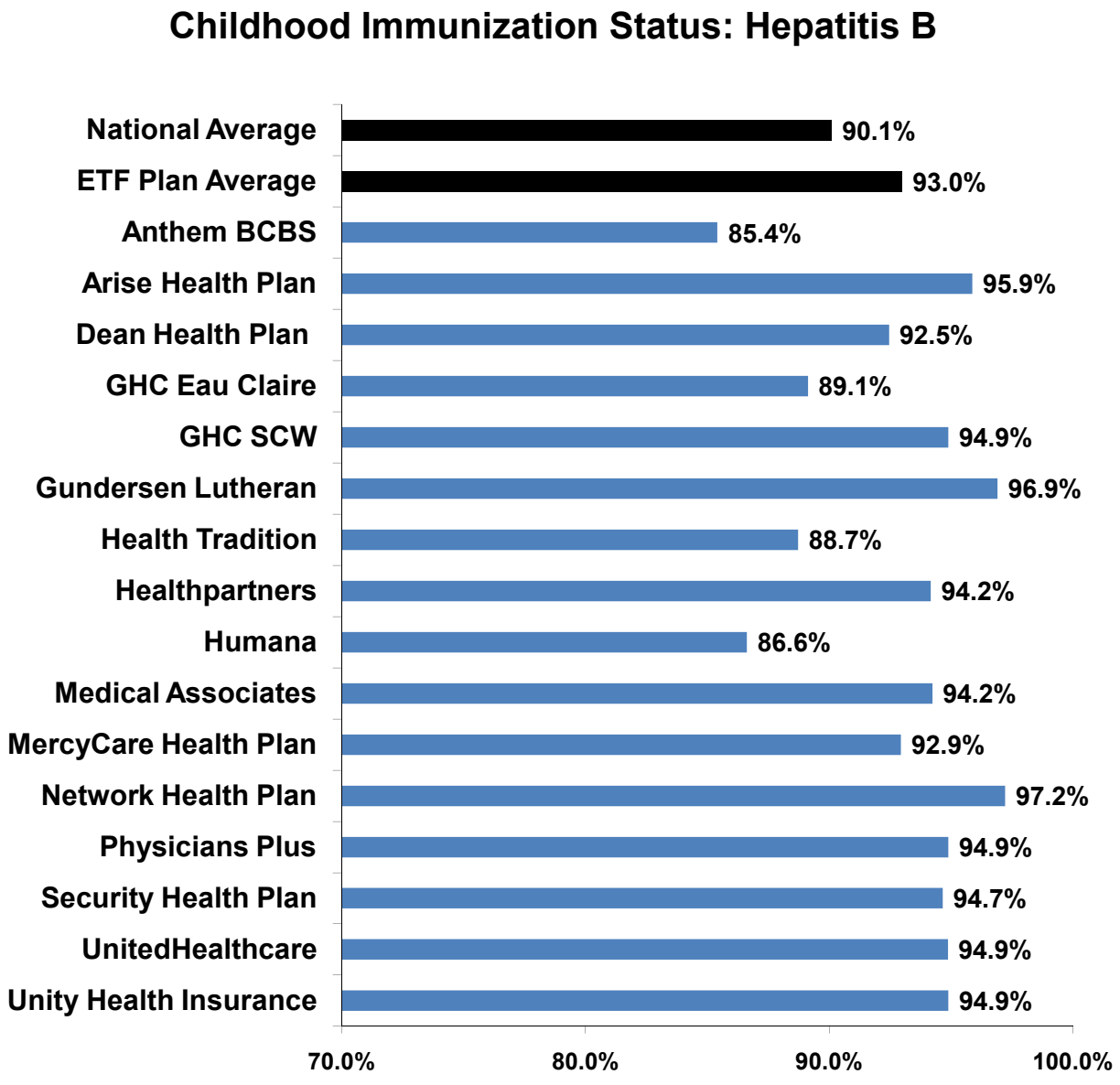
Question 5: What percentage of children received three hepatitis B vaccines before their second birthday?



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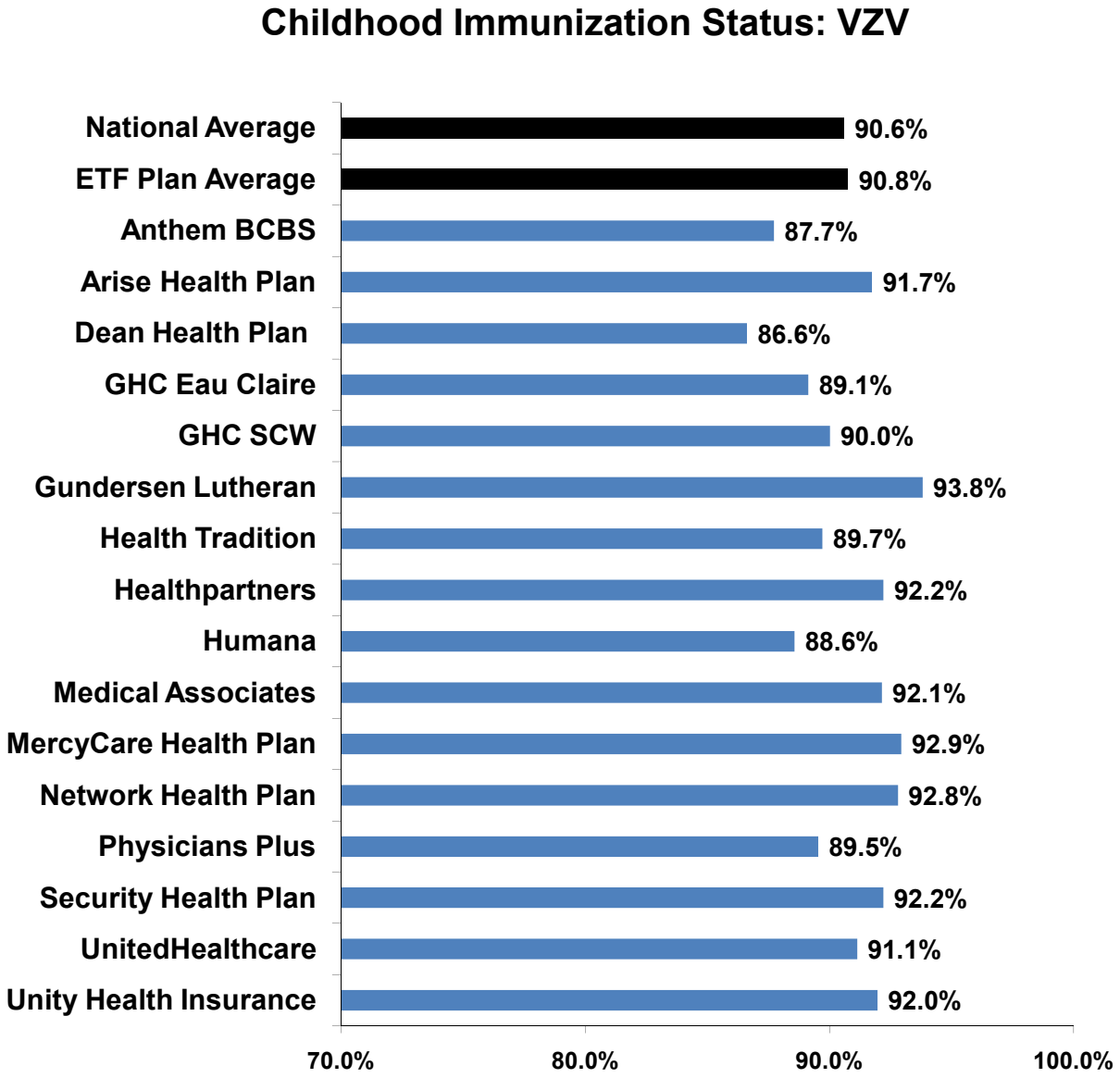
Question 6: What percentage of children received one chicken pox (VZV) vaccine before their second birthday?



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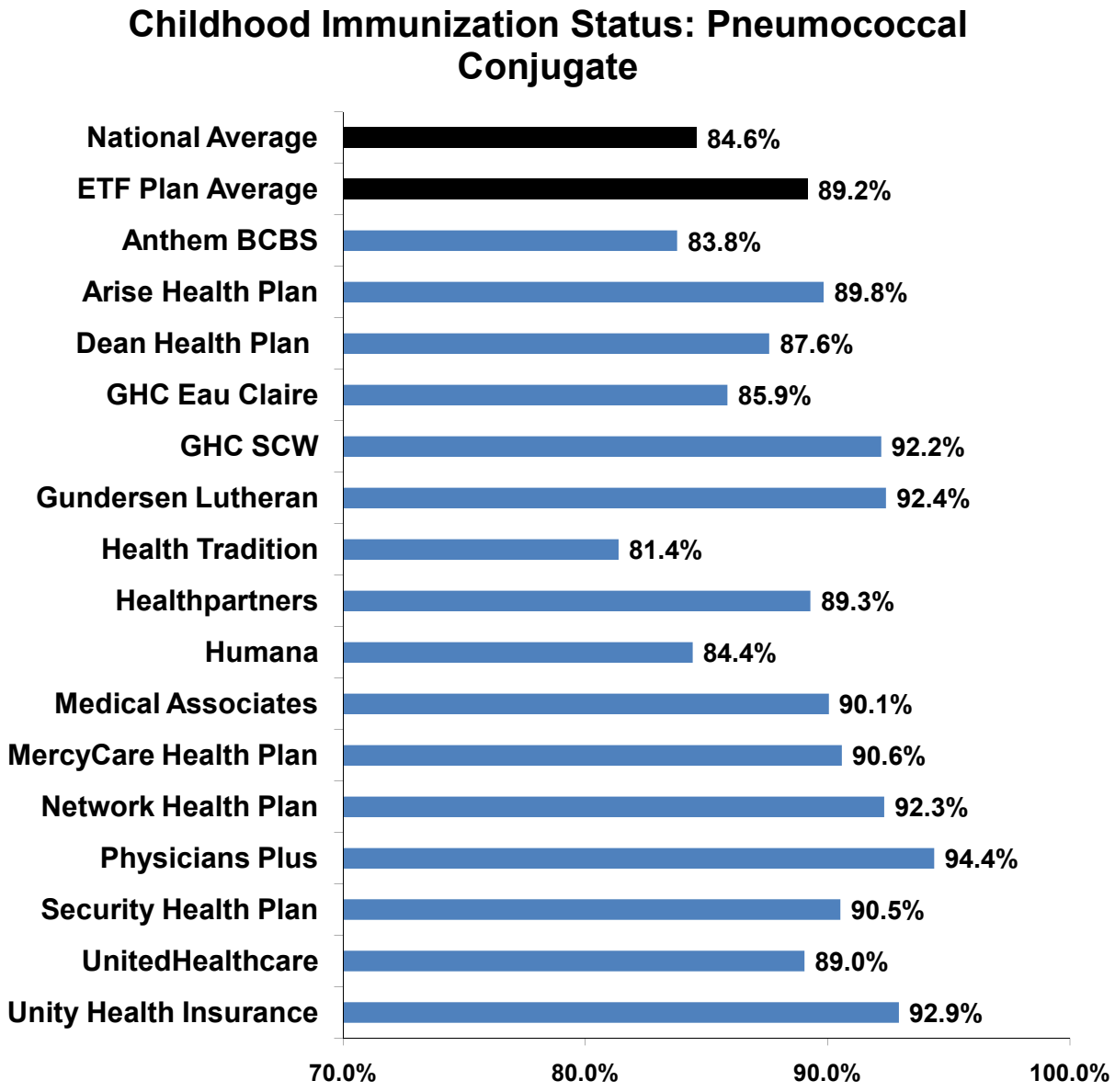
Question 7: What percentage of children received four pneumococcal conjugate vaccines before their second birthday?



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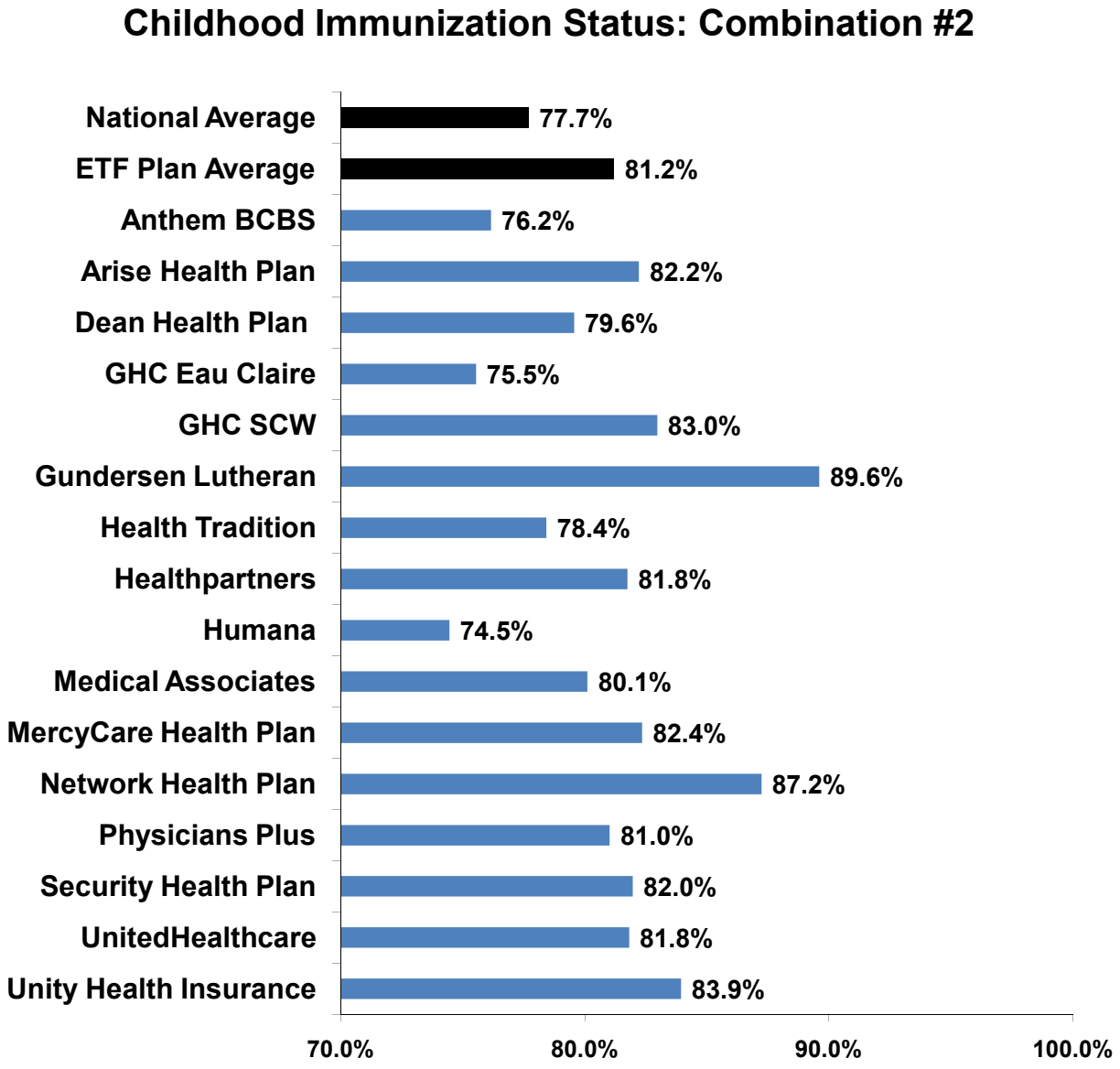
Question 8: What percentage of children received recommended vaccines—Combination 2 (DTaP, IPV, MMR, Hib, hepatitis B, VZV) before their second birthday?



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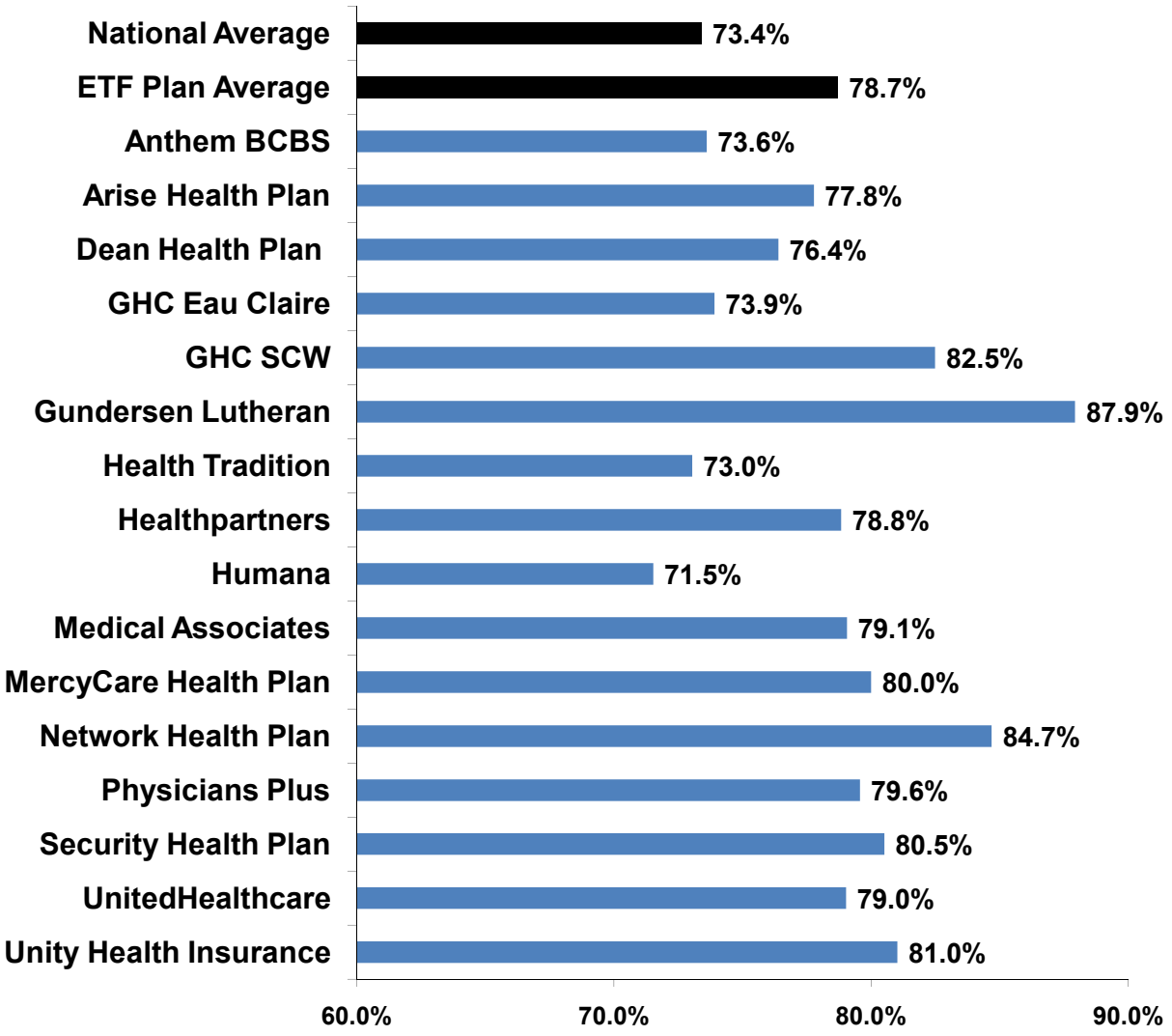
Question 9: What percentage of children received recommended vaccines—Combination 3 (DTaP, IPV, MMR, Hib, hepatitis B, VZV, pneumococcal conjugate) before their second birthday?

