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**PROGRESS  
REPORT CARD**

PUPIL \_\_\_\_\_  
TERM \_\_\_\_\_  
SCHOOL \_\_\_\_\_ GRADE \_\_\_\_\_  
TEACHER \_\_\_\_\_  
PRINCIPAL \_\_\_\_\_

# Mapping the Patient Experience

## Humana Military's Clinical Quality Report Card

HUMANA MILITARY  
HEALTHCARE SERVICES



2007



### Serving the Military Population for 11 Years – and Counting!

Humana Military Healthcare Services, Inc. (HMHS) was founded in 1993 to focus on military health care initiatives. It is a wholly-owned subsidiary of Humana Inc., one of the largest and most innovative health insurance companies in the country.

HMHS has provided health care services to TRICARE beneficiaries since 1996. Humana Military's mission is to work collaboratively with our Government partners in the delivery of high quality, cost effective, accessible health care services to the military populations we serve. Over the years, HMHS has been honored again and again for performance excellence in a host of different areas, from the quality of health care services delivered in collaboration with the Department of Defense to communication with its beneficiaries.

In 2004, HMHS implemented the second generation of the TRICARE program for approximately 2.7 million beneficiaries in the South Region (Arkansas, Alabama, Florida, Georgia, Louisiana, Mississippi, Oklahoma, South Carolina, Tennessee and Texas – except for the El Paso area).

HMHS is committed to building on its reputation of excellence. By working collaboratively with military and civilian health care professionals, developing innovative health care solutions, and providing superb customer service, we will administer military health care solutions in the true spirit of partnership that working side by side with our government partners entails.

*“I just spoke to a beneficiary who stated that ‘every time I call here I get 5 STAR service.’ He has nothing but praise for us and that is coming from a man of 37 years in the Military.”*

*-Comment from a  
HMHS Beneficiary  
Service  
Representative*



### Why a Health Care Report Card?

In 1999, Congress mandated the Agency for Healthcare Research and Quality (AHRQ) to develop an annual “national quality report on health care delivery”. The Institute of Medicine (IOM) was asked to research and help develop a report that would look at health care quality in the long term, create a design that would allow for annual comparisons, include the continuum of health care settings, and allow for state and regional analysis <sup>(1)</sup>.

This IOM committee recommended the components of the report include two dimensions. The first dimension covers patient safety, effectiveness, patient centeredness and timeliness. The second dimension demonstrates the changing needs of the consumer over their life span and includes prevention, getting better, and living with illness <sup>(1)</sup>.

Using these concepts, HMHS developed this Report Card to objectively evaluate its effort to provide the highest quality care at the most reasonable value. We use health outcome measures that pertain to the TRICARE beneficiary population. The reporting period is calendar year 2006. We looked to respected sources for standard measurement methodologies, benchmarks and performance goals when appropriate and available.

Resources include:

- The National Committee for Quality Assurance (NCQA) State of Healthcare Quality Report, Quality Profiles, and Quality Compass
- The Mortality and Morbidity Weekly Report from the CDC
- Healthy People 2010
- The Institute for Healthcare Improvement
- AHRQ

*“The BSR gave me the best customer service. She was caring and professional. She took care of my need. I travel around the world and work one on one with a lot of big companies and HMHS by far has offered me the best customer service I have ever received.”*

*- Comment from a  
HMHS Beneficiary*

## WHY A HEALTH CARE REPORT CARD?

The measures selected are based upon aggregate, organization-wide data and are not physician specific (i.e., these are macro measurements). Seven measures span the two dimensions of health care quality identified by the IOM and the cost of care:

1. Prevention and Wellness
2. Mental Health
3. Living with Illness
4. Patient Safety & Select Procedures
5. Provider Network
6. Managing Costs
7. Customer Satisfaction

This is the second annual HMHS Report Card. As we gain insight from ensuing years, the Report Card continues to evolve. This year we include comparative data for preventive measures and quality indicators for specific diseases, interventions that were implemented and their impact, and new processes that we are monitoring.

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A healthcare professional, likely a nurse or doctor, is shown from the chest down. They are wearing blue scrubs and have a white stethoscope with red tubing around their neck. They are holding a single, bright green apple with both hands in front of their chest. The background is a plain, light-colored wall.

**MEASURES OF  
HEALTH CARE  
QUALITY**



*"I don't know what I would have done without you guys. It means so much to me, and you all (HMHS) have given me hope as I get my medical treatment. I appreciate everything you all do. Everyone is so kind and helpful when I call. Thank you."*

*- Comment from a HMHS Beneficiary*

### **Prevention and Wellness**

Preventive care and promotion of healthy lifestyles are key strategies in precluding detrimental outcomes from illness and disease. HMHS actively promotes and measures use of preventative health services

### **Health Awareness Letters (HAL) Program**

HMHS proactively identifies beneficiaries in need of certain preventive services by utilizing a unique HAL system which reminds TRICARE network Prime enrollees and primary care managers (PCMs) of prevention and wellness recommendations. These letters communicate preventive health service recommendations based on the U.S. Preventive Services Task Force, the American Academy of Pediatrics, the American Academy of Family Physicians, and the Centers for Disease Control and Prevention. The letters provide recommendations for the identified age and gender groups, and provide safety tips for beneficiaries.

Six months after the HAL mailings, claims data are used to determine if preventive services have been rendered. If not, a letter to the beneficiary's PCM is generated advising that these important preventive services have not been reported, and requesting that the PCM follow up with the beneficiary.

We believe our proactive approach to preventive and wellness recommendations increases both awareness and utilization of these important services.

In 2006 HMHS mailed 242,865 beneficiary letters and 90,172 PCM letters.

### **Measuring Select Preventive Services**

According to the U.S. Centers for Disease Control and Prevention (CDC), cardiovascular disease is the leading cause of death in the United States with deaths attributable to cancer ranked number two<sup>(2)</sup>. Based on this information and the availability of data, the following preventive health services were selected for evaluation for this Report Card:

- Breast Cancer Screening
- Cervical Cancer Screening
- Colorectal Cancer Screening
- Cholesterol Screening

Adherence by TRICARE Prime enrollees to recommended standards of care is measured from claims using HEDIS<sup>®</sup> definitions<sup>(3)</sup>. Adherence rates are understated due to the absence of data for preventive services rendered in military treatment facilities (MTFs).

### ***Breast Cancer Screening***

According to the American Cancer Society (ACS), in 2007 approximately 178,480 women will be diagnosed with breast cancer in the United States. Women in the United States have a 1:8 risk of developing invasive breast cancer in their lifetime<sup>(4)</sup>.

Mammography is the best modality to find breast cancer at early stages and can detect 80 - 90% of breast cancers in women with no symptoms. Death rates from breast cancer are decreasing, most probably due to earlier detection and treatment improvements<sup>(5)</sup>.