Childhood Immunization Status: Combination #3



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Respiratory Conditions

The measure in question 10 calculates the rate of antibiotic prescribing in children with upper respiratory infection (URI). It examines the proportion of children between 3 months and 18 years of age who were given a single diagnosis of URI at an outpatient visit and **did not** receive an antibiotic prescription for that episode of care within three days of the visit. Only the first eligible episode of URI for each child during the measurement year will be counted. A higher rate indicates better performance.

The common cold (or URI) is a frequent reason for children visiting the doctor's office. A performance measure of antibiotic use for URI sheds light on the prevalence of inappropriate antibiotic prescribing in clinical practice and raises awareness of the importance of reducing inappropriate antibiotic use to combat antibiotic resistance in the community.

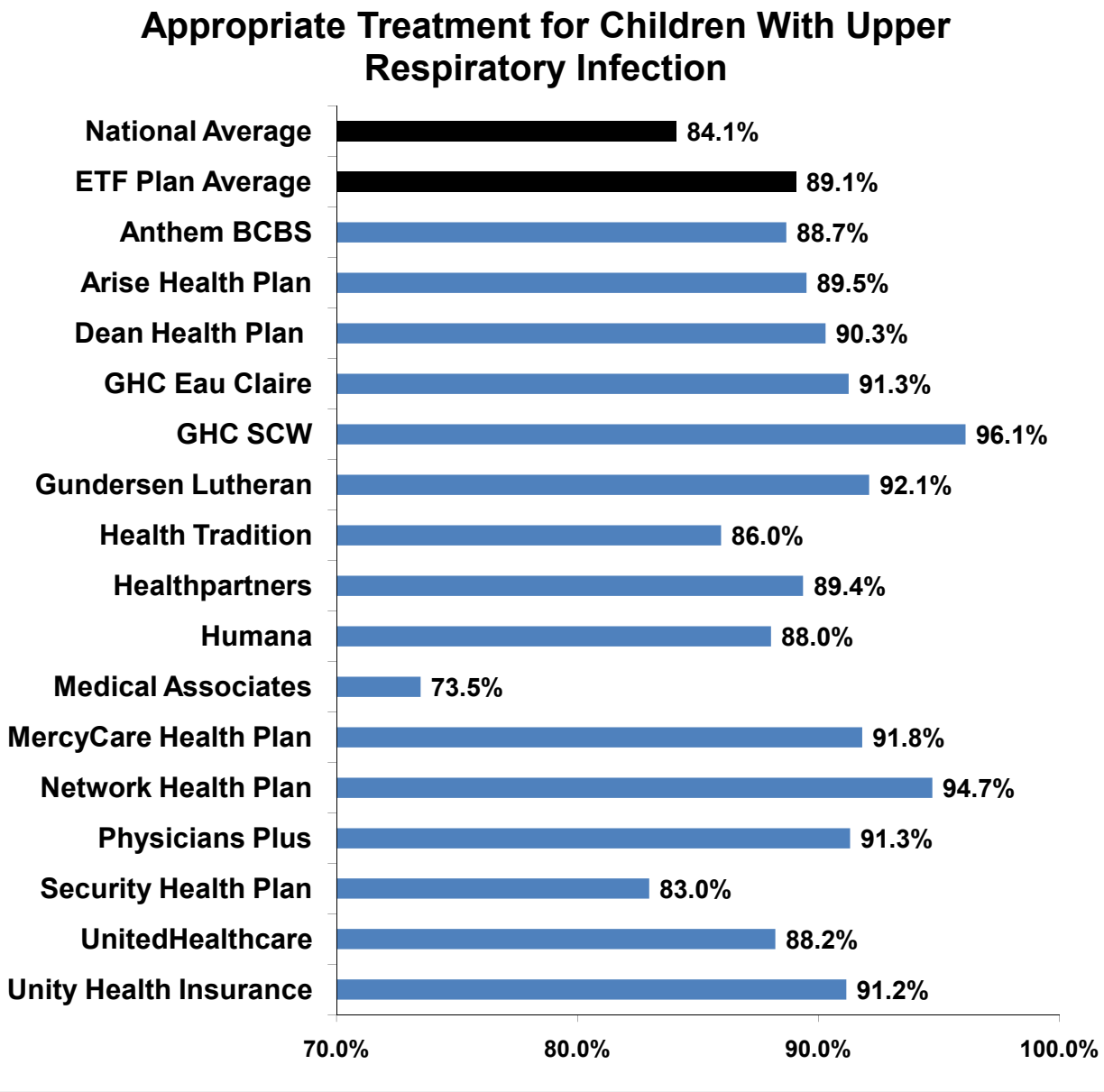
The measure in question 11 reports the percentage of children between 2 and 18 years of age who were diagnosed with pharyngitis, prescribed an antibiotic at an outpatient visit and received a group A strep test. A higher rate indicates better performance.

Pharyngitis is the only condition among upper respiratory infections (URI) where diagnosis is easily and objectively validated through administrative and laboratory data, and it can serve as an important indicator of appropriate antibiotic use among all respiratory tract infections. Overuse of antibiotics has been directly linked to the prevalence of antibiotic resistance. A strep test (rapid assay or throat culture) is the definitive test of group A strep pharyngitis.

The measure in question 12 assesses whether antibiotics were inappropriately prescribed for healthy adults 18 to 64 years of age with bronchitis and builds on an existing HEDIS measure that targets inappropriate antibiotic prescribing for children with URI.

Acute bronchitis consistently ranks among the 10 conditions that account for most ambulatory office visits to U.S. physicians. Despite that, the vast majority of acute bronchitis cases (more than 90%) have a nonbacterial cause, and antibiotics are prescribed 65% to 80% of the time. A lower rate indicates better performance.

Question 10: What percentage of children age 3 months to 18 years of age who were given a diagnosis of upper respiratory infection (URI) **were not** dispensed an antibiotic prescription?



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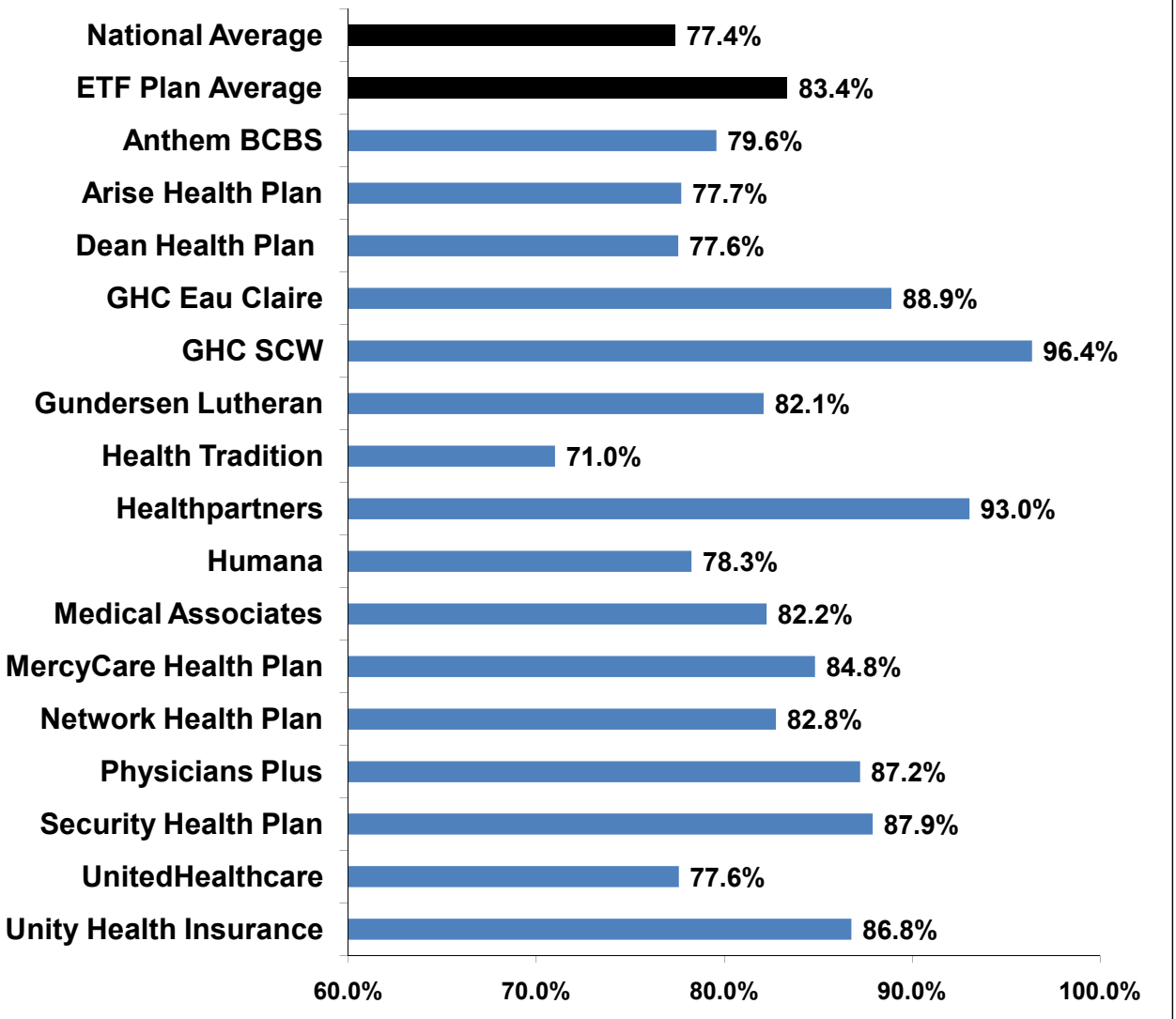
Question 11: What percentage of children ages 2 to 18 who were diagnosed with pharyngitis and dispensed an antibiotic, received a group A streptococcus (strep) test for the episode?

Appropriate Testing for Children With Pharyngitis



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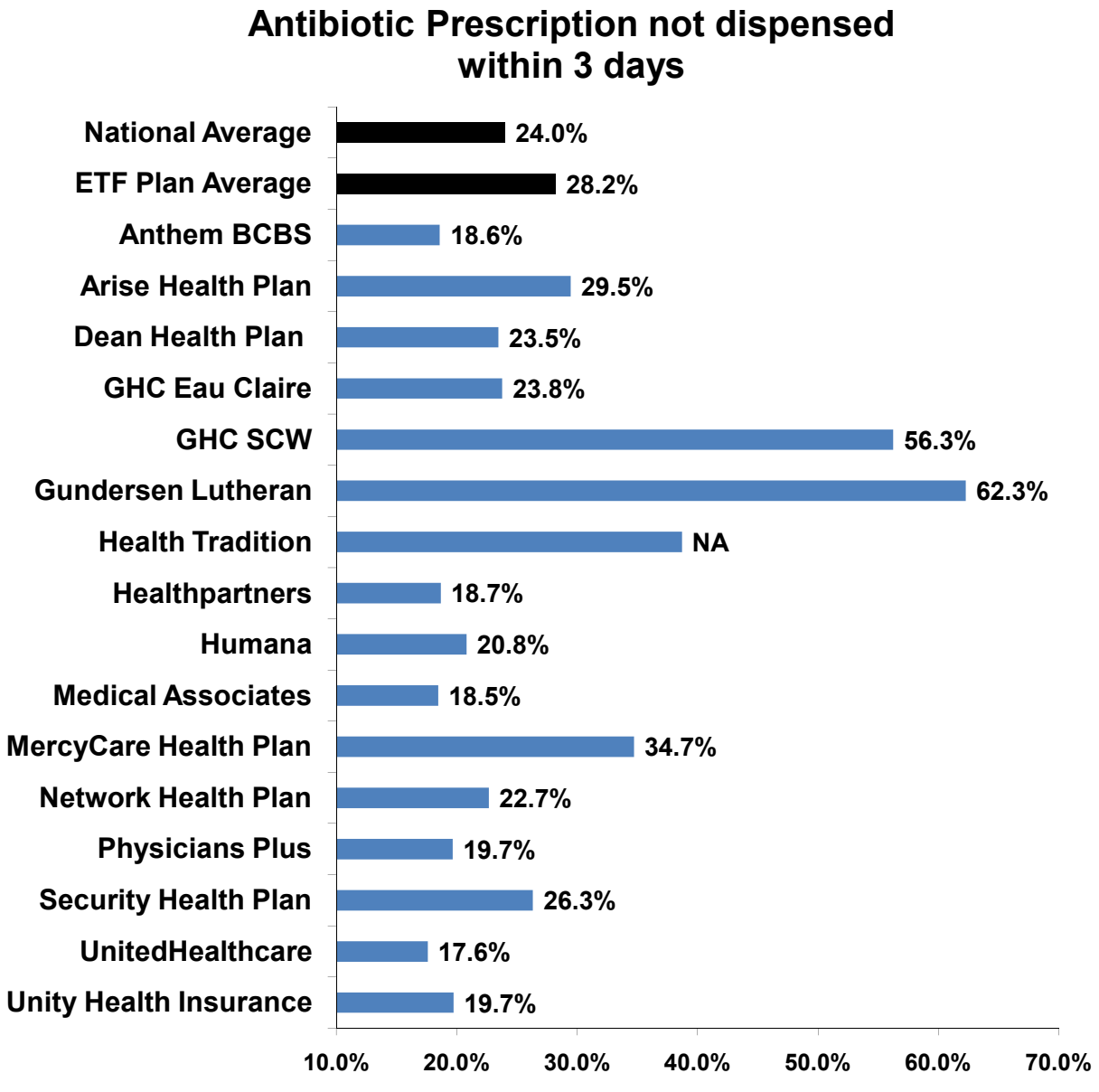
Question 12: What percentage of adults ages 18 to 64 with a diagnosis of acute bronchitis **were not** dispensed an antibiotic prescription?



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Cancer Screening

Colorectal Cancer

The measure in question 13 assesses whether adults 50–75 years of age have had appropriate screening for colorectal cancer (CRC). "Appropriate screening" is defined by meeting any one of the screening methods below.

- Fecal occult blood test (FOBT) during the measurement year.
- Flexible sigmoidoscopy during the measurement year or the four years prior to the measurement year.
- Colonoscopy during the measurement year or the nine years prior to the measurement year.

CRC is the second leading cause of cancer-related deaths in the U.S. It places significant economic burden on society: treatment costs over $6.5 billion per year. Unlike other screening tests that only detect disease, some methods of CRC screening can detect premalignant polyps and guide their removal, which in theory can prevent the cancer from developing.

Breast Cancer

The measure in question 14 looks at whether female members are being screened for breast cancer. It measures the percentage of women between 40 and 69 years of age who had at least one mammogram during the past two years.

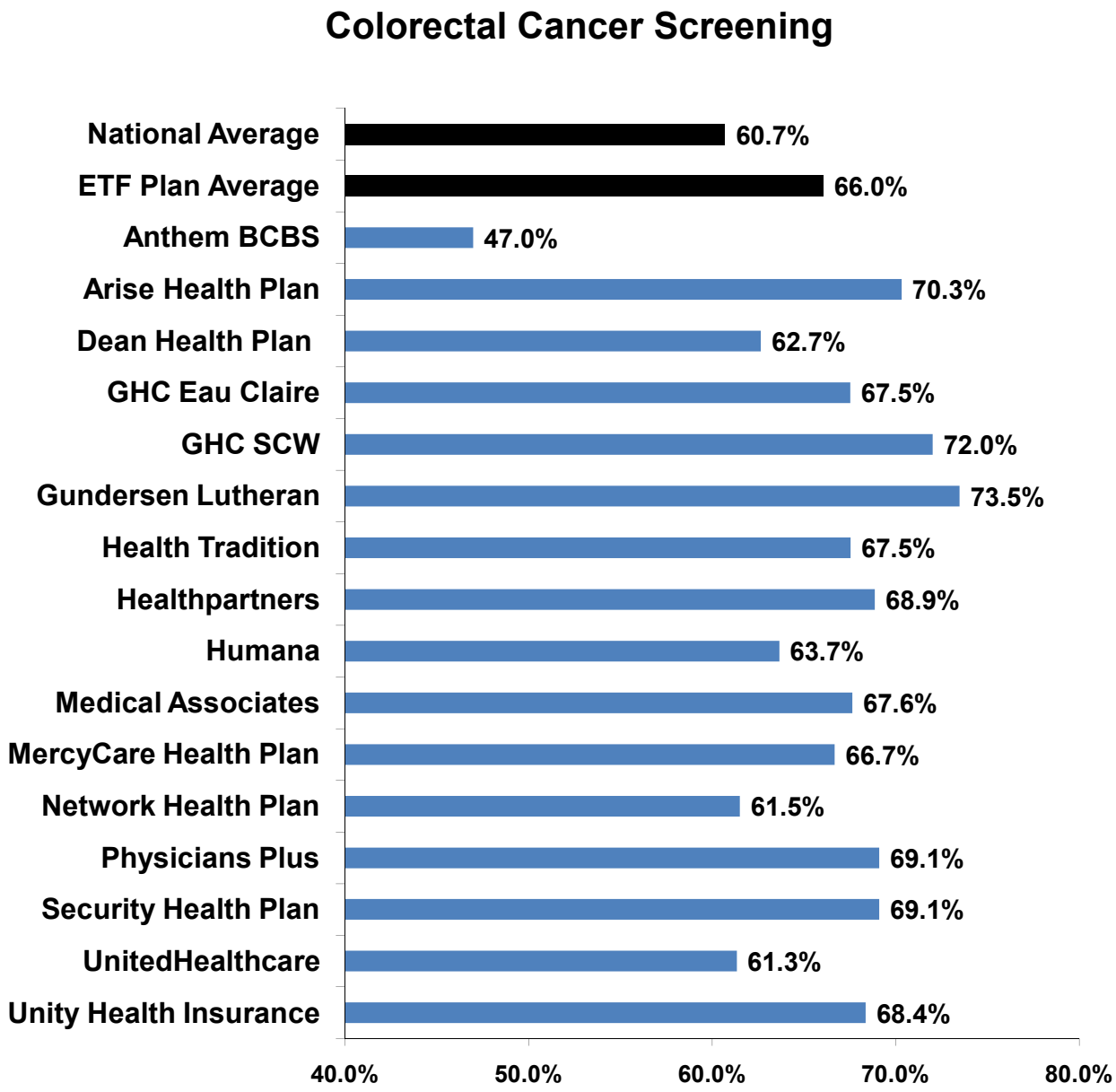
Breast cancer is the second most common type of cancer among American women, with about 178,000 new cases reported each year. It is most common in women older than 50 years. Women whose breast cancer is detected early have more treatment choices and better chances for survival. Mammography screening has been shown to reduce mortality by 20% to 30% among women 40 years old and older. A mammogram can reveal tumors too small to be felt by hand. It can also show other changes in the breast that may suggest cancer.

Cervical Cancer

The measure in question 15 assesses the percentage of women 21 to 64 years of age who had at least one Pap test during the past three years.

Cervical cancer can be detected in its early stages by regular screening using a Pap test. A number of organizations recommend Pap testing every one to three years for all women who have been sexually active or who are older than 21.

Question 13: What percentage of adults ages 50 to 80 received an appropriate screening for colorectal cancer?



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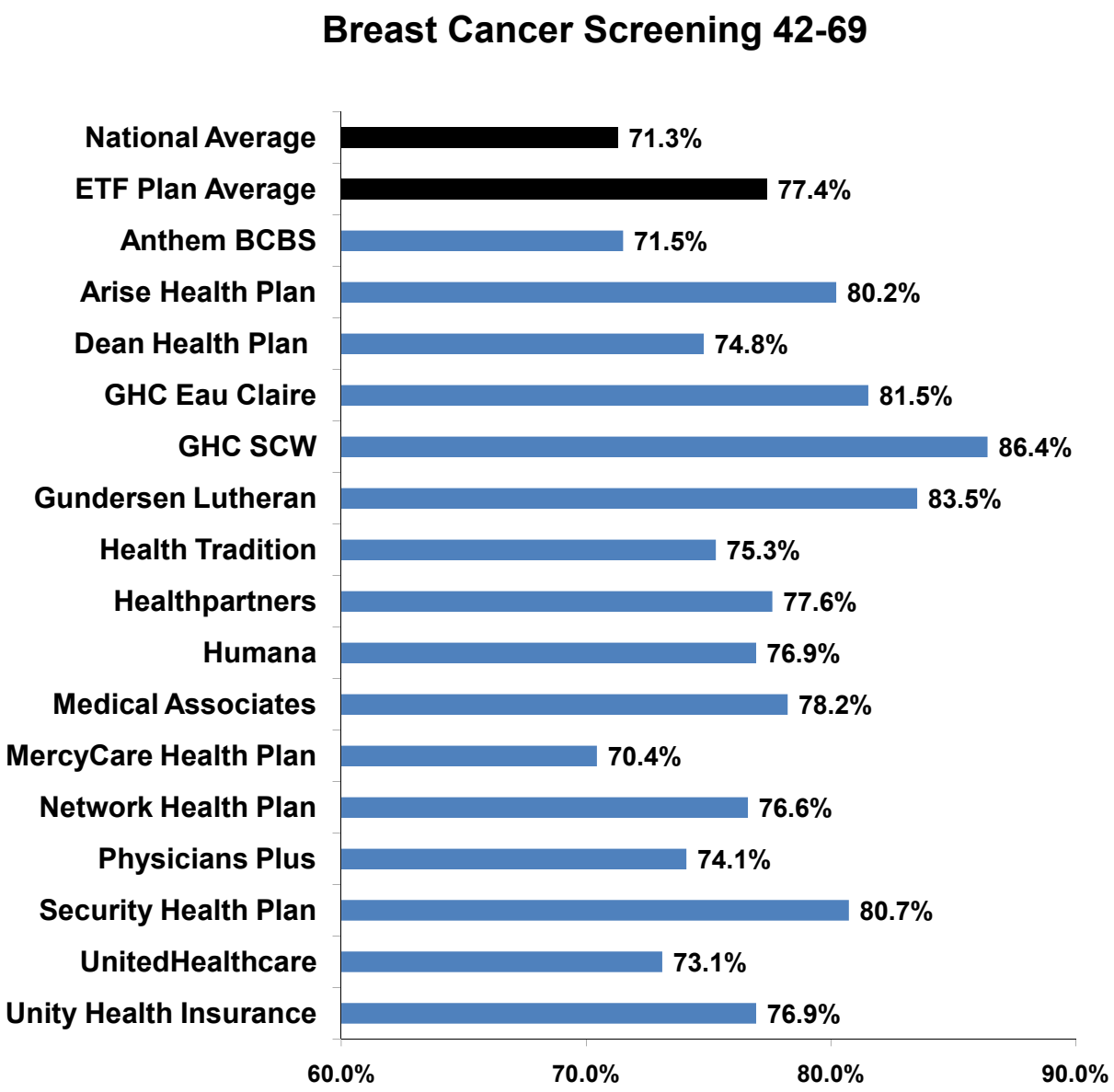
Question 14: What percentage of women ages 42 to 69 years old had a mammogram within the last two years?



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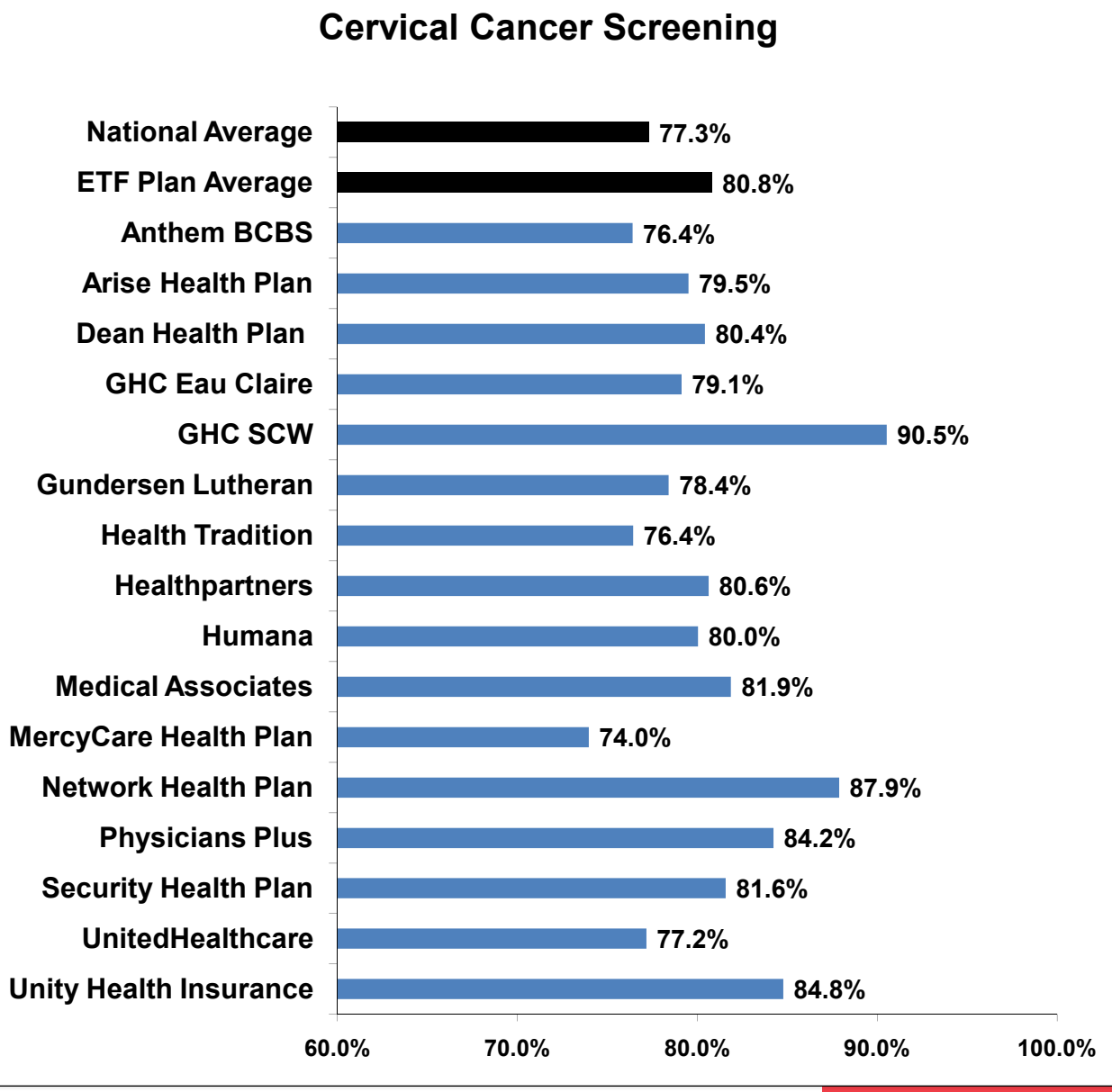
Question 15: What percentage of women ages 21 to 64 had at least one Pap test during the past three years?



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Chronic Conditions

Hypertension

The intermediate-outcome measure in question 16 looks at whether blood pressure was controlled among adults 18–85 years of age who were diagnosed with hypertension. Control is demonstrated by a blood pressure reading that is <140 mm Hg systolic and <90 mm Hg diastolic during the measurement year. Literature from clinical trials indicates that 53% to 75% of people under treatment achieved control of their blood pressure.

Approximately 50 million Americans have high blood pressure. Numerous clinical trials have shown that aggressive treatment of high blood pressure reduces mortality from heart disease, stroke and renal failure. Results are particularly striking in elderly hypertensives, who are more likely to have heart failure. A pool of past clinical trials demonstrated that a 5 mm–6 mm Hg reduction in diastolic blood pressure was associated with a 42 percent reduction in stroke mortality and a 14% to 20% reduction in mortality from coronary heart disease (CHD).

High Cholesterol

The measures in question 17 and question 18 assess multiple components of cholesterol management for people 18–75 years of age who are known to have heart disease by virtue of having had an acute cardiovascular event or diagnosis of ischemic vascular disease: the percentage of members who have an LDL-C screening (question 17) and the percentage of members who have a documented LDL-C level <100 mg/dL (question 18).

Total blood cholesterol is directly related to the development of coronary artery disease (CAD) and CHD, with most of the risk associated with LDL cholesterol. When LDL-C levels are high, cholesterol can build up within the walls of the arteries and cause atherosclerosis, a build-up of plaque. Hemorrhaging or clot formation can occur at the site of plaque build-up, blocking arteries and causing heart attack and stroke.

Reducing cholesterol in patients with known heart disease is critically important, as treatment can reduce morbidity (heart attack and stroke) and mortality by as much as 40 percent. Cholesterol screening and control depends on the combined efforts of the patient, physician and organization. Lifestyle factors and new medications offer tangible means for reducing cholesterol and the risk of heart disease.

Diabetes

The composite measures in questions 19 through 26 look at how well an organization cares for the common and serious chronic disease of diabetes. It uses a single sample of diabetic members 18 to 75 years of age to evaluate organization performance on aspects of diabetes care. As a set, the rates provide a comprehensive picture of the clinical management of patients with diabetes. This measure looks at the percentage of individuals with diabetes who meet the following criteria.

- Had a hemoglobin (HbA1c) blood test – question 19.
- Have controlled diabetes (HbA1c <9.0%) – question 20.
- Had a retinal eye examination – question 21.
- Had an LDL-C screening – question 22.
- Had a controlled LDL-C level (LDL-C<100 mg/dL) – question 23.
- Have been monitored for kidney disease – question 24.
- Have blood pressure <130/80 – question 25.
- Have blood pressure <140/90 – question 26.

Diabetes is one of the most costly and highly prevalent chronic diseases in the U.S. Approximately 20.8 million Americans have diabetes, and half these cases are undiagnosed. Complications from the disease cost the country nearly $100 billion annually. In addition, diabetes accounts for nearly 20 percent of all deaths in people older than 25. Many complications, such as amputation, blindness and kidney failure, can be prevented if detected and addressed in the early stages.

Asthma

The process measure in question 27 evaluates whether members 5 to 50 years of age with persistent asthma are being prescribed medications acceptable as primary therapy for long-term asthma control.

Asthma is the most common chronic childhood disease, affecting an estimated 5 million children. Overall, approximately 20 million people in the U.S. have asthma. Collectively, people with asthma have more than 100 million days of restricted activity and 5,000 deaths annually. Much of the death and morbidity associated with asthma is avoidable. Successful management of asthma can be achieved for most asthmatics if they take medications that provide long-term control.

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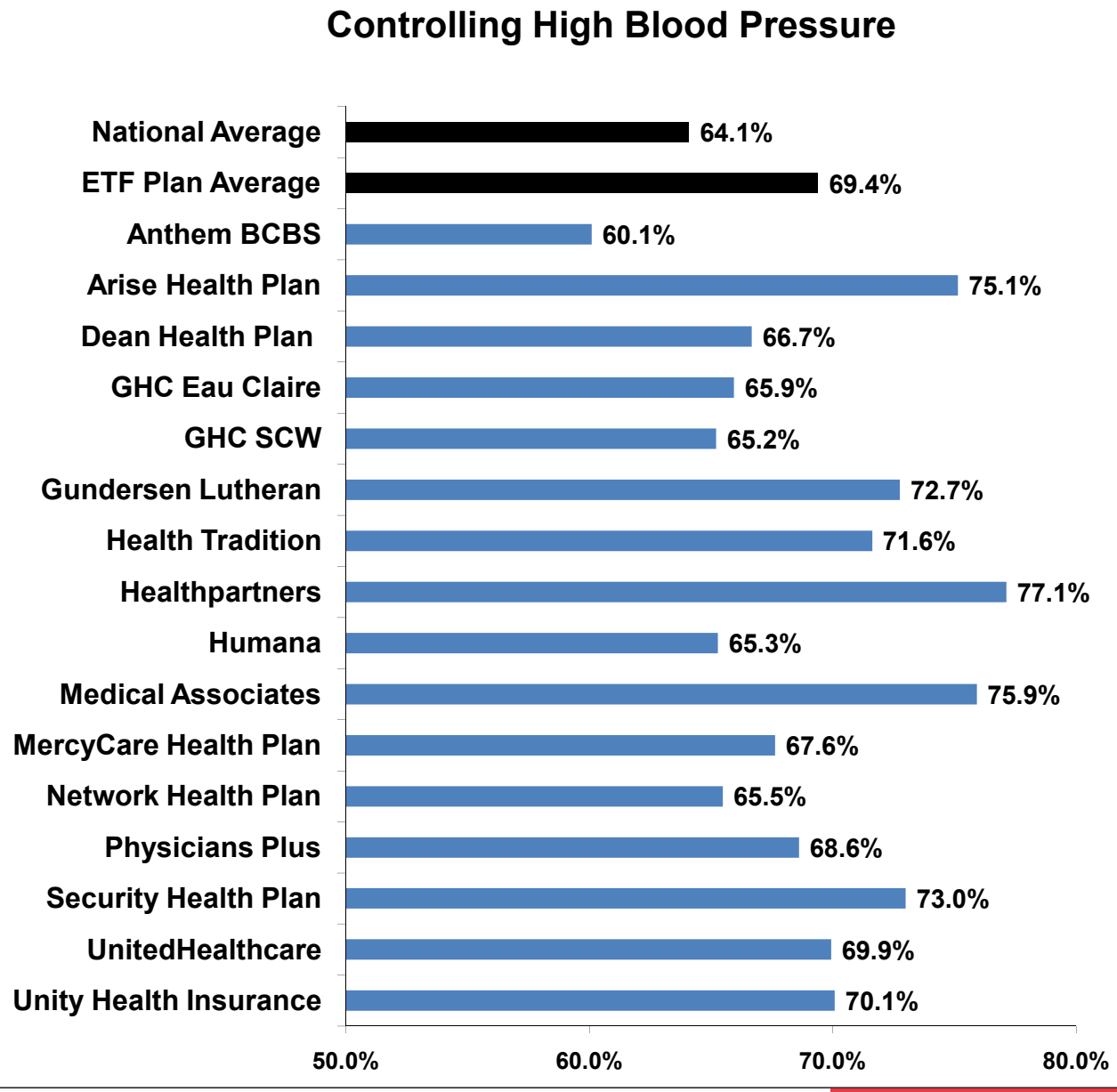
Chronic Obstructive Pulmonary Disease

The measure in question 28 looks at the percentage of members 40 years of age and older during the measurement year with a new diagnosis of chronic obstructive pulmonary disease (COPD) who received spirometry testing to confirm the diagnosis within a reasonable period.

Spirometry is a simple test that measures the amount of air a person can breathe out and the amount of time it takes to do so. Both symptomatic and asymptomatic patients suspected of COPD should have spirometry performed to establish airway limitation and severity.

COPD is a major cause of chronic morbidity and mortality throughout the world and in the U.S. COPD defines a group of diseases characterized by airflow obstruction, and includes chronic bronchitis and emphysema. Symptoms of COPD range from chronic cough and sputum production to severe, disabling shortness of breath, leading to significant impairment of quality of life. COPD afflicts nearly 16 million adults in the U.S. COPD is the fourth leading cause of death in the U.S., and is projected to move to third place by 2020.

Question 16: What percentage of members ages 18 to 85 who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90)?