**Data Parameters and Limitations**

This measure is the percentage of Network Prime enrolled women 40 - 69\* [HEDIS® AGES] <sup>(3)</sup> who received a mammogram during the measurement year or year prior [HMHS data are from claims for women ages 42 - 64 years old as of December 31 of the measurement year; age 64 is used due to the HMHS beneficiary population, which excludes Medicare eligible persons.

<b>2006 HMHS Breast Cancer Screening Rate</b>	<b>= 61.9%</b>
<b>2005 HMHS Breast Cancer Screening Rate</b>	<b>= 56.7%</b>
<b>NCQA Quality Compass (QC) 2007 <sup>(6)</sup> mean Benchmark *</b>	<b>= 64.4%</b>
<b>NCQA QC 25<sup>th</sup> and 75<sup>th</sup> percentiles</b>	<b>= 61.0% - 68.1%</b>

*\*NCQA South Central region compares well in geographic distribution to the South Region; it includes Alabama, Arkansas, Kentucky, Louisiana, Mississippi, Oklahoma, Tennessee, and Texas. Therefore, these benchmarks are representative of the population we serve <sup>(7)</sup>.*

**Cervical Cancer Screening**

The incidence of cervical cancer and its mortality rates have decreased by 67% in the past 30 years <sup>(8)</sup>. This is due primarily to increased awareness and adherence to screening for cervical cancer using a Papanicolaou Test (Pap smear). Despite increased awareness regarding the importance of screening for cervical cancer, sixty to eighty percent of women with advanced cervical cancer have not had a Pap smear in five years <sup>(9)</sup>. The ACS estimates 11,150 new cases of invasive cervical cancer in 2007 <sup>(10)</sup>. Pap screening detects over 90% of cervical lesions and also detects abnormal cells that may become cancerous. With early detection and treatment, the cure rate for cervical cancer is nearly 100% <sup>(11)</sup>.

**Data Parameters and Limitations**

Screening rates are for women ages 21 – 64, enrolled in Network Prime, with at least one Pap smear in the last 3 years. This indicator only captures 26 – 29 months of HMHS data; this is a 3 year measure as defined by NCQA. Thus our true rates are likely higher than reflected in this report.

<b>2006 HMHS Cervical Cancer Screening Rate</b>	<b>= 61.4%</b>
<b>2005 HMHS Cervical Cancer Screening Rate</b>	<b>= 49.4%</b>
<b>NCQA QC 2007 mean Benchmark South Central Region <sup>(6)</sup></b>	<b>= 76.4%</b>
<b>NCQA QC 25<sup>th</sup> and 75<sup>th</sup> percentiles</b>	<b>= 76.1% - 81.6%</b>

**Colorectal Cancer Screening**

According to 2002 CDC data, colorectal cancer ranks fourth in cancer incidence in the United States and primarily affects those age 50 and older <sup>(12)</sup>. Decreasing the number of deaths from colorectal cancer depends on early detection, removing precancerous polyps, and early treatment. Regular screening could decrease mortality by 60%, yet less than 40% percent of colorectal cancers are detected early enough for effective treatment <sup>(13)</sup>. When colorectal cancer is found and treated early, the five year survival rate is 90 percent; unfortunately, only 39% of cases are identified at an early stage <sup>(8)</sup>.

**Data parameters and limitations**

Percentage of Network Prime enrolled adults age 51 - 64 receiving one or more colorectal cancer screenings within recommended time periods [HEDIS ages 51 – 80]. Appropriate screenings are any one of the following four procedures:

- Fecal Occult Blood Test
- Flexible Sigmoidoscopy – within the last 5 years

## MEASURES OF HEALTH CARE QUALITY

- Double Contrast Barium Enema – within the last 5 years
- Colonoscopy – within the past 10 years

This preventive measure requires 5 to 10 years of data and medical record review to sufficiently capture all the appropriate screening measures. Our rate is reflective of only 26 – 29 months of data. We anticipate this rate will increase in the coming years with additional data and the expanded TRICARE benefit to include colonoscopy screening.

<b>2006 HMHS Colorectal Cancer Screening Rate for all Indicators</b>	<b>= 24.0%</b>
<b>2005 HMHS Colorectal Cancer Screening Rate for all Indicators</b>	<b>= 24.0%</b>
<i>NCQA QC 2007 mean Benchmark South Central Region</i> <sup>(6)</sup>	<b>= 48.5%</b>
<i>NCQA QC 25<sup>th</sup> and 75<sup>th</sup> percentiles</i>	<b>= 41.1% - 55.0%</b>

### ***Cholesterol Screening***

Elevated cholesterol is a significant risk factor for cardiovascular disease (CVD). The American Heart Association estimates that nearly 105 million adults have total cholesterol levels of over 200 (milligrams per deciliter, or, mg/dL). Nearly 37 million of these adults have cholesterol levels of 240 and above <sup>(14)</sup>.

Screening for cholesterol is critical in identifying this cardiovascular risk factor. Much can be done to prevent and treat high cholesterol <sup>(15)</sup>. Although CVD remains the number one cause of death in the U.S., according to the American Heart Association, there has been a decline in the death rate from CVD due to positive changes in behavior and lifestyle <sup>(16)</sup>. Modifications in lifestyle can impact cholesterol levels. Eating a healthy diet, reducing the saturated fats and cholesterol in the diet, maintaining a healthy weight, and increasing physical activity can significantly influence cholesterol. Effective medications also lower cholesterol.

#### ***Data parameters and limitations***

Percentage of Network Prime enrolled adults ages 18 – 64 with evidence of at least one cholesterol screening test during the recommended period. Measuring the cholesterol screening rate requires five years of data. Because data are available for only 26 – 29 months this is not an accurate reflection of adherence for this measure at this time. We anticipate this rate will increase over time with additional data.

<b>2006 HMHS Cholesterol Screening Rate</b>	<b>= 69%</b>
<i>Benchmark utilized = Healthy People 2010 baseline</i>	<b>= 67%</b>
<i>Healthy People 2010 target</i>	<b>= 80%</b>

We did not measure overall cholesterol screening rate in the 2005 Report Card; therefore, there is no comparative 2005 measurement.

*“A general and his wife both complimented a BSR for her **diligence** in working with them to get his wife’s referral approved. Both wanted the BSR recognized for all of her **hard work** to make sure that they were taken care of.”*

*- Comment from a HMHS BSR*

Adherence to Select Preventive Services

Preventive Service	2005 Percent Adherence	2006 Percent Adherence*	Benchmark	NCQA 25 <sup>th</sup> and 75 <sup>th</sup> Percentiles
Breast Cancer Screening	56.7%	<b>61.9%</b>	64.4	61.0% - 68.1%
Cervical Cancer Screening	49.4%	<b>61.4%</b>	76.4	76.1% - 81.6%
Colorectal Cancer Screening	24.0%	<b>24.0%</b>	48.5	41.1% - 55.0%
Cholesterol Screening	N/A	<b>69.0%</b>	67.0	N/A

\* Using only 26 to 29 months of claims data, omits services rendered in Military Treatment Facilities.