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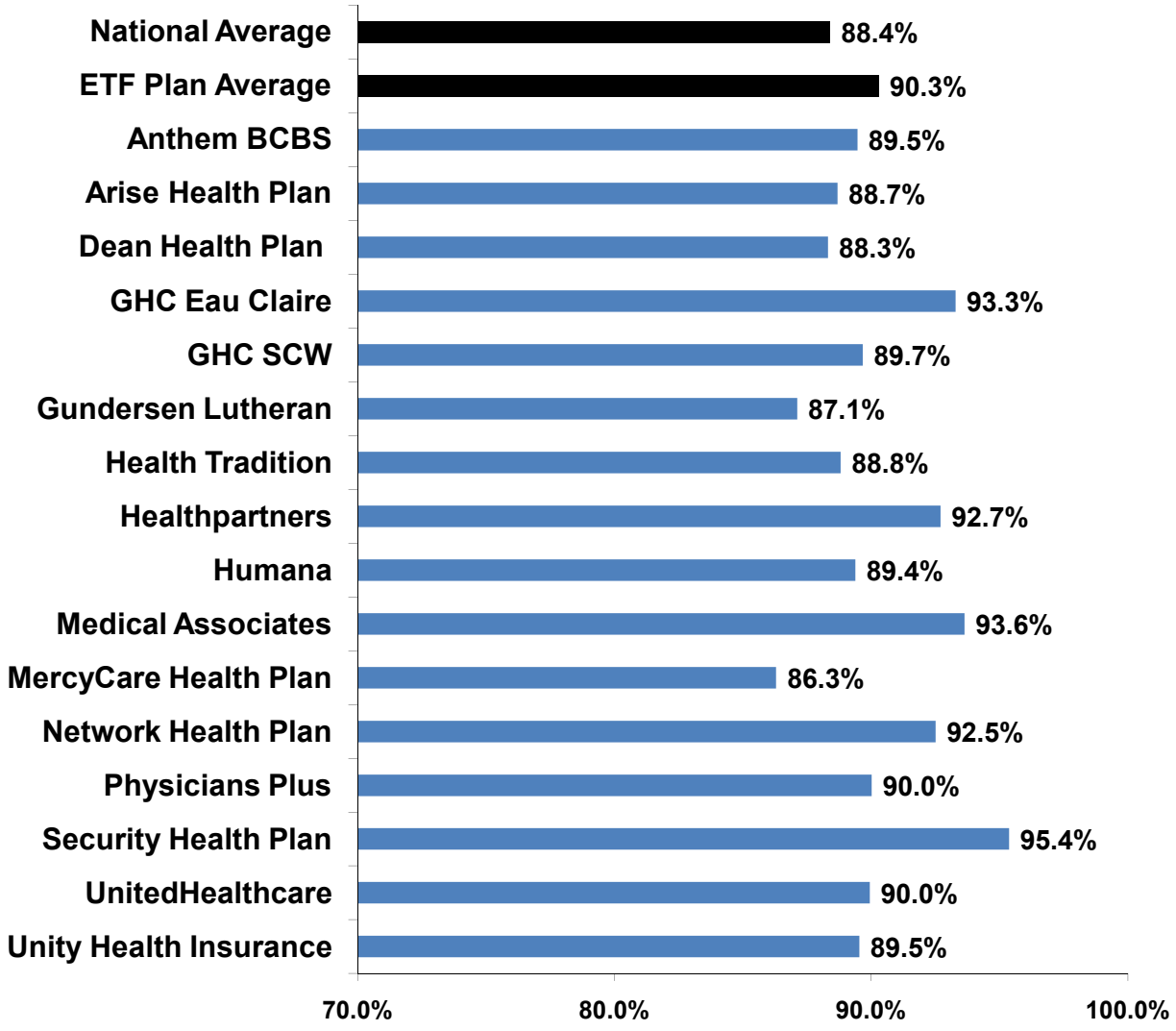
Question 17: What percentage of members ages 18 to 75 with cardiovascular conditions within the prior year had their LDL-C (cholesterol) screened between 60 and 365 days after the event?

Cholesterol Management for Patients With Cardiovascular Conditions: LDL-C Screening



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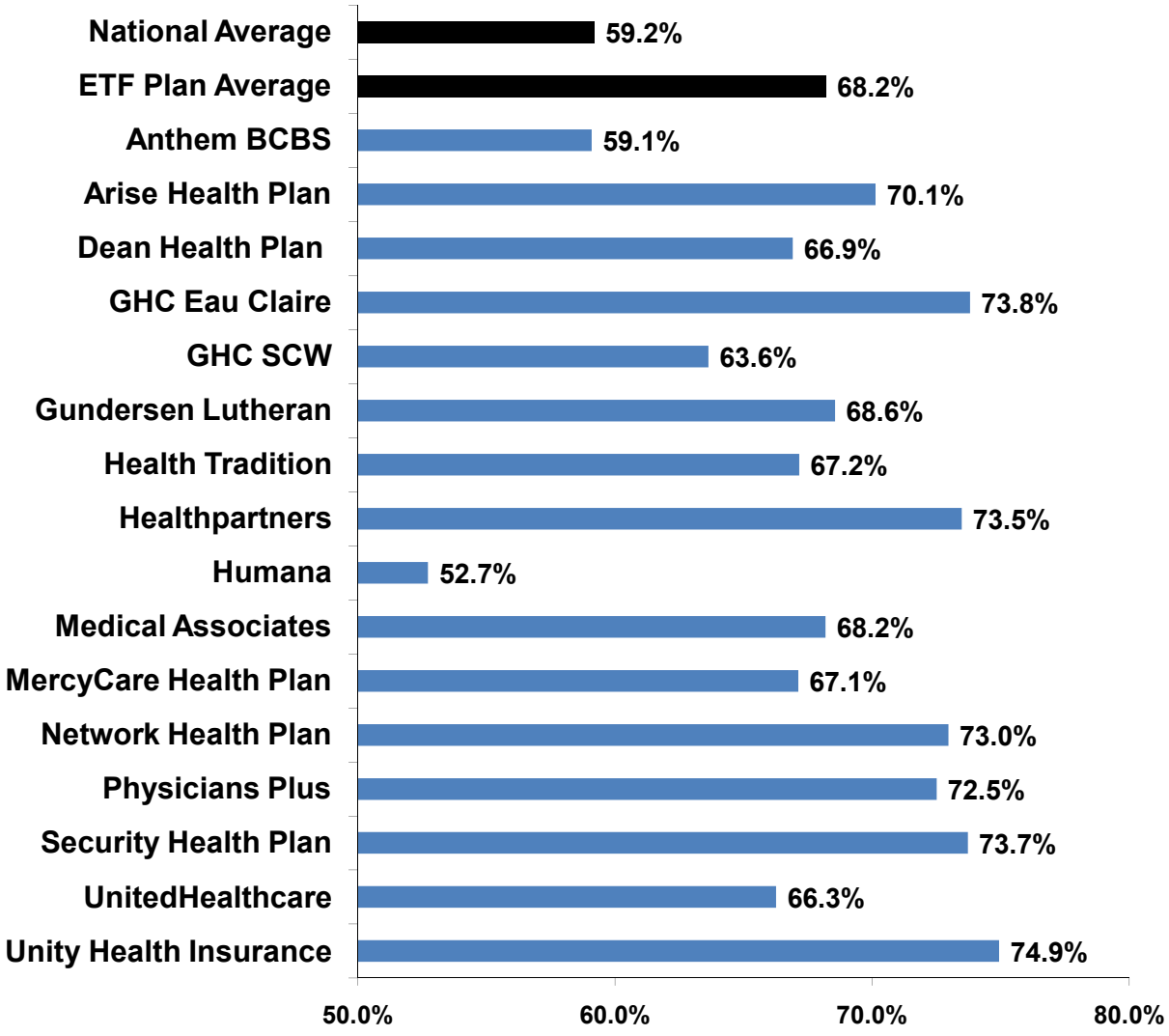
Question 18: What percentage of members ages 18 to 75 with cardiovascular conditions within the prior year had their LDL-C (cholesterol) have a documented LDL-C (cholesterol) level <100 mg/dL?

Cholesterol Management for Patients With Cardiovascular Conditions: LDL-C Level <100 mg/dL



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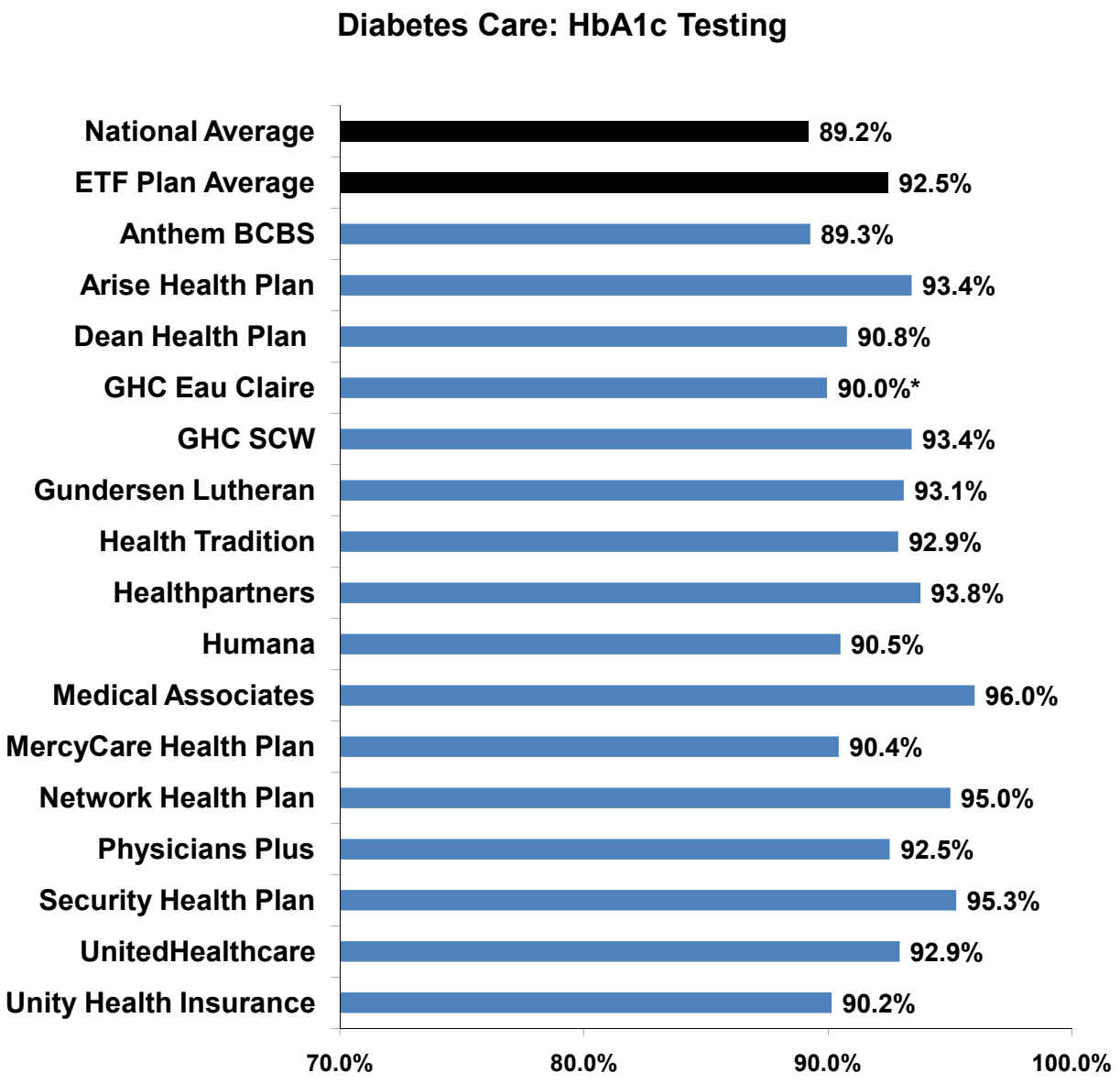
Question 19: What percentage of members ages 18 to 75 with either type 1 or type 2 diabetes had a Hemoglobin A1c (HbA1c) test?



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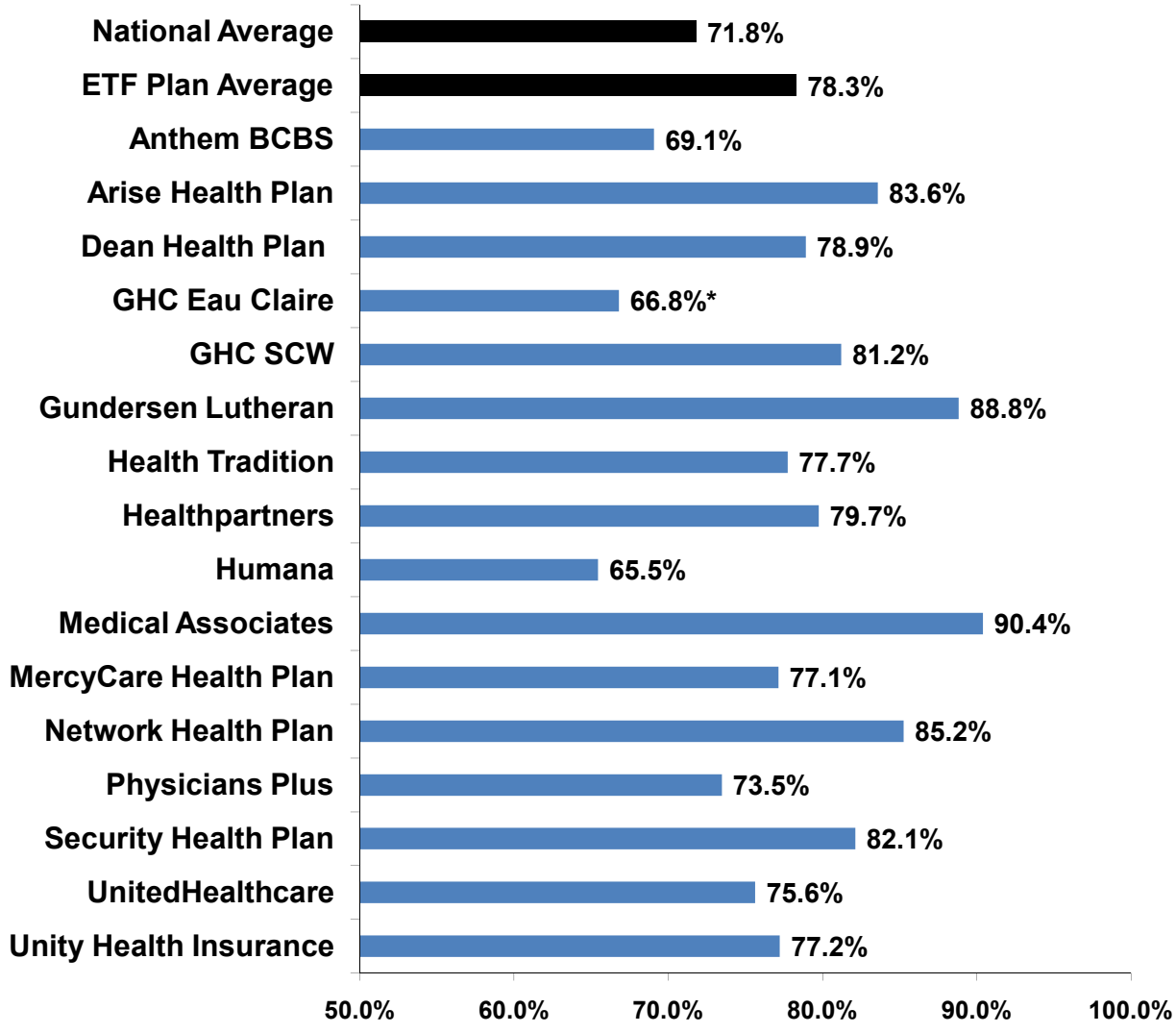
Question 20: What percentage of members ages 18 to 75 with either type 1 or type 2 diabetes had a Hemoglobin A1c (HbA1c) level that was **not** poorly controlled (<9.0%)?

Diabetes Care: NOT Poor HbA1c Control <9.0%



*Data discrepancies were identified when reporting this measure.

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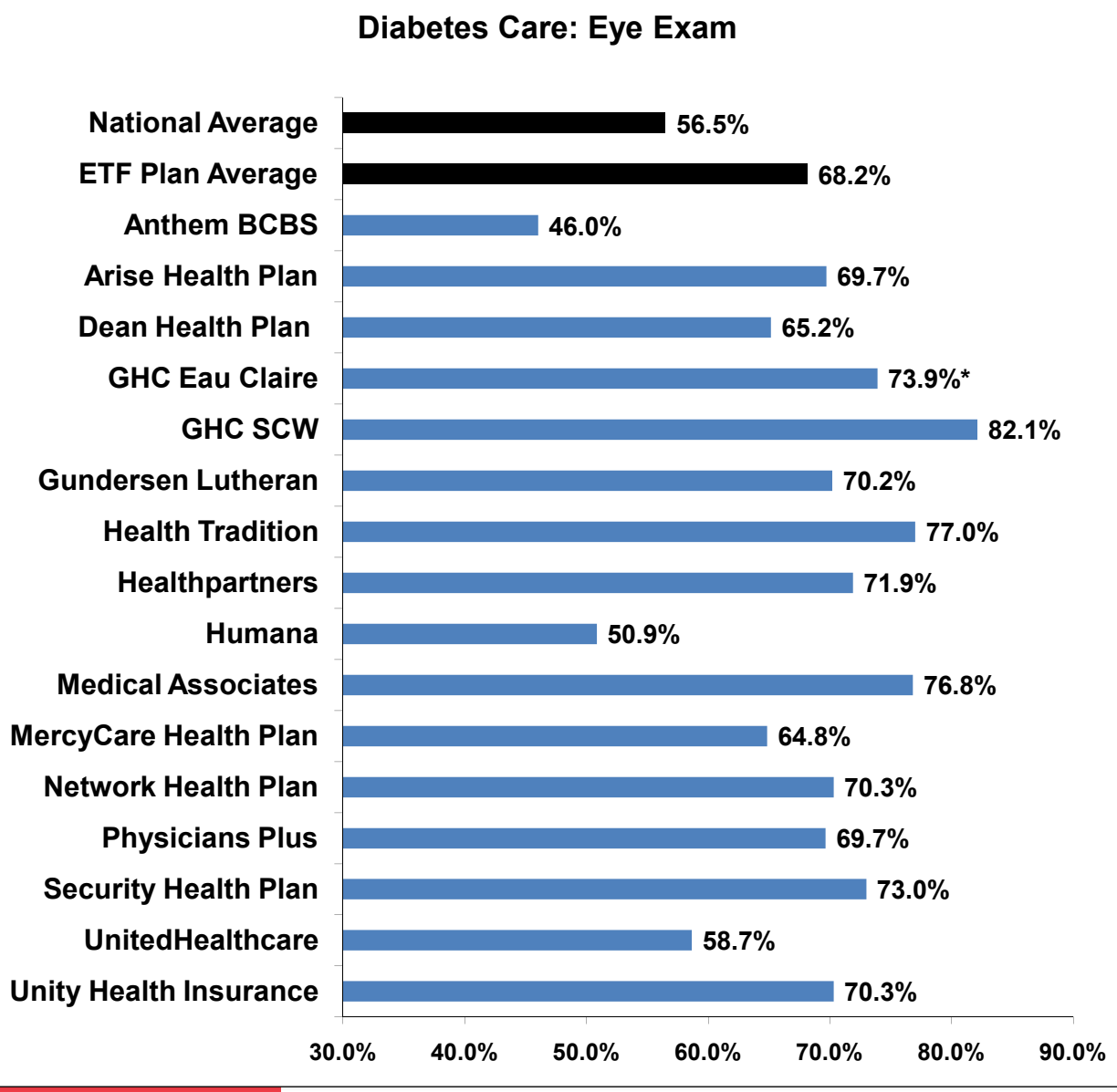
Question 21: What percentage of members ages 18 to 75 with either type 1 or type 2 diabetes had an eye example performed?



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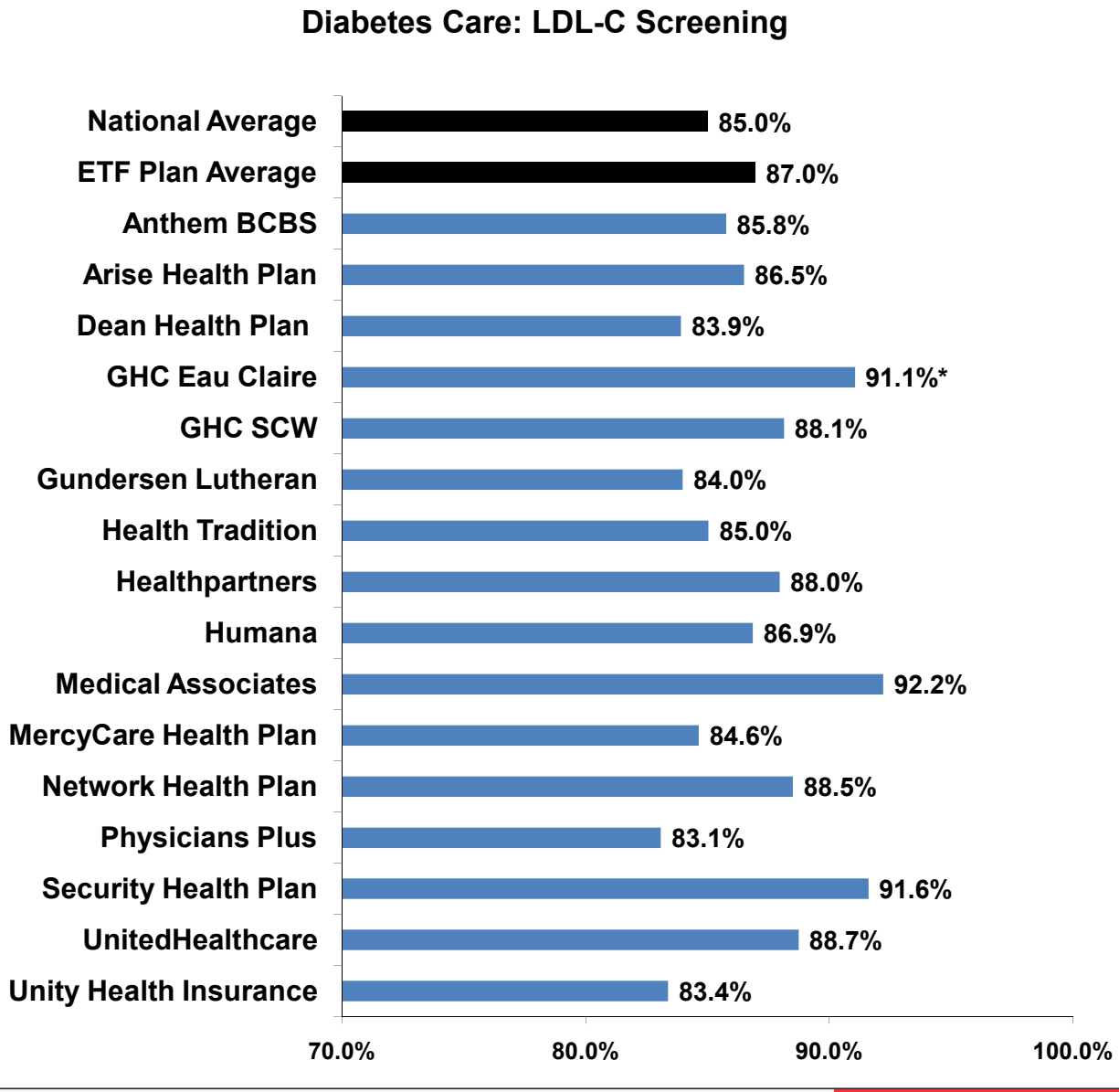
Question 22: What percentage of members ages 18 to 75 with either type 1 or type 2 diabetes had a LDL-C screening?



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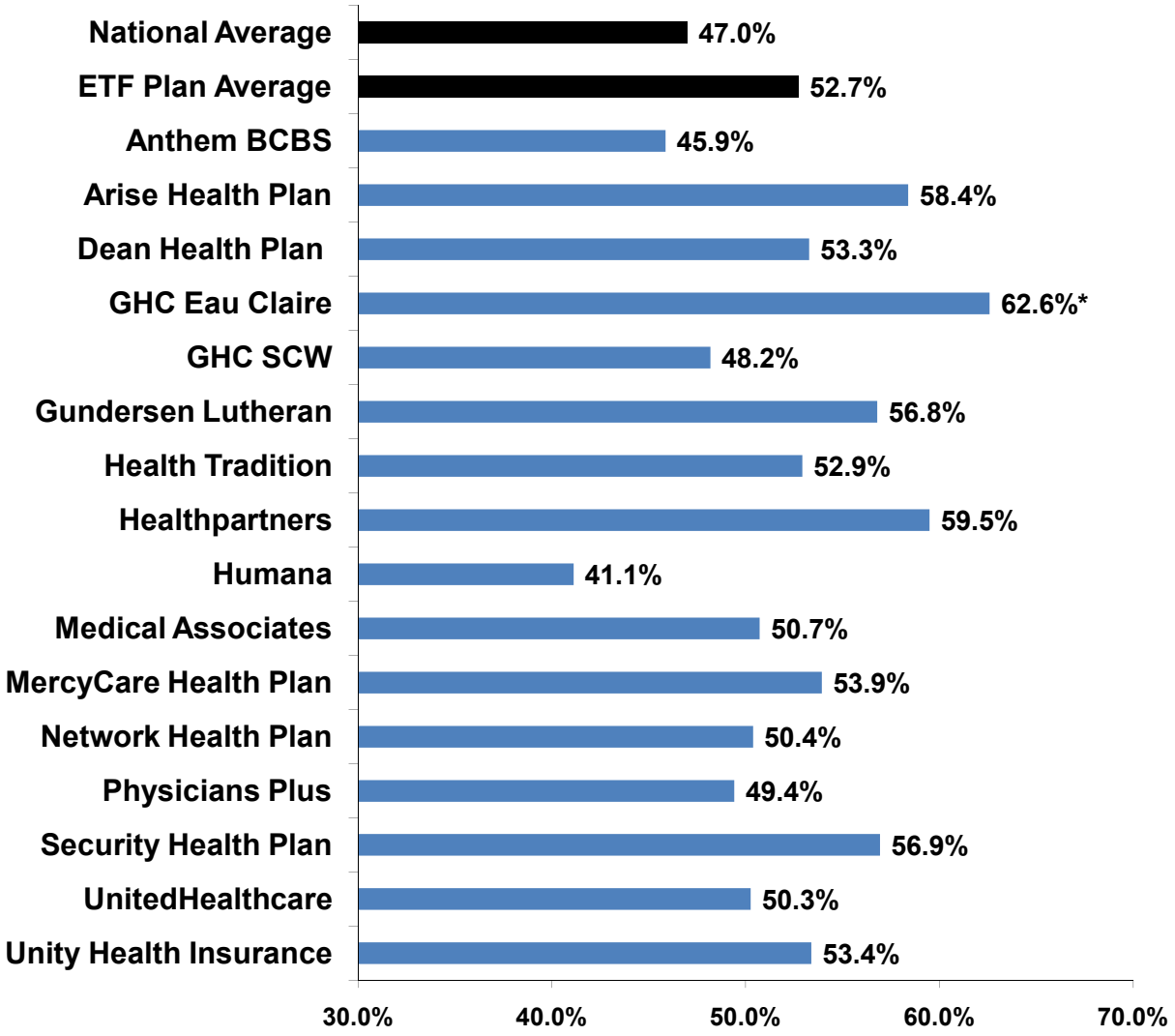
Question 23: What percentage of members ages 18 to 75 with either type 1 or type 2 diabetes had their LDL-C levels under control (<100 mg/dL)?

Diabetes Care: LDL-C Level <100 mg/dL



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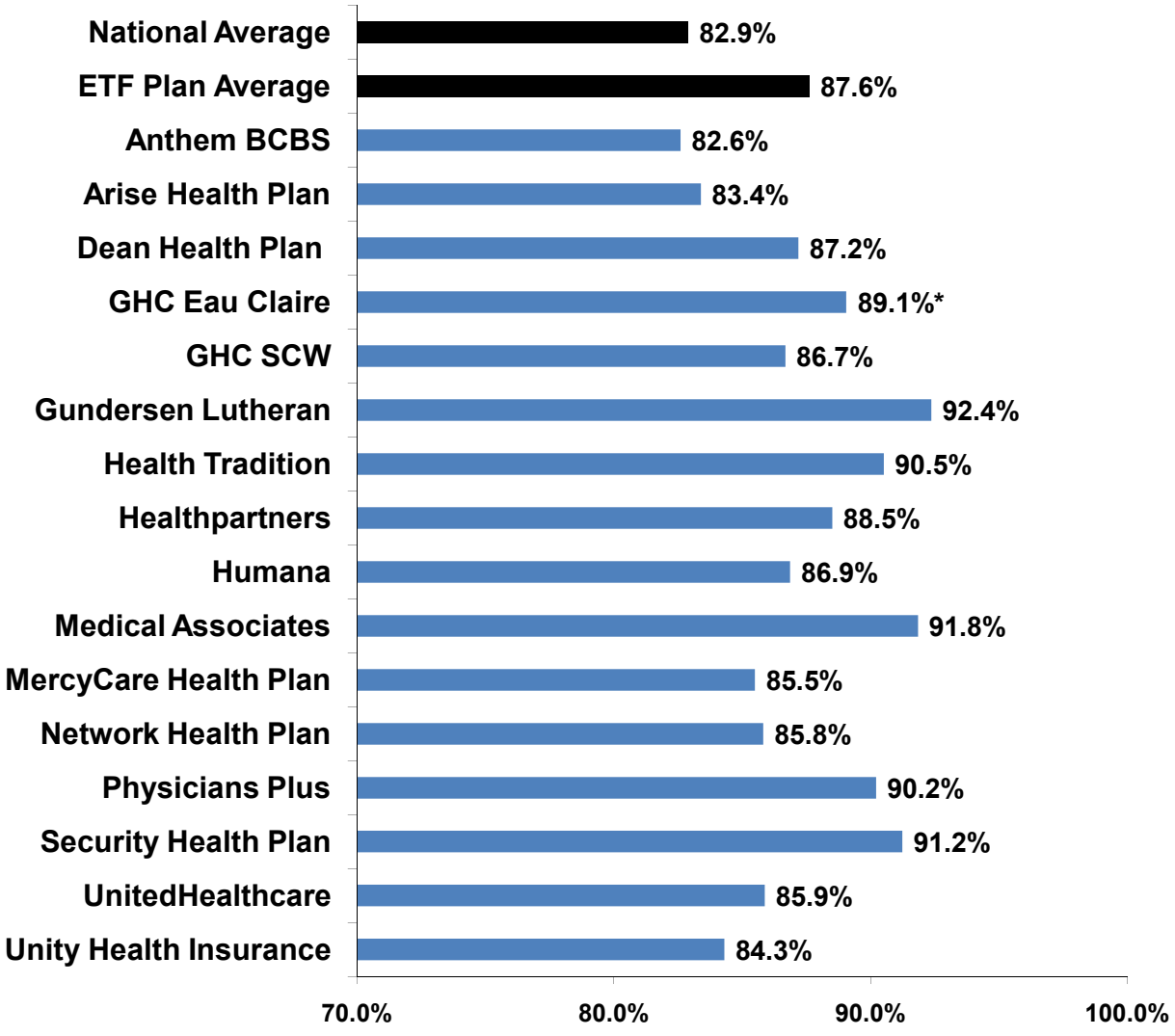
Question 24: What percentage of members ages 18 to 75 with either type 1 or type 2 diabetes received medical attention for kidney disease?

Diabetes Care: Medical Attention for Kidney Disease



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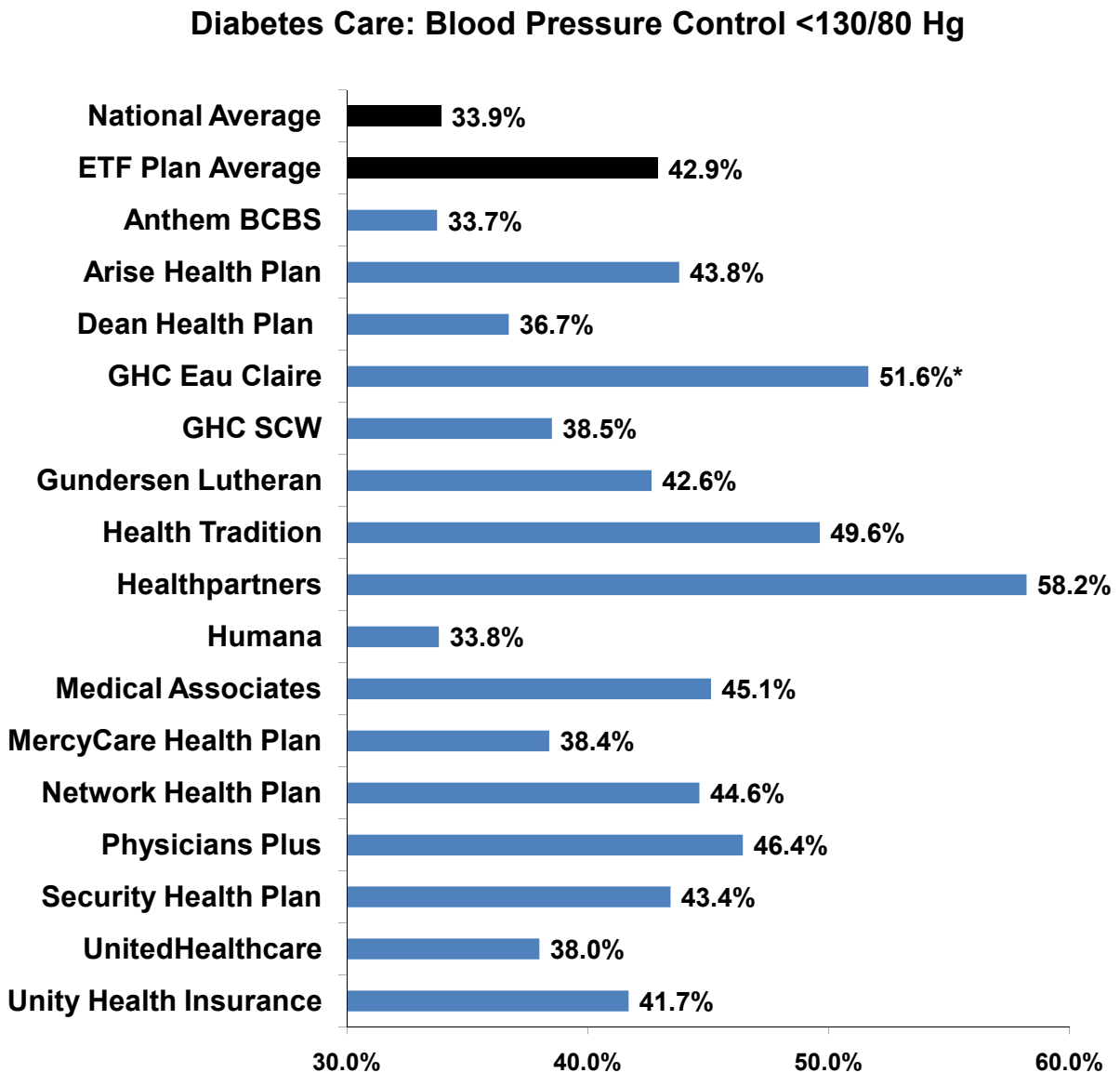
Question 25: What was the percentage of members ages 18 to 75 with either type 1 or type 2 diabetes whose blood pressure was controlled (<130/80)?



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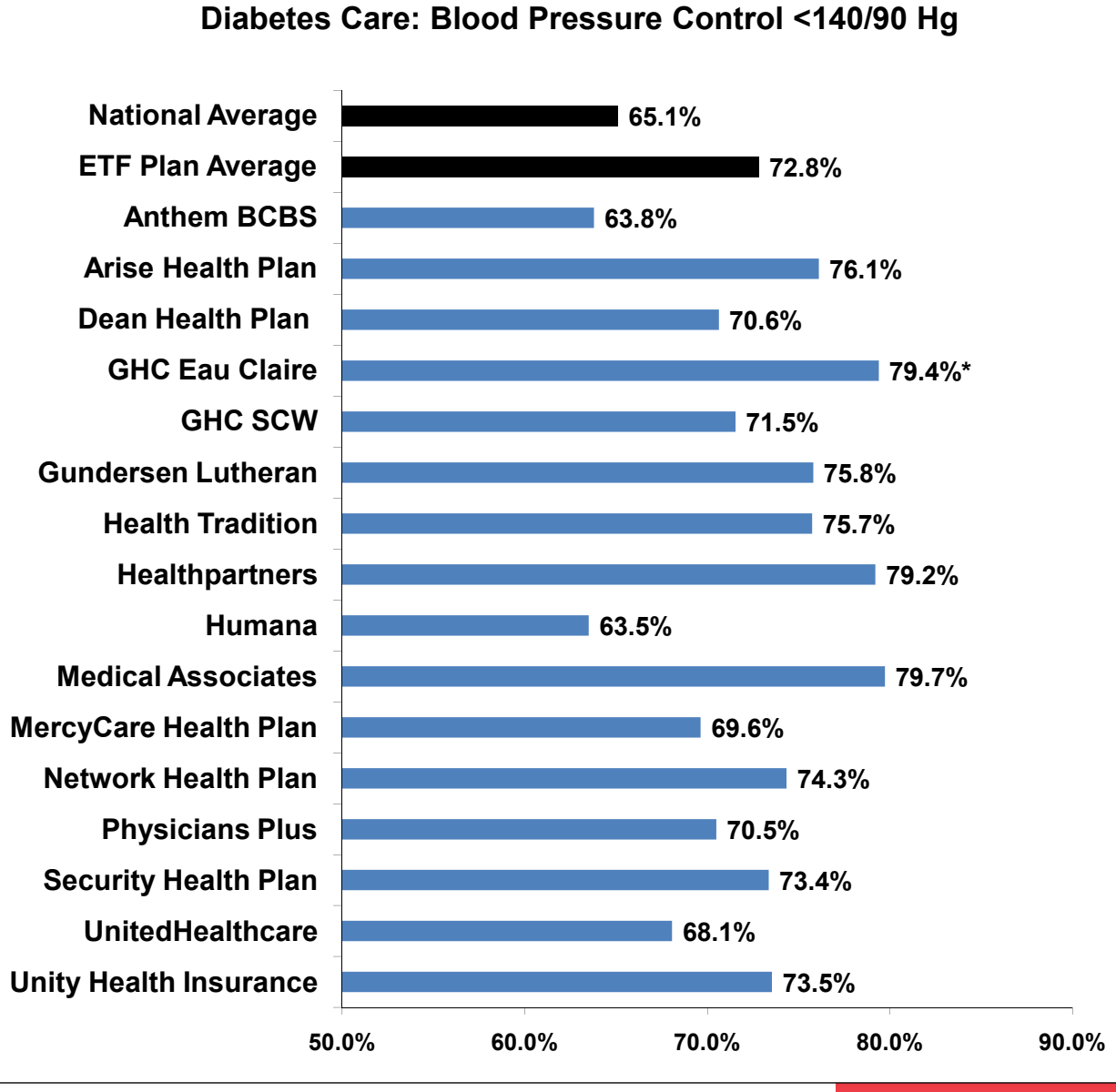
Question 26: What was the percentage of members ages 18 to 75 with either type 1 or type 2 diabetes whose blood pressure was controlled (<140/90)?