Screening rates for breast cancer and cervical cancer continue to increase year over year. The long look-back period, up to 10 years, affects our colorectal screening measure. To address the latent change from 2005 to 2006 in colorectal screening, we recently initiated screening for colorectal cancer through the HAL Program. PCMs are notified of those beneficiaries who may be in need of screening for colorectal cancer. Notification letters, initiated through the HAL Program, continue to serve as a reminder to beneficiaries who may be in need of these preventative services.



**Mental Health**

**30-Day Acute Readmission Rate**

The Substance Abuse and Mental Health Services Administration (SAMHSA) includes *Reduced Utilization of Psychiatric Inpatient Beds* as an area of focus. SAMSHA monitors 30 day psychiatric inpatient readmission rates as a measure in this domain <sup>(17)</sup>.

Measurement of acute psychiatric inpatient readmissions can be used to help assess system efficiency across the continuum of care. It can be used to determine the access and availability of appropriate less restrictive levels of care, including community resources.

This measure provides an indicator of appropriateness of care immediately after discharge. A higher level of readmission may require increased network recruitment in certain areas or additional facility education on appropriate discharge planning. When individual facilities or geographic areas have high readmission rates, partnering with facilities may be needed to assist with discharge planning. Case management may be utilized to assist high risk patients in accessing care.

The annual average rate for 30-day readmissions in 2005 was 11%. Consistent with the previous year, the 2006 rate was 11%.

This is a retired HEDIS® measure; therefore, additional benchmark data are not available. ValueOptions is the HMHS subcontractor for mental health services in the South Region. The ValueOptions Corporate benchmark of 10% was established from the collection and analysis of data across all ValueOptions’ service centers nationwide. The annual nationwide average is also 11%.

## MEASURES OF HEALTH CARE QUALITY

### *Data Parameters and Limitations*

This measure includes all non active duty TRICARE Network Prime enrolled beneficiaries, regardless of age, with a discharge from an authorized acute psychiatric inpatient facility.

### **Psychiatric Evaluation or Treatment within 30 Days of a New Episode of Care for Major Depression**

A recent World Health Organization (WHO) report predicts depression will be the leading cause of disability and premature death in the industrialized world by the year 2020. Without treatment, 10-15% of people suffering from severe Major Depressive Disorder (MDD) commit suicide<sup>(18)</sup>. With treatment, the majority of patients with this illness recover. The American Psychiatric Association (APA) reports that if major depression is untreated, an episode typically lasts 6 months or longer<sup>(19)</sup>.

Improvement of referrals for psychiatric evaluation or treatment and improving medical and psychiatric follow-up after being diagnosed with major depression will result in improved quality of life for TRICARE beneficiaries and reduced complications.

In 2006, 32,719 beneficiaries received a new diagnosis of major depression from a non-physician provider. This number is up slightly from 32,363 in 2005. Physician treatment mirrors that of 2005, with 76.1% of these beneficiaries receiving treatment within 30 days in 2006.

*This is a ValueOptions Corporate performance measure, and additional benchmark data are not available. Initially the goal for the TRICARE population was established at 75%, and has since been increased to 80%.*

### *Data Parameters and Limitations*

This measure examines the percentage of Network Prime enrolled beneficiaries who had a psychiatric evaluation or treatment within 30 days of a new episode of care for a diagnosis of Major Depression. (A new episode is defined as no visits 30 days prior to the start of care.) A psychiatric evaluation or treatment is defined as any visit with an MD, DO, or ARNP in any setting.

### **Guard and Reservists Returning from War Zones Are More Likely to Need Mental Health Guidance**

Focused on the potential mental health disorders among returning Guard and Reserve war veterans, HMHS and ValueOptions designed a trifold brochure to increase awareness of various mental health conditions that can occur upon returning home, and to provide points of contact if the veteran or family member should need assistance. In early 2006, HMHS mailed brochures to over 32,000 households in the South Region and all TRICARE network behavioral health providers. The mailing encouraged them to be aware of the diagnosis and treatment of behavioral health disorders such as Posttraumatic Stress Disorder (PTSD), depression and substance abuse. According to an article published in the Journal of the American Medical Association, 19% of soldiers returning from Iraq met the military's risk criteria for a mental health concern, such as PTSD or depression<sup>(20)</sup>.

“There is still a stigma associated with seeking help for depression, PTSD and substance abuse, especially for the military who have been taught to be strong,” said John Crum, M.D., Chief Medical Officer for HMHS. “It is important for these individuals to understand that help is just around the corner, and in seeking help, they can regain control of their lives.”

“Homecomings bring a wealth of emotions and some unexpected challenges. Knowing how to cope with those emotions and challenges is crucial to the families’ stability,” said Gary R. Proctor, M.D., Chief Medical Officer for ValueOptions. “It is important for not just the returning soldier or marine, but for the family to understand the warning signs and know when to ask for help.”

Analysis of data 30 days post mailing showed an increase in authorizations and a slight increase in claims for active duty service members with a diagnosis of depression.



## Living with Illness

### Diabetes Mellitus

Diabetes is the sixth deadliest disease in the U.S. and affects almost twenty-one million persons; approximately 7% of the population <sup>(21)</sup>. Type 2 diabetes has a rising incidence and prevalence due to obesity, sedentary lifestyle, consumption of foods high in fat and refined carbohydrates, and the aging population <sup>(22)</sup>.

Persons with both type 1 and type 2 diabetes are at increased risk for cardiovascular disease, kidney disease, neuropathy, and retinopathy caused by macro and micro vascular complications associated with this disease <sup>(23)</sup>. Progression to the complications and co-morbid conditions associated with diabetes can be delayed and may be prevented by strict adherence to treatment guidelines.

Maintaining good blood glucose levels is critical to the management of diabetes.

Glycosylated hemoglobin (A<sub>1c</sub>) is a laboratory test that measures the average level of blood glucose over the prior 2–3 months. Expert consensus recommends A<sub>1c</sub> testing twice a year, and more often if control of blood glucose is not achieved <sup>(24)</sup>.

Associated with the rise in the diabetic population is an increased risk for diabetic kidney (renal) disease. Approximately 10% to 40% of all diabetics develop end-stage renal disease (ESRD) <sup>(25)</sup>. Diabetic kidney disease is the leading cause of ESRD in the U.S. and in many cases can be delayed or prevented by good glycemic control <sup>(26)</sup>. According to the 2007 American Diabetes Association (ADA) guidelines, screening for microalbuminuria to detect kidney disease in type 2 diabetics should begin at initial diagnosis and continue annually thereafter <sup>(24)</sup>.

Because persons with diabetes tend to have increased lipid abnormalities, they are at greater risk for cardiovascular disease. Studies have shown that good lipid management helps reduce macro vascular complications associated with diabetes. The ADA recommends that adults with diabetes be tested at least annually for lipid disorders <sup>(24)</sup>.