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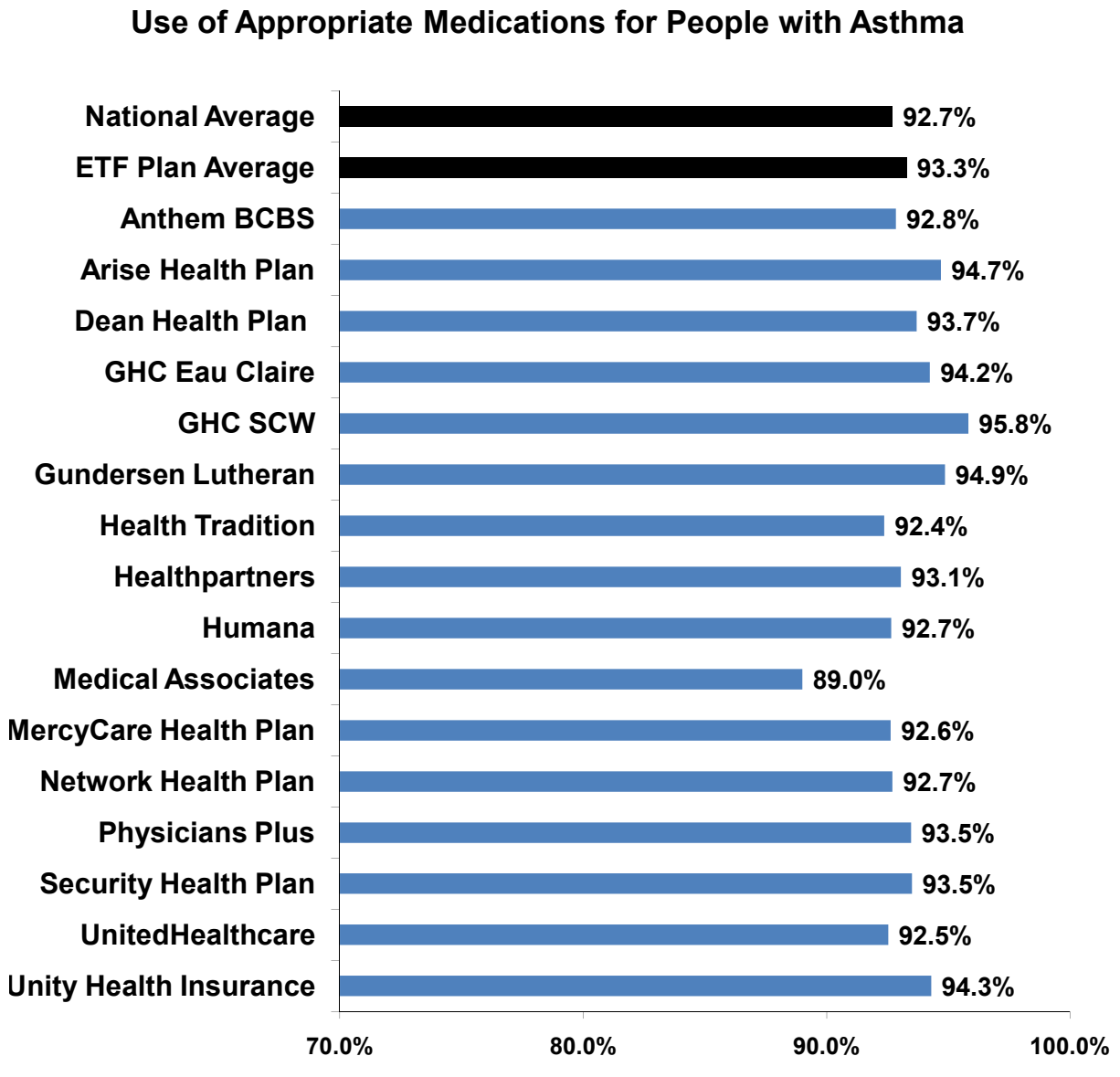
Question 27: What percentage of members age 5 to 56 who were identified as having persistent asthma, were appropriately prescribed medication?



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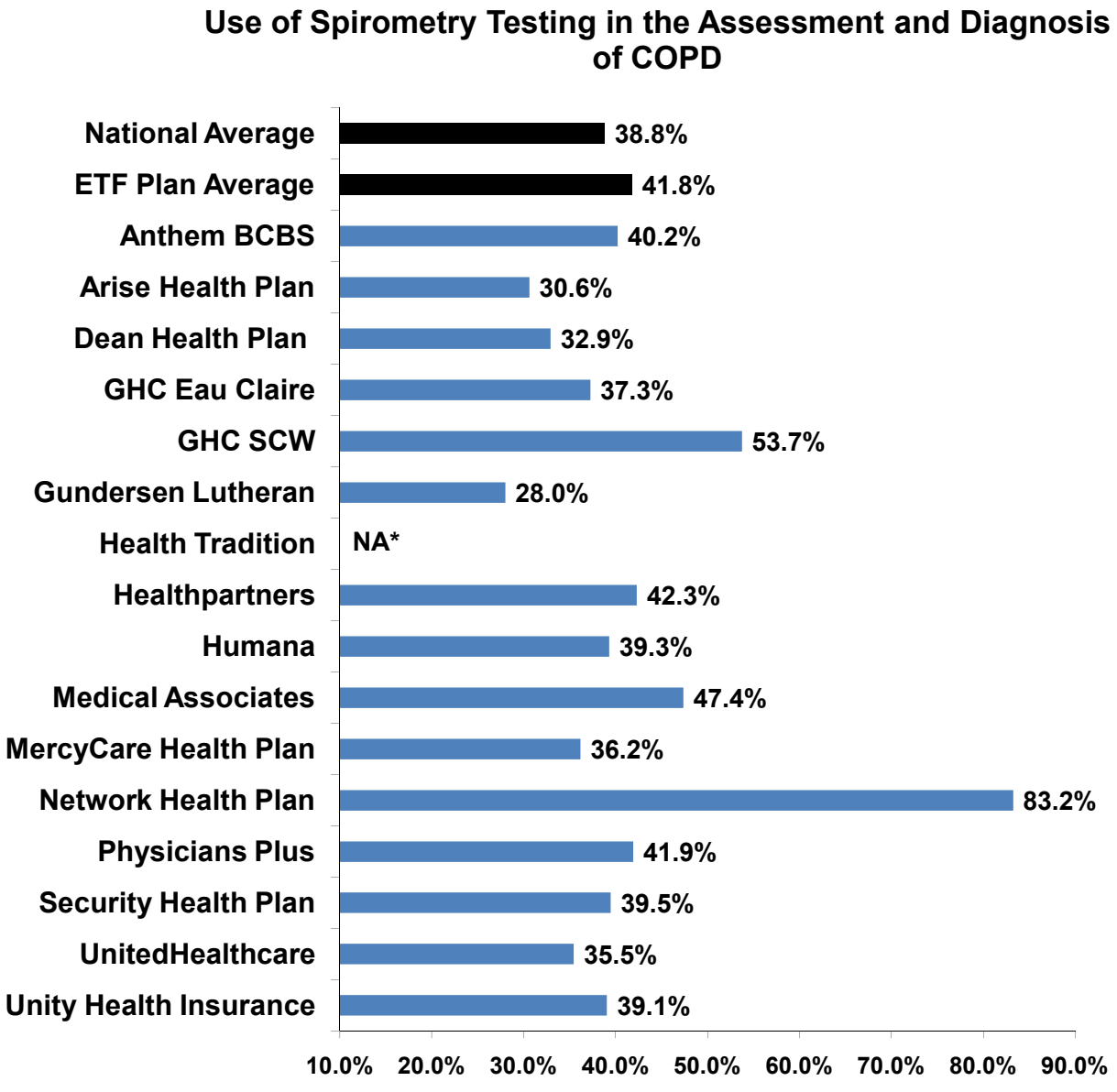
Question 28: What percentage of members age 40 and older with a new diagnosis or newly active chronic obstructive pulmonary disease (COPD) received appropriate spirometry testing to confirm the diagnosis?



*HEDIS score not reported because sample size was too small to be meaningful.

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Mental Health

The measures in question 29 and question 30 look at continuity of care for mental illness. It measures the percentage of organization members 6 years old and older who were hospitalized for selected mental disorders and were seen on an outpatient basis by a mental health provider within 7 days (question 29), or within 30 days (question 30) after their discharge from the hospital.

It is important to provide regular follow-up therapy to patients after they have been hospitalized for mental illness. An outpatient visit with a mental health practitioner after discharge

is recommended to make sure that the patient's transition to the home or work environment is supported and that gains made during hospitalization are not lost. It also helps health care providers detect early post-hospitalization reactions or medication problems and provide continuing care.

The measures in question 31 and question 32 look at:

- The percentage of members with major depression who were initiated on an antidepressant drug and received an adequate acute-phase trial of medications (three months) – question 31.
- The percentage of members with major depression who were initiated on an antidepressant drug and who completed a period of continuous medication treatment (six months) – question 32.

In a given year, an estimated 20.9 million American adults suffer from a depressive disorder or depression. Untreated, symptoms associated with these disorders can last for years, or eventually lead to death by suicide or other causes. Fortunately, many people can improve through treatment with appropriate medications.

Successful treatment of patients with major depressive disorder is promoted by a thorough assessment of the patient and close adherence to treatment plans. Treatment consists of an acute phase, during which remission is induced; a continuation phase, during which remission is preserved; and a maintenance phase, during which the susceptible patient is protected against the recurrence of a subsequent major depressive episode.

When pharmacotherapy is part of the treatment plan, it must be integrated with the psychiatric management and any other treatments that are being provided. Patients who have started taking an antidepressant medication should be carefully monitored to assess their response to pharmacotherapy, their safety as well as the emergence of any side effects and/or clinical condition. Factors to consider when determining the frequency of patient monitoring include the severity of illness, the patient's cooperation with treatment, the availability of social supports and the presence of simultaneously occurring but independent general medical problems. In practice, the frequency of monitoring during the acute phase of pharmacotherapy can vary from once a week in routine cases to multiple times per week in more complex cases.

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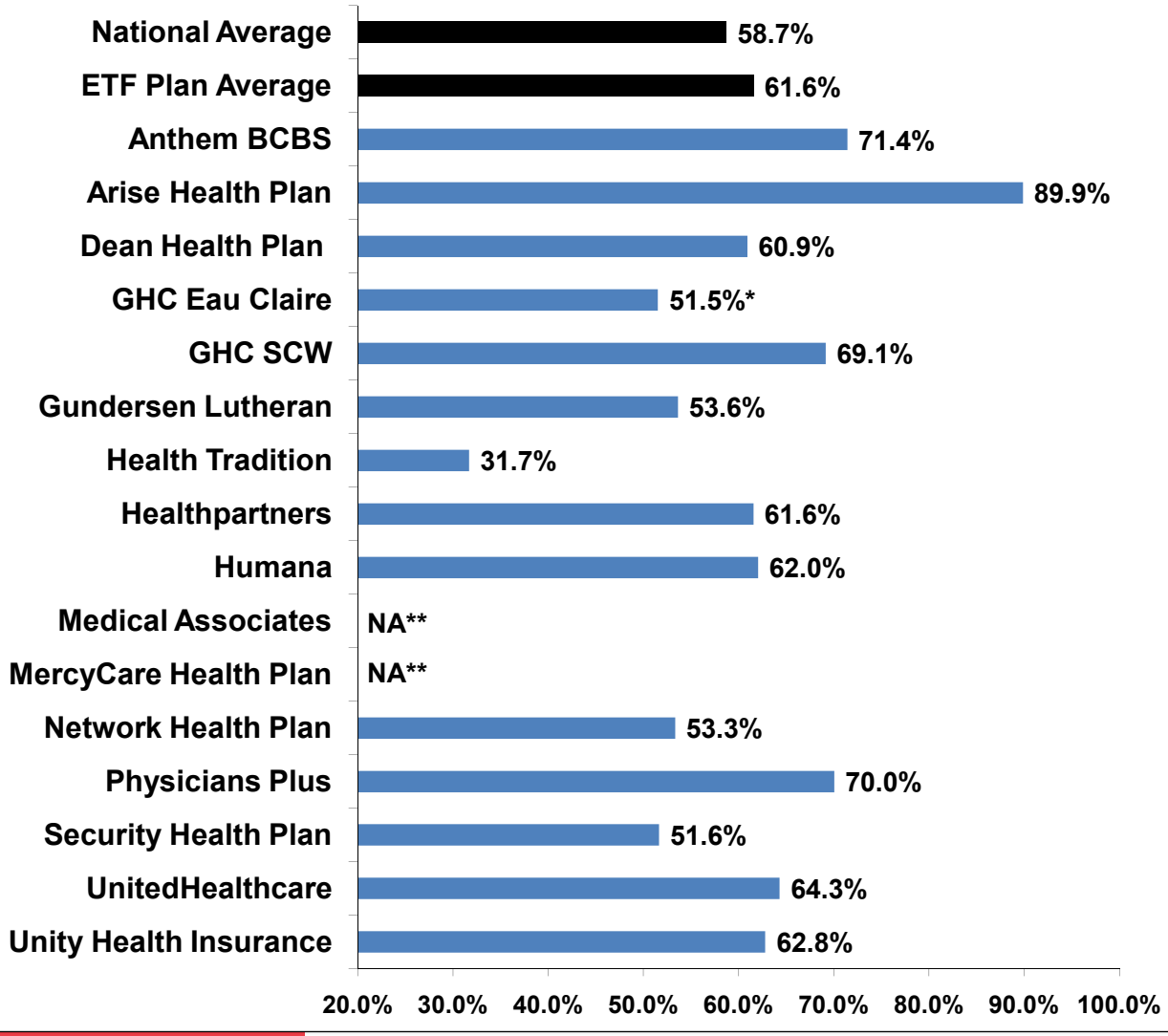
Question 29: What percentage of members age 6 years and older who were hospitalized for treatment of selected mental health disorders received follow-up care (an outpatient visit, an intensive outpatient encounter or partial hospitalization) with a mental health practitioner within 7 days of being discharged from the hospital?

7-Day Follow-Up After Hospitalization for Mental Illness



*HEDIS scores are not reported because sample size was too small to be meaningful.

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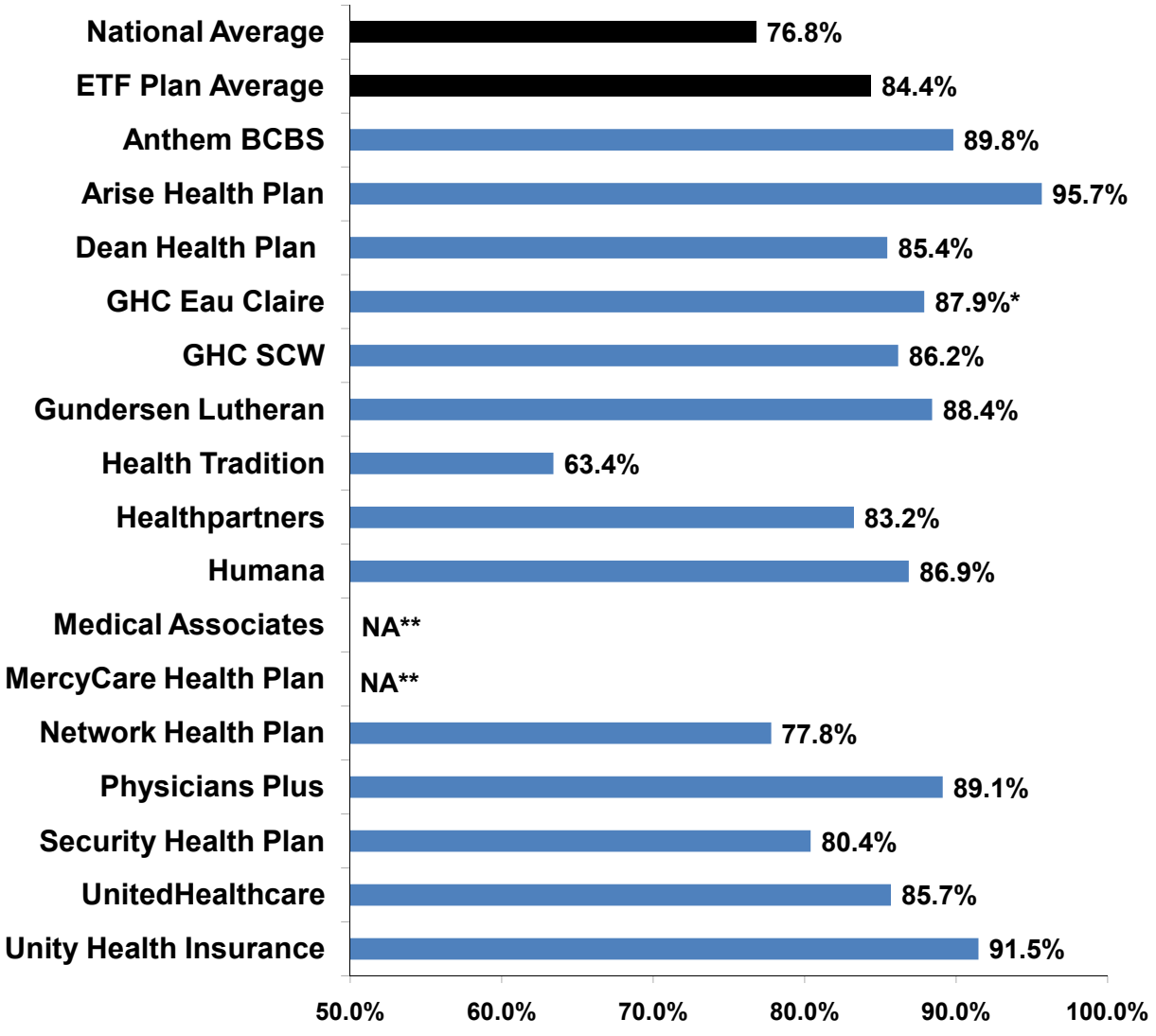
Question 30: What percentage of members age 6 years and older who were hospitalized for treatment of selected mental health disorders received follow-up care (an outpatient visit, an intensive outpatient encounter or partial hospitalization) with a mental health practitioner within 30 days of being discharged from the hospital?