Retinopathy is a common micro vascular complication seen in the diabetic population and the leading cause of blindness in adults 20 – 74 years of age. Good control of diabetes and its co-morbid conditions; e.g., hypertension, can reduce the risk and progression of retinopathy associated with diabetes. The ADA recommends that all persons with diabetes have a dilated eye exam at onset of diagnosis, annually thereafter, and more frequently if progression of retinopathy is noted <sup>(24)</sup>.

Diabetes is a lifelong condition and appropriate care is dependent upon prevention of secondary complications. Although there is no cure for diabetes, much can be done to delay and even prevent the progression to the catastrophic complications caused by uncontrolled diabetes.

*“I want to tell the world how wonderful HMHS has been over the last few months. My husband is battling cancer and without HMHS here to assist me with all of our insurance needs I do not know what kind of state I would be in. I am so thankful to have HMHS here to keep me informed. You all are always professional, helpful, informative, and encouraging. I specifically wanted to recognize the BSR I spoke with today for her thoughts of encouragement and information.”*

*- Comment from a HMHS Beneficiary*

## MEASURES OF HEALTH CARE QUALITY

### *Data Parameters and Limitations*

We measure the percentage of Network Prime enrolled beneficiaries with a diagnosis of diabetes, ages 18 – 64, who received an appropriate diabetic screening test during the measurement year. Measurements include only claims data and do not include care rendered in the MTF or pharmacy data. For 2005, the NCQA benchmark for monitoring diabetic nephropathy was 47.9%. This year, NCQA significantly changed their methodology for identifying “medical attention for nephropathy”; appreciably increasing the mean benchmark. Many of the new elements can only be identified through medical record review; our data only reflects claims information. Therefore, the NCQA benchmark is not entirely applicable to the HMHS result.

Screening for retinopathy and A1c are slightly less than benchmark. Though these findings may reflect missing encounter data from MTFs, they may represent opportunities for improvement.

Based on the 2005 Report Card results, HMHS mailed notification letters in the 4<sup>th</sup> quarter of 2006 to

### Adherence to Diabetic Indicators of Care

Diabetes Preventive Services Indicator	2005 Percent Adherence	2006 Percent Adherence	NCQA Benchmark	NCQA 25 <sup>th</sup> and 75 <sup>th</sup> Percentiles
Eye Screening	N/A*	36.4%	43.7%	39.7% - 48.8%
A1c	76.5%	73.0%	84.3%	82.4% - 88.7%
LDL-C	79.4%	81.4%	80.2%	78.3% - 85.1%
Nephropathy Screening**	29.9%	34.1%	76.9%	73.4% - 80.2%

\*Change in methodology renders 2005 comparison not applicable.

\*\*NCQA has renamed this measure “Medical attention for diabetic nephropathy”.

those diabetic beneficiaries who had no evidence of nephropathy screening. These educational letters included appropriateness of screening for A1c, LDL-C, nephropathy, and retinopathy. PCMs were also notified of those beneficiaries who may be in need of nephropathy screening. The effectiveness of interventions in the specific diabetic population will be evaluated in the 4<sup>th</sup> quarter of 2007. Additionally, HMHS launched a Diabetic Disease Management Program mid 2007 to help manage this population.

## Heart Failure

Heart Failure (HF) is one of the major chronic medical conditions in the United States. According to the National Heart, Lung, and Blood Institute, the prevalence of HF in the United States is approximately 5 million persons or about 1 in 56. Nearly 1.5 million of these persons are under age 60. HF is twice as likely to occur in persons with hypertension and five times as likely in those who have experienced a myocardial infarction<sup>(27)</sup>.

HF generally occurs because the heart cannot effectively pump enough oxygenated blood throughout the body, causing fluid to build up in tissues. This fluid, combined with decreased oxygen in the blood, causes breathlessness, tiredness, and swelling<sup>(28,29)</sup>.

HF is one of the most frequently selected conditions for Disease Management; these programs have been effective in reducing admissions and emergency room visits in addition to increasing the quality of life of the participants. The primary focus of disease management is to slow the progression of HF.

“Sponsor was very pleased with the degree of service provided by the BSR. She said that she was so ‘helpful, knowledgeable, patient, and professional’ throughout the call. She took the time to give her the information she needed but also explained and probed to help her with the things she needed but wasn’t aware of with her Medicare issue (like explaining the role of WPS). Her service was ‘magnificent,’ and she ended by saying that she wished ‘every person was like her.’”

- Comment from a HMHS BSR

One of the mainstays in managing HF is the use of medications called angiotensin converting enzyme inhibitors (ACEI) and angiotensin II receptor blockers (ARBs)<sup>(30)</sup>. These drugs have been shown to reduce morbidity and mortality in HF<sup>(31, 32, 33)</sup>.

Because persons with HF are already compromised, they are at increased risk for influenza and pneumonia and more susceptible to complications associated with these illnesses<sup>(34)</sup>. Vaccinations against flu and pneumonia help prevent these illnesses<sup>(35)</sup>. According to a study published in 1996, there was a 28.6% reduction in hospitalizations for HF and a 45% reduction in deaths in persons receiving the influenza vaccination<sup>(36)</sup>.

Persons enrolled in the HMHS HF disease management program are surveyed for use of ACEI or ARB and vaccination for flu and pneumonia. Every time the disease management nurse interacts with the beneficiary, she/he has an opportunity to educate the member on specific issues. Specific references to audio library topics are also used to reinforce or augment the educational session when the nurse determines the need for better understanding of a particular topic. References to high quality web educational materials are also used to enhance a beneficiary’s understanding of his/her disease and self-management of the disease and its co-morbidities. Below are the results of three of the measures (use of ACEI or ARB, flu vaccination, and pneumonia vaccination) used to evaluate the effectiveness of the HMHS HF program.

**Data Parameters and Limitations**

We measure the percentage of beneficiaries enrolled in the HMHS HF disease management program that receive recommended care. These data come from beneficiary self-reporting.

**Adherence to Disease Management Measures  
Heart Failure**

Measure	2005 Percent Adherence	2006 Percent Adherence	Benchmark
HF - Pneumonia Vaccine	51.0%	52.3%	16.0%*
HF - Influenza Vaccine	51.0%	61.6%	26.0%*
HF - ACEI &/OR ARB	65.0%	70.8%	65.0%**

\*Benchmark utilized Healthy People 2010 (High-risk adults 18 – 64 – 1998 baseline)<sup>(37)</sup>

\*\*Benchmark utilized AHRQ (Percentage of HF patients prescribed ACEI and/or ARB upon hospital discharge)

**Asthma**

Asthma is a chronic disease affecting the airways and is characterized by coughing, wheezing, and shortness of breath. According to the CDC, approximately 7.7% of the U.S. population, or 22 million persons, have asthma<sup>(38)</sup>. Achieving good control is the primary goal of asthma treatment to help control or prevent morbidity and mortality<sup>(39)</sup>.

Asthma significantly disrupts lifestyle causing missed work, school absenteeism, limitations on physical and sports activities, sleep disruption, unscheduled doctor visits, emergency room visits, and unplanned hospitalizations<sup>(38)</sup>. Asthma accounts for almost 14 million days missed from school and over 10 million

## MEASURES OF HEALTH CARE QUALITY

work days missed among adults <sup>(38, 40)</sup>. Asthma can be life threatening if not properly treated.

The National Asthma Education and Prevention Program has identified key clinical activities in caring for asthma. Part of routine care and evaluation of asthma is assessment of airway function. The best method for evaluation is use of spirometry testing, which measures how much and how fast air can be exhaled. Pharmacotherapy of choice for persons with persistent asthma is use of long-term controller medication; inhaled corticosteroids are the preferred drug. These medications are effective because they reduce the inflammation associated with asthma. Additionally, development of a written management plan between the health care provider and the patient should be an integral part of asthma management <sup>(41)</sup>.

HMHS implemented a disease management program for asthma in September 2006. One of the mainstays of asthma treatment is to control the symptoms. When HMHS disease management nurses interact with beneficiaries, they have the opportunity to assess their symptoms and provide education on specific topics. Below are three indicators used to evaluate the effectiveness of the Asthma Program.

### *Data Parameters and Limitations*

We measure the percentage of beneficiaries enrolled in the HMHS Asthma disease management program that receive recommended care for spirometry testing, use of an action plan, and use of long term controller medication.

This program began September 2006 and these data come from beneficiary self-reporting. Rates have increased for each measure since initial enrollment.

### Adherence to Disease Management Measures Asthma

Measure	Baseline	Post-enrollment	Benchmark
2006 HMHS Asthma DM Program Spirometry Testing Rate	77.2%	<b>79.6%</b>	N/A
2006 HMHS Asthma DM Program Action Plan Adherence	25.5%	<b>36.2%</b>	N/A
2006 HMHS Asthma DM Program Long Term Controller Rx Use	55.9%	<b>81.5%</b>	N/A



## Patient Safety and Monitoring of Select Procedures

### Patient Safety

Patient safety is defined by the IOM as “avoiding injuries to patients from care that is intended to help them” <sup>(1)</sup>. In 2000, the IOM identified medical errors as the 8th leading cause of death in the U.S., with more people dying each year from medical errors than from highway accidents, breast cancer, or AIDS <sup>(42)</sup>.

The IOM has called for the establishment of a standardized and mandatory reporting system to allow for comparisons and trending over time. Medical errors can occur at any point in the health care delivery system. AHRQ classifies errors as follows: medication errors, surgical errors, diagnostic

“A former marine, who is now in a wheel chair, wanted to let us know what a great job our BSR did. He said she was very **courteous and professional** and assisted him on getting his electronic funds transfer corrected. He was very **impressed** by the way she took her time and went the extra mile to help him. He also wanted to say that our training shows in the BSRs he has talked with. He wants us to keep up the good work and is glad we have BSRs like the one he encountered working to assist the military personnel.”

- Comment from a HMHS BSR

inaccuracies, and system failures <sup>(42)</sup>.

For identification and trending of safety issues, HMHS supplements the National Quality Forum list of Quality Indicators with AHRQ indicators selected to flag safety issues <sup>(43)</sup>.

AHRQ indicators drive reporting of infection, mortality, and adverse events at both the practitioner and facility level.

For this Report Card, HMHS selected measures for infections, retained foreign bodies, and accidental punctures and lacerations.

### **Accidental Puncture and Laceration**

Accidental puncture and laceration is described by AHRQ as ‘technical difficulty’ while performing a procedure. Reporting may be variable for two reasons; provider reluctance to report for fear of disciplinary actions, and the issue that some punctures are not preventable, for example during laparoscopic procedures.

#### **Data Parameters and Limitations**

Network Prime enrolled beneficiaries age 18 – 64 discharged from a hospital with a diagnosis identifying accidental puncture. The benchmark includes those over age 64.

**HMHS Accidental Puncture Rate** = 39.5 per 100,000  
 Benchmark utilized - AHRQ (2004) = 47.8 per 100,000

### **Infections**

This indicator measures infections due to medical care; primarily infections related to vascular access devices.

#### **Data Parameters and Limitations**

Prime enrolled beneficiaries, ages 0 - 64, discharged from a hospital with select diagnostic codes for infection in any diagnostic field on a claim form. The benchmark includes those over age 64.

**HMHS Infection Rate** = 20.5 per 100,000  
 Benchmark utilized - AHRQ (2004) = 30.8 per 100,000

### **Retained Foreign Body**

This indicator monitors the number of discharges from an inpatient facility with a foreign body accidentally left in following a procedure.

#### **Data Parameters and Limitations**

Network Prime enrolled beneficiaries with a discharge from a hospital with select diagnostic codes for foreign body in any diagnosis field on a claim form. This measure applies to persons age 18 – 64. Benchmark includes those over age 64.

**HMHS Foreign Body Rate** = 0.7 per 100,000  
 Benchmark utilized - AHRQ (2004) = 1.5 per 100,000

## MEASURES OF HEALTH CARE QUALITY

### Adverse Event Rates 2006

Adverse Event	Age Range	Benchmark	HMHS Rate/100,000 Pop.
Puncture	18 – 64	47.8	39.5
Infection	0 – 64	30.8	20.5
Foreign Body	18 – 64	1.5	0.7

HMHS compares favorably to benchmarks for all three adverse events studied; our patient safety measures are substantially better than benchmarks.

## Select Procedures

### *Coronary Artery Bypass Graft*

Coronary Artery Bypass Graft (CABG) surgeries have been evaluated by the AHRQ Healthcare Cost and Utilization Project (HCUP) for performance and quality issues. CABG and cardiopulmonary bypass, commonly performed in association with CABG, have decreased by 19% since 1997<sup>(44)</sup>.

According to AHRQ, there is a potential for overuse of CABG, but statistics have shown performance of CABGs for inappropriate indications occurred less than 10% of the time<sup>(45)</sup>. Although overall rates for inappropriate use of CABG are low, there is evidence of inappropriate rate variation across geographic areas. Monitoring for areas with rates significantly below or above the norm is recommended by AHRQ. This procedure requires proficiency with the use of complicated equipment; technically related errors may cause myocardial infarction, stroke, or death<sup>(46)</sup>. Therefore, this measure should also assess the number of deaths per 100 discharges for a CABG<sup>(39)</sup>.

#### *Data Parameters and Limitations*

Network Prime enrolled beneficiaries age 40 – 64 discharged with CABG in any procedure field on a claim form. Of those beneficiaries discharged with a CABG, percent with discharge status of death. CABG rate is per 100,000 population; CABG death rate is per 100 CABG procedures. Of note, the benchmark utilized includes adults over age 64.