30-Day Follow-Up After Hospitalization for Mental Illness



*HEDIS scores are not reported because sample size was too small to be meaningful.

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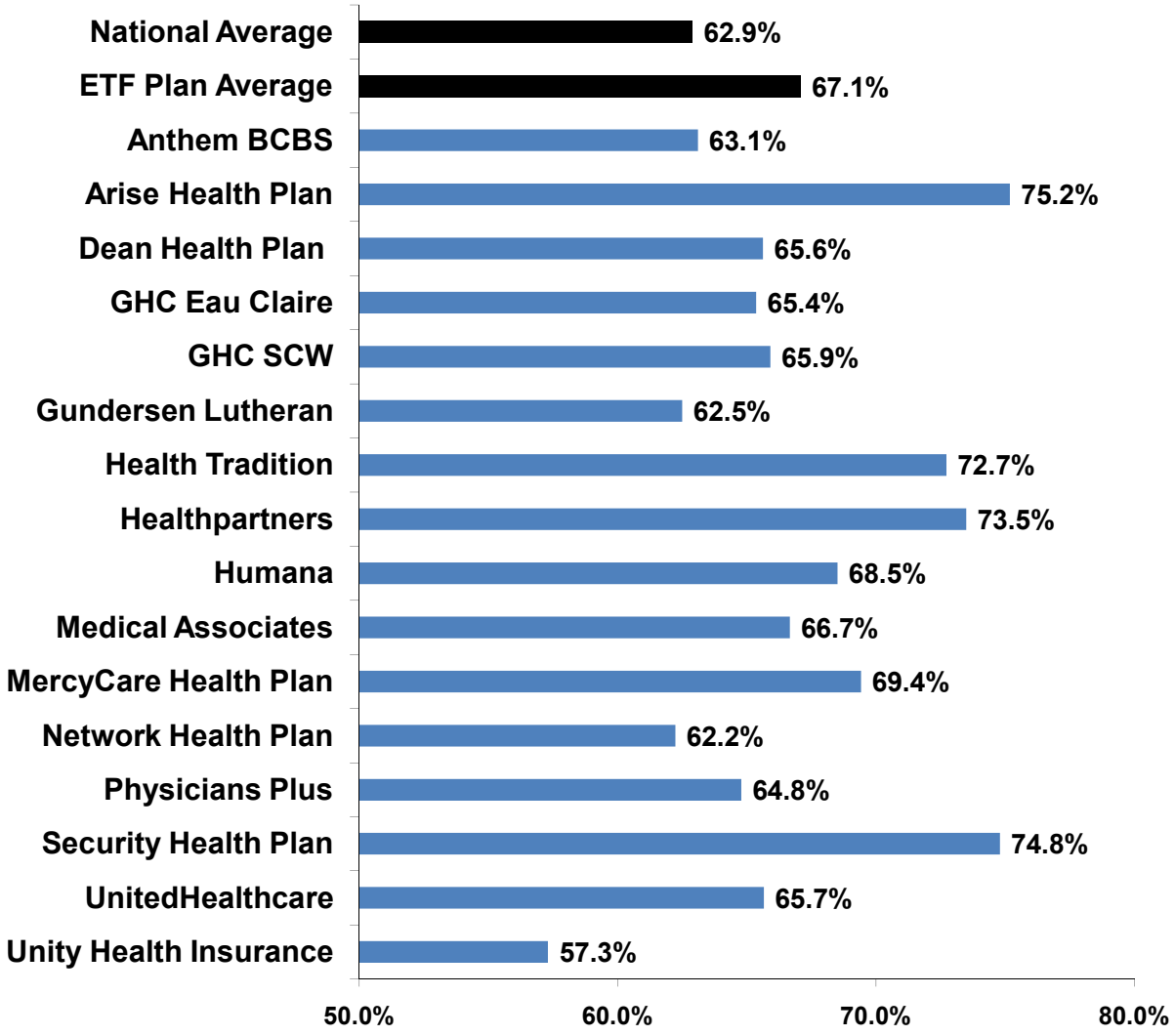
Question 31: What percentage of members age 18 and older who were diagnosed with a new episode of major depression, treated with antidepressant medication, remained on an antidepressant medication for at least 12 weeks?

Antidepressant Medication Management: Effective Acute Phase Treatment



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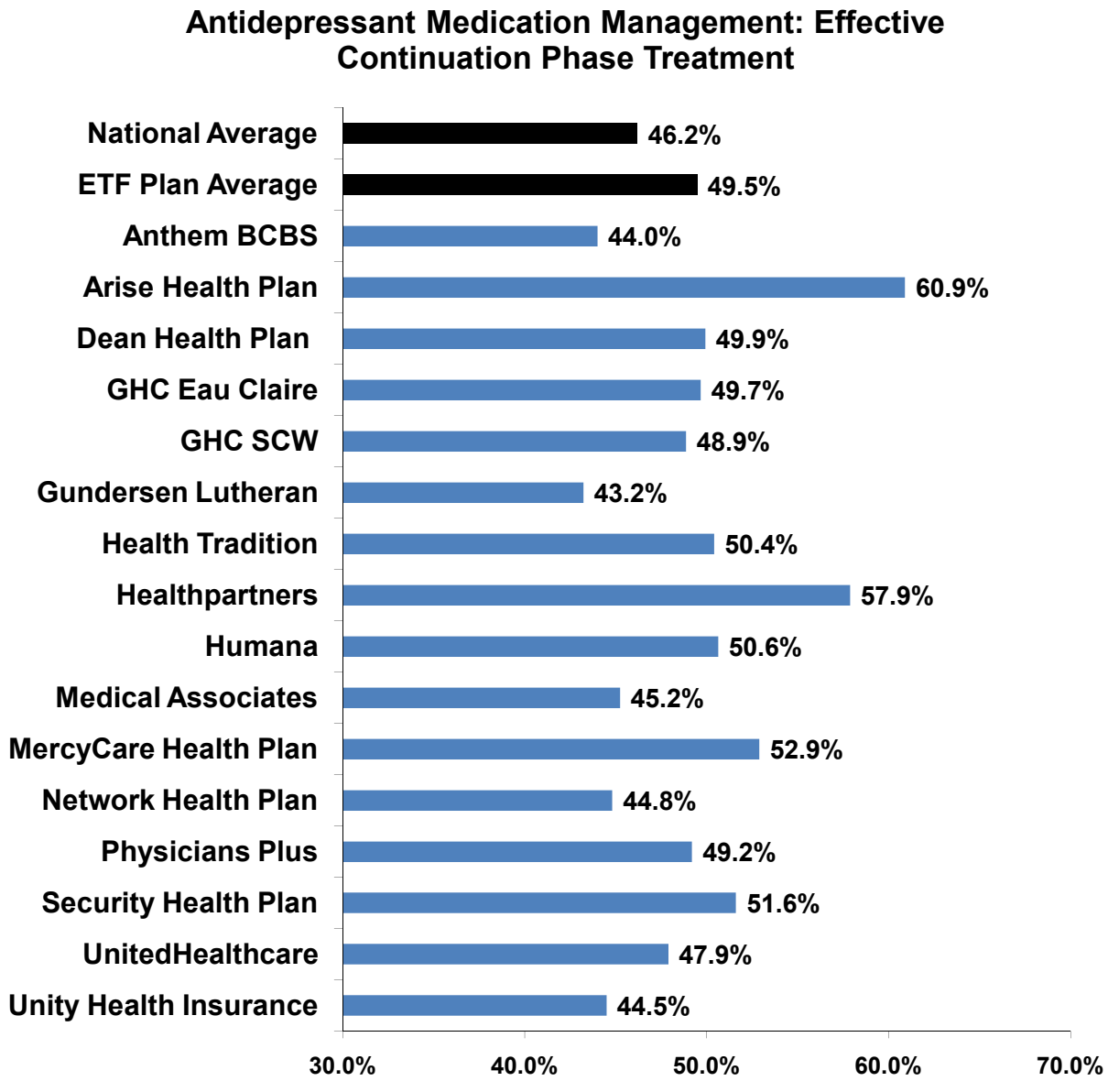
Question 32: What percentage of members age 18 and older who were diagnosed with a new episode of major depression, treated with antidepressant medication, remained on an antidepressant medication for at least six months?



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Medication Management

The measure in question 33 looks at the percentage of members 18 years old and older on persistent medications who received annual monitoring for the drugs of interest, reported as a combined rate and five separate rates.

Patient safety is highly important, especially for patients at increased risk of adverse drug events from long-term medication use. Persistent use of these drugs warrants monitoring and follow-up by the prescribing physician to assess for side-effects and adjust drug dosage/therapeutic decisions accordingly. The drugs included in this measure have harmful effects in the elderly.

The costs of annual monitoring are offset by the reduction in health care costs associated with complications arising from lack of monitoring and follow-up of patients on long-term medications. The total costs of drug-related problems due to misuse of drugs in the ambulatory setting has been estimated to exceed $76 billion annually.

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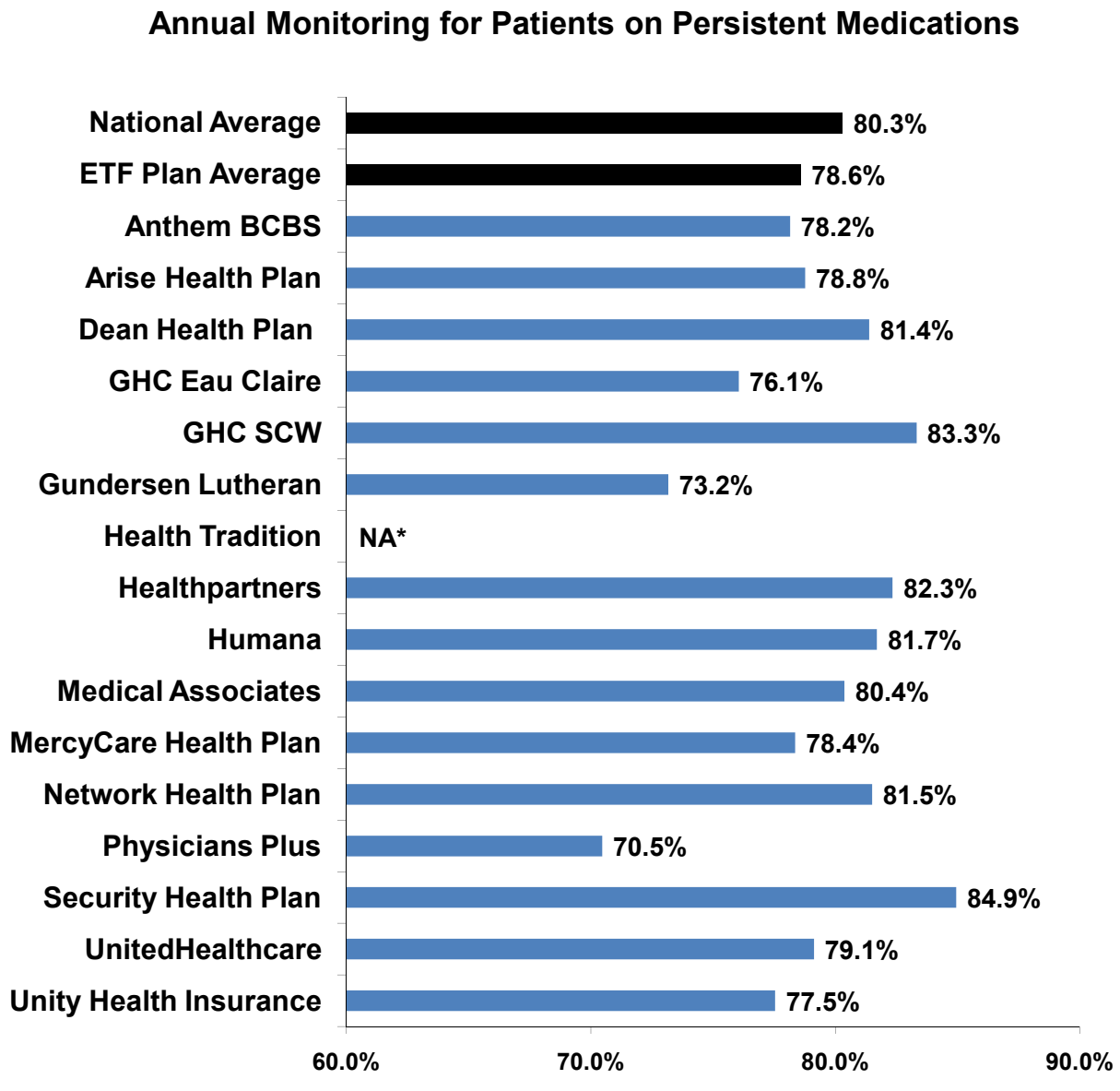
Question 33: What percentage of members age 18 years old and older who received at least a 180-days supply of medications of interest (angiotensin converting enzyme inhibitors or angiotensin receptor blockers; digoxin; diuretics; and anticonvulsants) received an annual monitoring?



*Data discrepancies were identified when reporting this measure.

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ACCESS/AVAILABILITY OF CARE

The measures in questions 34 through 38 look at how members access basic and important services offered by their organization. Access refers to members' ability to get the services they require from a health care system.

Prenatal and Postnatal Care

The measure in question 34 looks at how well the organization provides timely prenatal care to pregnant women. It measures the percentage of pregnant women in the organization who began prenatal care during the first 13 weeks of pregnancy, or within 42 days of enrollment, for women who were more than 13 weeks pregnant when they enrolled. Care can be delivered by a variety of appropriate obstetrical, primary care or nurse-midwife practitioners.

Preventive medicine is fundamental to prenatal care. Healthy diet, counseling, vitamin supplements, identification of maternal risk factors and health promotion must occur early in pregnancy to have an optimal effect on outcome. Poor outcomes include spontaneous abortion, low-birth-weight babies, large-for-gestational-age babies and neonatal infection. Early prenatal care is also an essential part of helping a pregnant woman prepare to become a mother. Ideally, a pregnant woman will have her first prenatal visit during the first trimester of pregnancy. Some women enroll in an organization at a later stage of pregnancy. In this case, it is essential for the organization to begin providing prenatal care as quickly as possible.

The measure in question 35 looks at care rendered to women after they have delivered a baby. It measures the percentage of women who had live births and a postpartum visit between 21 and 56 days after delivery.

Well-child (15 months)

The measure in question 36 looks at the adequacy of well-child care for infants. It measures the percentage of children who had six or more well-child visits by the time they turned 15 months old.

Regular check-ups are one of the best ways to detect physical, developmental, behavioral and emotional problems. They also provide an opportunity for the clinician to offer guidance and counseling to the parents.

These visits are of particular importance during the first year of life, when an infant undergoes substantial changes in abilities, physical growth, motor skills, hand-eye coordination, and social

and emotional growth. The AAP recommends six well-child visits in the first year of life: the first within the first month of life, and then at around 2, 4, 6, 9 and 12 months of age.

Well-child (six years)

The measure in question 37 looks at the use of routine check-ups by preschool and early school-age children. It assesses the percentage of children 3 to 6 years of age who received at least one well-child visit with a primary care practitioner during the measurement year.

Well-child visits during the preschool and early school years are particularly important. A child can be helped through early detection of vision, speech and language problems. Intervention can improve communication skills and avoid or reduce language and learning problems. The American Academy of Pediatrics (AAP) recommends annual well-child visits for 2 to 6 year old children.

Well-adolescent (12-21 years)

The measure in question 38 looks at the use of regular check-ups for adolescents. It reports the percentage of adolescents 12–21 years of age who had one or more well-care visits with a primary care provider or OB/GYN during the measurement year. Adolescents benefit from an annual preventive health care visit that addresses the physical, emotional and social aspects of their health.

Adolescence is a time of transition between childhood and adult life and is accompanied by dramatic changes. Accidents, homicide and suicide are the leading causes of adolescent deaths. Sexually transmitted diseases, substance abuse, pregnancy and antisocial behavior are important causes of—or result from—physical, emotional and social adolescent problems. The AAP guidelines recommend comprehensive annual check-ups for adolescents.