<b>HMHS CABG Rate</b>	<b>= 166.66 per 100,000</b>
<i>Benchmark utilized AHRQ (Version 3.0 - Feb. 2006)</i>	<i>= 278.82 per 100,000</i>
<b>HMHS CABG Death Rate</b>	<b>= 1.76 per 100 procedures</b>
<i>AHRQ Benchmark (Version 3.0 - Feb. 2006)</i>	<i>= 3.39 per 100 procedures</i>

### *Cholecystectomy*

Nationally, seventy-five per cent of uncomplicated cholecystectomies (gallbladder removals) are performed laparoscopically<sup>(47)</sup>. Advantages associated with the laparoscopic procedure are decreased post-operative pain, decrease in pain medication use, better respiratory function, better oxygenation, and

quicker return to activities of daily living.

HMHS monitors the percentage of all cholecystectomies performed as closed (laparoscopic) procedures. The desired outcome is a high rate of closed cholecystectomy procedures compared to open procedures.

**Data Parameters and Limitations**

Network Prime enrolled beneficiary adults age 18 – 64 with a procedure code for either an open or closed cholecystectomy. The rate is based on closed cholecystectomy (laparoscopic) procedures per total cholecystectomy procedures.

**HMHS Closed Cholecystectomy Rate** = 94.03 per 100 procedures  
 AHRQ Benchmark 2002 (3.0 - Feb. 2006) = 75.55 per 100 procedures

**Hysterectomy**

One-third of women in the U.S. have had hysterectomies by the age of 60<sup>(48)</sup>. Hysterectomy is the second most common surgery for women in the U. S., behind only cesarean section. According to a Cochrane review in 2005 and current ACOG recommendations, vaginal hysterectomy should be performed when technically feasible rather than abdominal hysterectomy<sup>(49)</sup>. Use of this technique generally reduces the complication rate, length of stay, and time to return to normal activity<sup>(50)</sup>. Hysterectomy, as with any surgery, involves risk and possible long term complications. Many times effective, but less radical, alternatives to hysterectomy are available. Approximately 16 – 30% of hysterectomies performed in the U.S. are unnecessary and are associated with a complication rate between 25 – 50%<sup>(51)</sup>. There is a potential for overuse of this procedure.

Last year, we reported our hysterectomy rate exceeded the national norm; which offered an opportunity for further investigation. Because we are a health plan, we refined our search criteria to mirror HEDIS<sup>®</sup> specifications rather than AHRQ, which is hospital focused. To be consistent with HEDIS<sup>®</sup>, we lowered our age range from 18 to 15 years of age and examined our rates by vaginal versus abdominal hysterectomy. We feel this methodology gives us a more valid comparison. A recent article published in Clinical Obstetrics and Gynecology shows the rate of hysterectomy differs markedly by geographic region; with a rate as high a 9/1000 in the Southern U.S.<sup>(52)</sup> Our overall rate of hysterectomy is 8.52 per 1000, which is below the rate reported for the Southern U.S.

The decision to perform a specific type of hysterectomy is usually based on the practitioner’s level of expertise, comfort with a specific surgical approach considering the patient’s medical condition, and the reason for surgery. Unfortunately, current residency programs are not offering the level of proficiency in vaginal hysterectomy to meet this need<sup>(52)</sup>.

**Data Parameters and Limitations**

Network Prime enrolled female beneficiaries age 15 - 64 with a procedure code for an abdominal or vaginal hysterectomy. Hysterectomy rates are expressed per 1,000 member years

**HMHS Vaginal Hysterectomy Rate age (15 – 44)** = 4.31  
 NCQA QC 2007 mean Benchmark South Central Region = 4.00  
 NCQA QC 25<sup>th</sup> and 75<sup>th</sup> percentiles = 2.75 - 5.14  
**HMHS Vaginal Hysterectomy Rate ages (45 – 64)** = 3.28  
 NCQA QC 2007 mean Benchmark South Central Region = 4.44  
 NCQA QC 25<sup>th</sup> and 75<sup>th</sup> percentiles = 2.90 - 4.67

## MEASURES OF HEALTH CARE QUALITY

<b>HMHS Abdominal Hysterectomy Rate ages (15 – 44)</b>	<b>= 4.50</b>
NCQA QC 2007 mean Benchmark South Central Region	= 5.33
NCQA QC 25 <sup>th</sup> and 75 <sup>th</sup> percentiles	= 4.28 - 6.01
<b>HMHS Abdominal Hysterectomy Rate ages (45 – 64)</b>	<b>= 4.85</b>
NCQA QC 2007 mean Benchmark South Central Region	= 6.74
NCQA QC 25 <sup>th</sup> and 75 <sup>th</sup> percentiles	= 5.22 - 7.62

Age	Hysterectomies		Female Population	Rate/1000
	Abdominal	Vaginal		
15-44	511	489	113,435	8.82
45-64	417	282	85,935	8.13
Subtotal	928	771		
<b>TOTAL</b>		1699	199,370	8.52

Our overall proportion of hysterectomies performed vaginally is 45.4% with 54.6% performed abdominally. According to the 2002 report by the CDC, over 60% of hysterectomies are performed abdominally. Our abdominal hysterectomy rate is favorable to the CDC benchmark and our overall rate of hysterectomy is slightly below that of the Southern U.S. <sup>(53)</sup>.

### Back Procedures

Spinal procedures have significantly advanced in recent years, from disc reduction procedures to more complex spinal reconstruction and stabilization procedures. Back procedure, including laminectomy, use shows wide variation between regions and has a potential for overuse. Several studies have shown, approximately 23 to 38% of laminectomies were performed for inappropriate indications <sup>(54)</sup>. According to AHRQ, this indicator can sometimes be used as a proxy for potential quality issues and should be monitored for rates that are considerably above or below the norm.

#### Data Parameters and Limitations

Network Prime enrolled beneficiary adults age 18 – 64 with a procedure code for back procedures as defined by NCQA HEDIS<sup>®</sup> measures <sup>(3)</sup>.

<b>HMHS Back Procedures (F 20-44)</b>	<b>=14.30/1000</b>
NCQA QC 2007 mean Benchmark South Central Region	=16.74/1000
NCQA QC 25 <sup>th</sup> and 75 <sup>th</sup> percentiles	=11.63 – 21.94
<b>HMHS Back Procedures (F 45-64)</b>	<b>=26.74/1000</b>
NCQA QC 2007 mean Benchmark South Central Region	=33.03/1000
NCQA QC 25 <sup>th</sup> and 75 <sup>th</sup> percentiles	=26.56 – 38.88
<b>HMHS Back Procedures (M 20-44)</b>	<b>=15.89/1000</b>
NCQA QC 2007 mean Benchmark South Central Region	=12.61/1000
NCQA QC 25 <sup>th</sup> and 75 <sup>th</sup> percentiles	=10.51 – 15.45
<b>HMHS Back Procedures (M 45-64)</b>	<b>=20.68/1000</b>
NCQA QC 2007 mean Benchmark South Central Region	=26.16/1000
NCQA QC 25 <sup>th</sup> and 75 <sup>th</sup> percentiles	=20.61 – 31.18

Our rates for back procedures are below benchmarks except for the younger male population; however, these are still within the 10<sup>th</sup> and 90<sup>th</sup> percentiles of the NCQA QC, 5.15 and 18.7 respectively.

**Ear Procedures**

Middle ear infection is the most frequently diagnosed illness in children in the U.S. Recurrent ear infections are frequently treated by placement of tubes in the middle ear; approximately 600,000 myringotomies are performed annually in the U.S. <sup>(55)</sup> A study of 6,611 children under the age of 16 showed approximately one fourth of the tube insertions were inappropriate and another one third were questionable <sup>(56)</sup>. As with any surgery, there is risk involved, especially with the administration of anesthesia. Monitoring myringotomies allows us to determine if our rates are within the national norms.

**Data Parameters and Limitations**

Network Prime enrolled beneficiaries age 0 - 19 with a procedure code for ear procedures as defined by NCQA HEDIS<sup>®</sup> measures <sup>(3)</sup>

<b>HMHS Ear Procedure Rate Ages 0 - 4</b>	<b>= 42.00 per 1,000</b>
NCQA QC 2007 mean Benchmark South Central Region	= 78.41/1,000
NCQA QC 25 <sup>th</sup> and 75 <sup>th</sup> percentiles	= 57.26 – 95.02
<b>HMHS Ear Procedure Rate Ages 5 - 19</b>	<b>= 2.81 per 1,000</b>
NCQA QC 2007 mean Benchmark South Central Region	= 4.65/1,000
NCQA QC 25 <sup>th</sup> and 75 <sup>th</sup> percentiles	= 3.81 – 5.85

Our rates of ear procedures are favorable to benchmarks.

**Summary of Monitoring of Select Procedures**

HMHS has a favorable comparison to benchmarks in rates of CABG, CABG mortality, percent of cholecystectomies performed laparoscopically, overall back procedures, hysterectomies, and ear procedure rates. Based on findings in the 2005 Report Card, we further investigated hysterectomy. Using refined criteria we found our overall rate of hysterectomy is 8.52 per 1000, which is below the rate reported for the Southern U.S.

*“A beneficiary wanted to let us know how helpful and friendly the BSR was. She said they are moving from the West Region and had a lot of questions about what they needed to do. She said the BSR took the time to explain everything that she needed to do; she feels like he is just the person that she needed to speak with. He put all her fears and concerns about the move at ease. The beneficiary said the BSR made her first experience with HMHS a positive one and he deserves 4 stars!”*

*- Comment from a HMHS BSR*

## MEASURES OF HEALTH CARE QUALITY

### Summary of Monitoring Select Procedures 2006

Procedure	Age Range	Gender	Benchmark*	HMHS Rate/100,000 Pop.
CABG	40 - 64	All	279	167
CABG death rate	40 - 64	All	3.4	1.8
Open Cholecystectomy	18 - 64	All	N/A	121
Closed Cholecystectomy	18 - 64	All	N/A	1,905
Closed Cholecystectomy Rate/100 total	18 - 64	All	75.6	94.0

\*Benchmark = AHRQ

Procedure	Age Range	Gender	Benchmark**	HMHS Rate/1,000
Hysterectomy/Vag	15 - 44	F	4.00	4.31
Hysterectomy/Vag	45 - 64	F	4.44	3.28
Hysterectomy/Abd	15 - 44	F	5.33	4.50
Hysterectomy/Abd	45 - 64	F	6.74	4.85
Back Surgery	20-44	F	16.74	14.30
Back Surgery	45-64	F	33.03	26.74
Back Surgery	20-44	M	12.61	15.89
Back Surgery	45-64	M	26.16	20.68
Ear Procedures	0 - 4	All	78.41	42.00
Ear Procedures	5 - 19	All	4.65	2.81

\*\*Benchmark = NCQA



## Provider Network

### Network Adequacy

It is HMHS' goal to ensure that TRICARE beneficiaries have access to qualified providers, an appropriate amount of choice, and a diverse range of specialists to provide the full range of health care services. To meet this goal, we evaluate location and number of providers to

ensure they are geographically accessible to TRICARE beneficiaries. Additionally, practitioners must be accessible during reasonable operating hours and adhere to appointment and wait times.

The chart on the following page depicts the relative size of our beneficiary population and provider network density. It also shows provider participation in the TRICARE network has increased year over year in all ten states of the South Region.

STATE	TRICARE NETWORK % OF TOTAL STATE PROVIDERS	TRICARE NETWORK % OF TOTAL STATE PROVIDERS	TRICARE ELIGIBLES % OF TOTAL STATE POPULATION	TRICARE ELIGIBLES % OF TOTAL STATE POPULATION
	2005	2006	2005	2006
ALABAMA	30%	34%	3.3%	3.3%
ARKANSAS	55%	57%	3.3%	3.3%
FLORIDA	30%	35%	4.3%	4.3%
GEORGIA	40%	45%	4.4%	4.4%
LOUISIANA	33%	38%	2.8%	2.8%
MISSISSIPPI	41%	46%	4.2%	4.2%
OKLAHOMA	41%	55%	3.9%	3.9%
SOUTH CAROLINA	25%	26%	5.3%	5.3%
TENNESSEE	42%	46%	2.0%	2.0%
TEXAS	38%	43%	3.0%	3.0%
<b>Average</b>	38%	40.9%	3.6%	3.7%

*“(The BSR) was exemplary and provided the kind of ‘exceptional’ service that I wished other insurers provided. He went out of his way, not only to research the information I needed, but to guide me on how to find that same information myself in the future.”*

*- Comment from a Provider’s Office*

### **Provider Credentialing**

Credentialing is the process of obtaining and reviewing the documentation (licensure, educational degree, certifications, malpractice insurance, etc.) of health professionals to validate their qualifications to ensure a quality network. This process includes reviewing information given by the provider and verifying with primary and/or acceptable sources that the information is correct and complete. The credentialing process ensures each provider meets the specific criteria and prerequisites defined by the HMHS Credentialing Committee for determining initial and ongoing participation in the network.

HMHS providers are credentialed in accordance with URAC Health Network Standards, Version 5.0, as well as TRICARE and Humana, Inc. requirements. Humana Military Healthcare Services utilizes an internal application to track and trend potential problematic provider issues, such as access, attitude, and quality. Providers identified with issues are evaluated by nursing associates, working in conjunction with the Credentialing Department to ensure quality networks.

## MEASURES OF HEALTH CARE QUALITY

During 2006, HMHS delegated authority to credential and recredential a portion of providers to 74 contracted groups. All participating groups granted delegation of credentialing activity are audited on-site annually in order to determine their continued ability to perform credentialing and recredentialing in accordance with the standards of HMHS. Increased provider participation in the TRICARE network directly impacts credentialing activities. Credentialing and recredentialing activities have increased year over year; thus ensuring a quality network.