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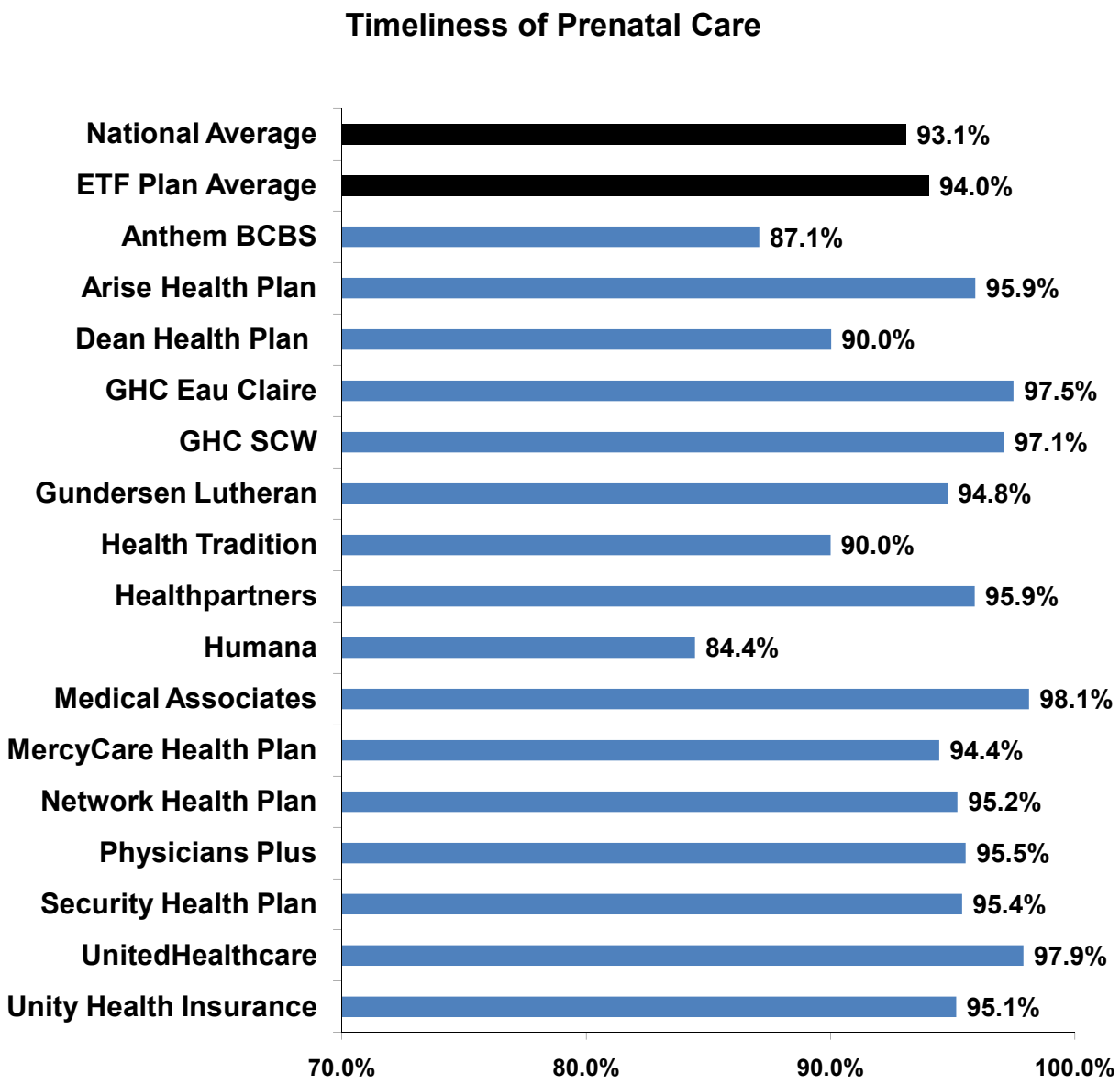
Question 34: What percentage of pregnant women began prenatal care during the first 13 weeks of pregnancy or within 42 days of enrollment, if more than 13 weeks pregnant when enrolled?



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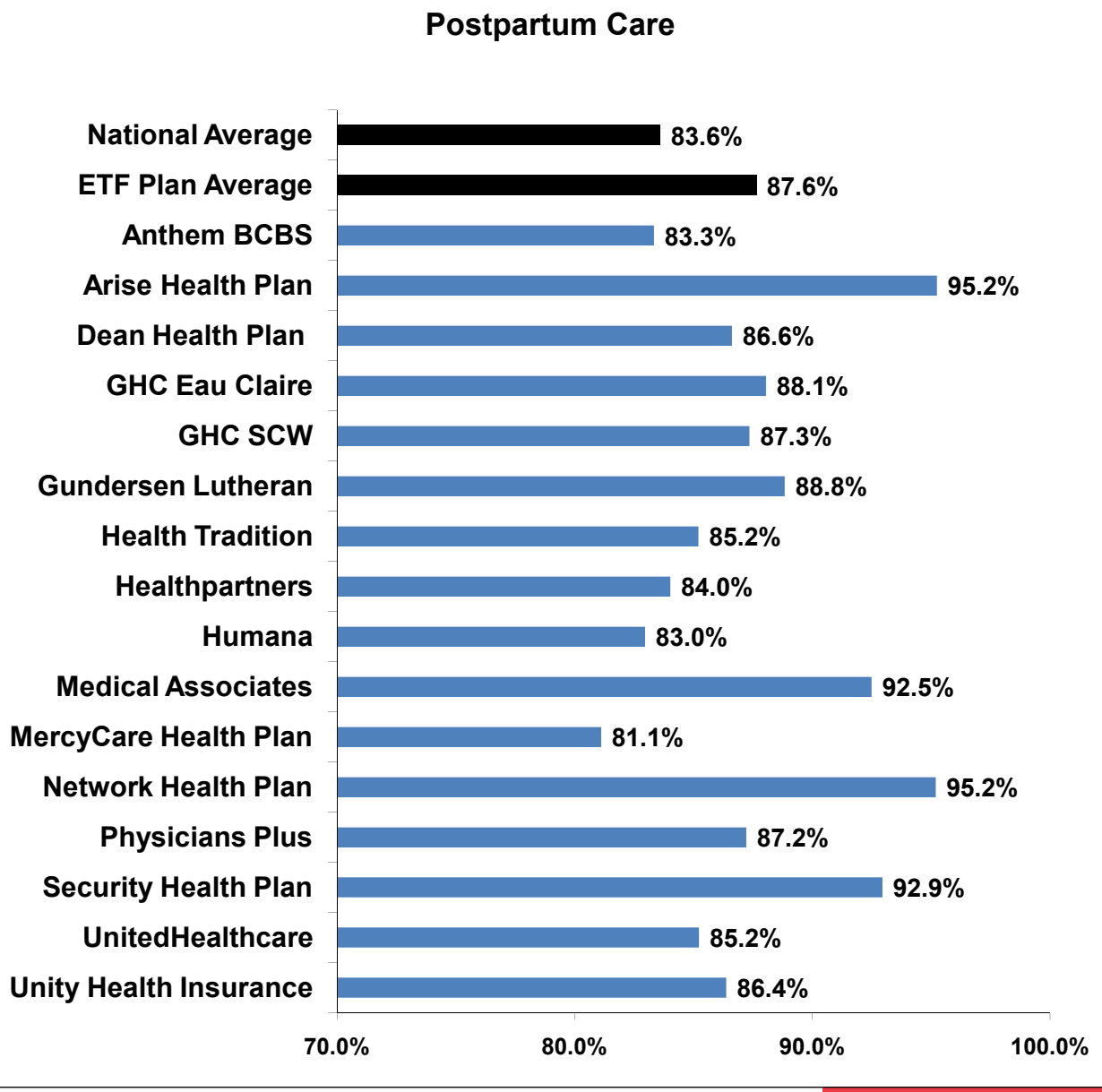
Question 35: What percentage of women who had live births, have a postpartum visit between 21 and 56 days after delivery?



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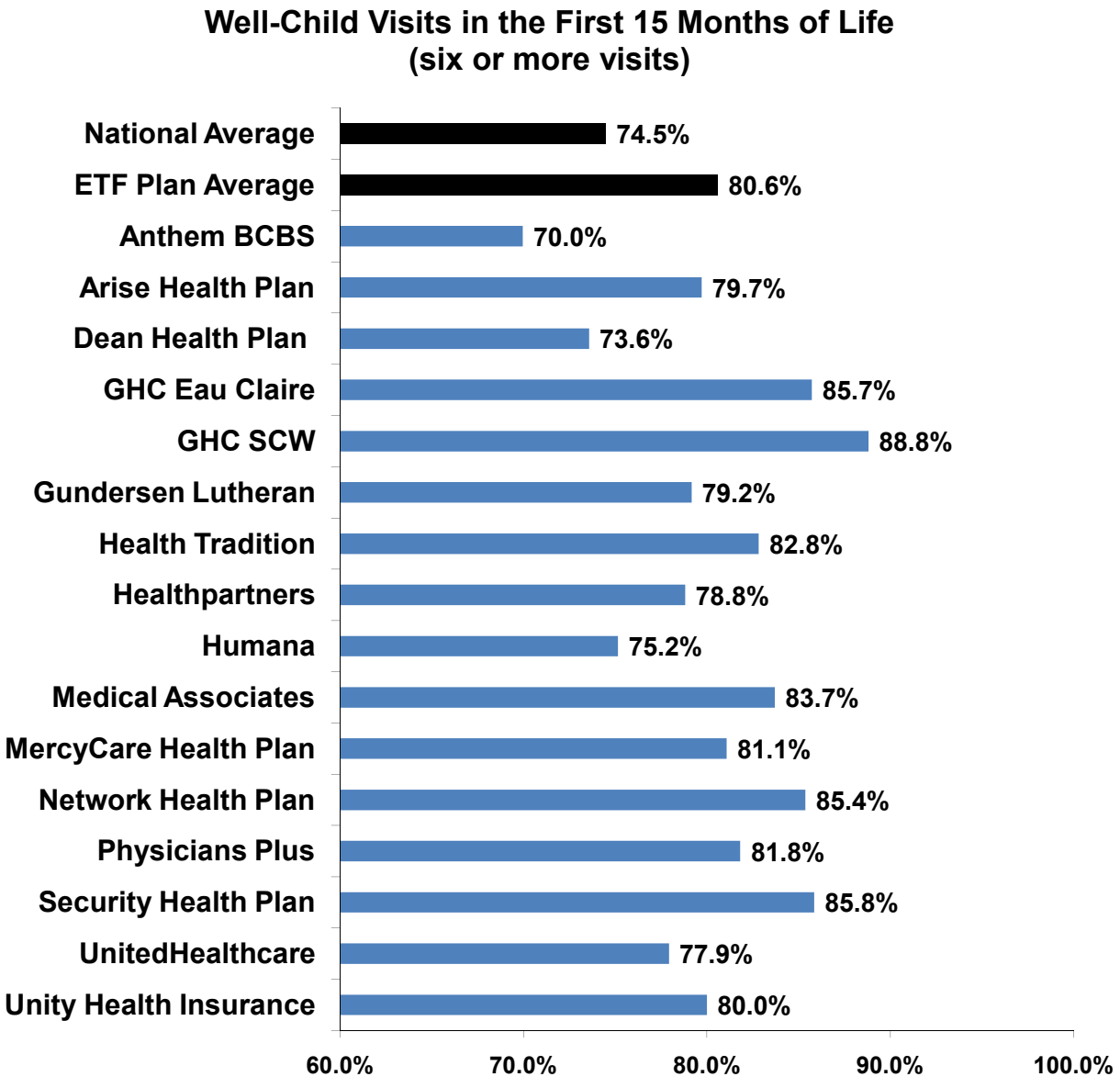
Question 36: What percentage of children had six or more well-child visits during their first 15 months of life?



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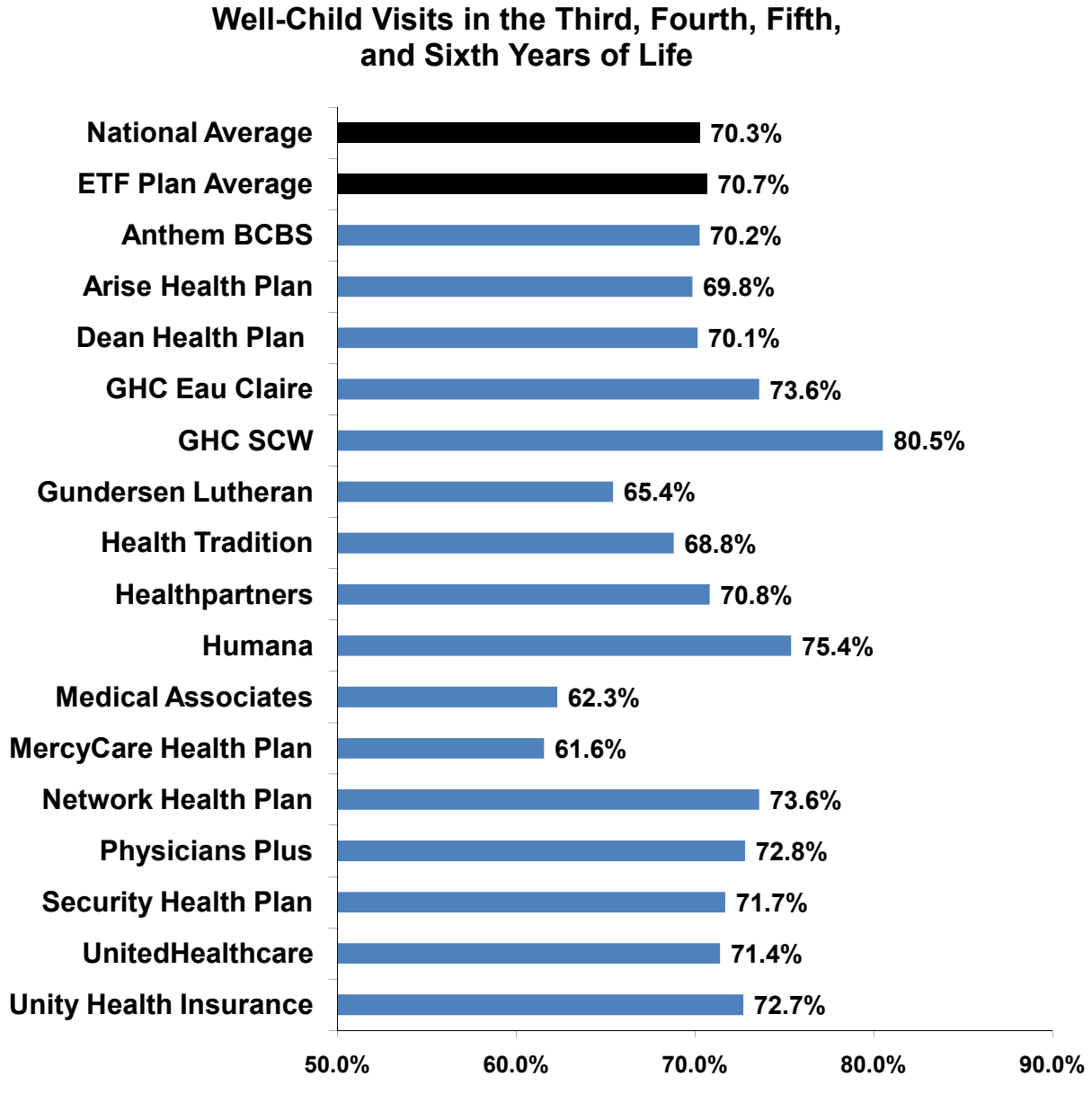
Question 37: What percentage of children ages 3 to 6 received at least one well-child visit with a primary care practitioner during the past year?



LINKS

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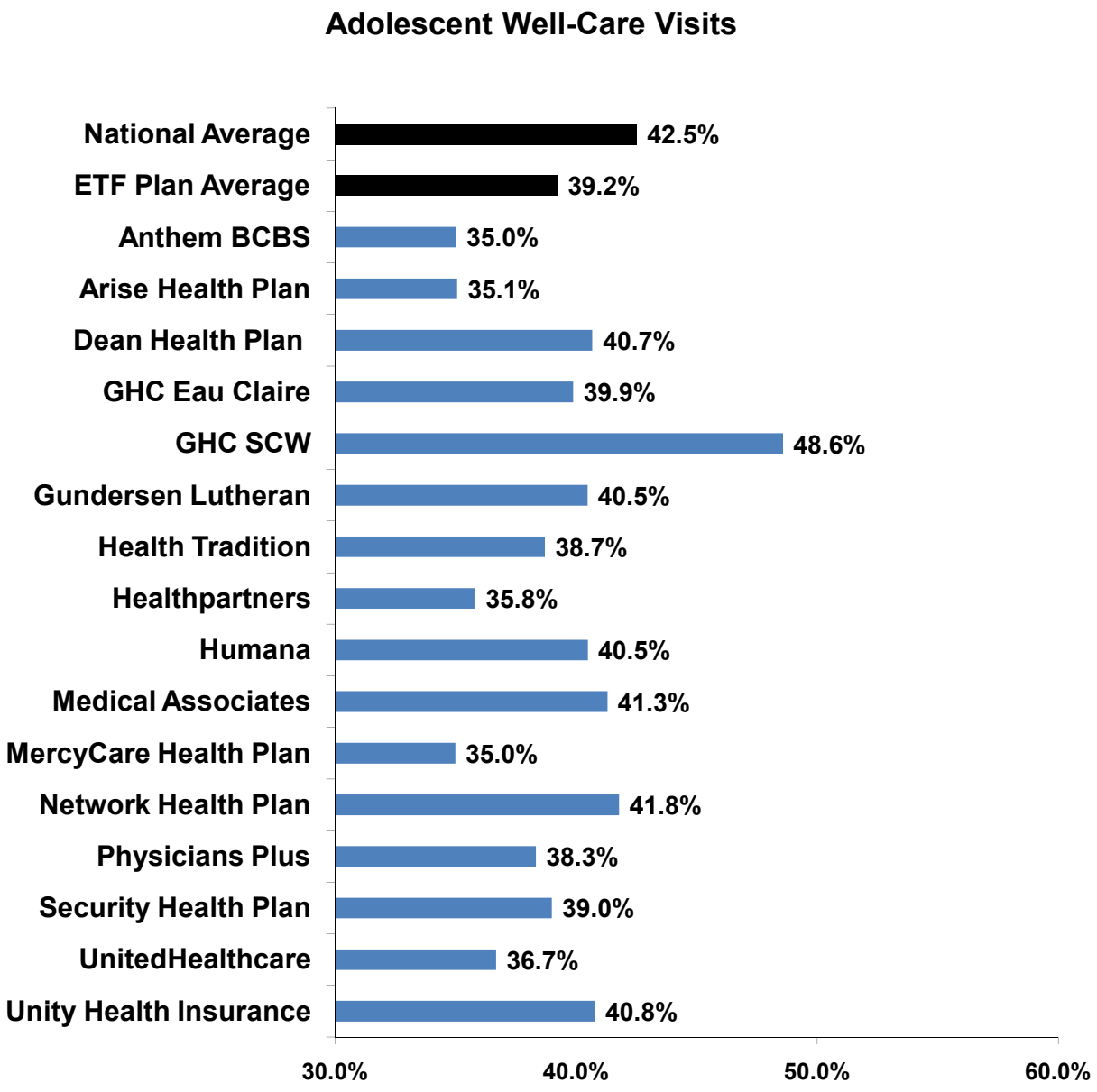
Supplemental Report Card 2

Question 38: What percentage of adolescents ages 12 to 21 had at least one well-care visit with a primary care practitioner during the past year?



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