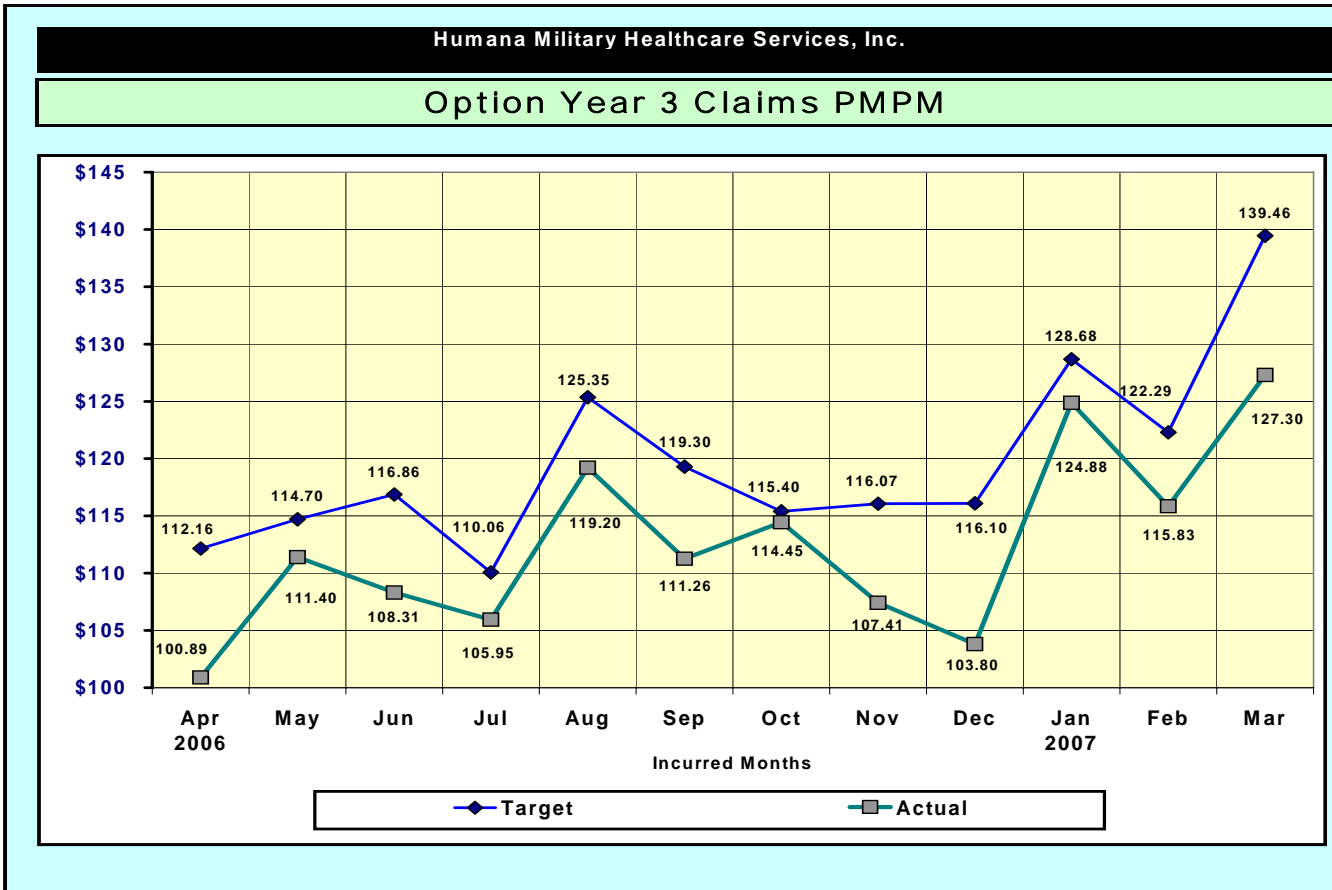
2006 Credentialing

2005	2006	Action Type
4,667	6,194	Initially Credentialed
5,557	7,261	Recruited



### Managing Cost

Each option year, HMHS works with the government to formulate a cost target for managing health care. HMHS has consistently maintained health care costs below target during Option Year 3 (April 2006 – March 2007). Some methods used to help manage these costs are provider discounts, referral management, case management, utilization management, disease management, and an effective quality management program. The graph below illustrates the target and actual cost per member per month (PMPM) for Option Year 3.





## Customer Satisfaction and Service

### Consistently Meeting Beneficiary Needs

HMHS is committed to beneficiary and customer satisfaction. Our Department of Quality Improvement and Customer Satisfaction provides HMHS the oversight to align the needs of beneficiaries to the improvement efforts of the corporation. HMHS measures numerous customer interactions that allow us to understand our performance. Beneficiary complaints are gathered and analyzed monthly to address all concerns of the customers. Customer Satisfaction surveys and comments are analyzed to propose and implement internal quality projects, thus improving HMHS overall customer satisfaction. These efforts allow HMHS to focus on the needs of beneficiaries.

*“I took a compliment call from beneficiary regarding the way the BSR handled his issue. He stated ‘She went above and beyond in resolving the issue with my wife’s ER claim.’ He has never had a better experience; the BSR was very responsive and took the utmost care to take care of this and relieve him of the stress that it was causing him since he is about to be deployed.”*

*- Comment from a*

In 2006 HMHS has continuously been close, met, or exceeded the standards pertaining to beneficiary services. Telephone inquiries such as answer speed, response rate (percent answered in 30 seconds by an individual), abandonment rate (disconnected calls), and follow-up calls (questions not answered will have a follow up call within two working days), met or exceeded their respective standards in 2006. HMHS also met the standard of processing 95% of all grievances to completion within 60 calendar days of the date of receipt

TRICARE Service Center (TSC) walk in inquiries also exceeded the standard of 95% acknowledged within five minutes of entering the reception areas. The TSC standard of 100% of walk in inquiries acknowledged within ten minutes was the only standard not consistently met throughout 2006. HMHS TSCs have continuously acknowledged over 99.5% of the beneficiaries within ten minutes.

HMHS provides opportunities for beneficiaries to provide feedback. One is a survey located on the HMHS Web Site. The survey is voluntary and can be utilized when beneficiaries interact with HMHS.

A five point scale is used for this survey because it provides adequate distribution of results without being overly cumbersome for the beneficiary. The survey asks participants to respond to statements by giving their level of agreement, with one equating to “strongly disagree” and five corresponding to “strongly agree”. Additionally, participants can give a not applicable response. The questions and results below reflect consumer satisfaction. In 2006, there were 13,514 respondents. Customer interaction improved year over year with improved scores for each survey question.

2006 CUSTOMER SATISFACTION		
Question	2005 Annual Weighted Average	2006 Annual Weighted Average
I would recommend my TRICARE health plan to a friend.	3.87	3.97
I am able to get the health care I need.	3.81	3.90
My doctor's staff is helpful.	3.97	4.04
When contacting Humana Military, I am able to get the information I need.	3.58	3.80

# MEASURES OF HEALTH CARE QUALITY

## Call Quality Monitoring Process

The Call Quality Monitoring Process was established by our Call Center leadership to ensure HMHS provides exceptional customer service to our beneficiaries and our providers. This process evaluates accuracy, tone, clarity, and responsiveness; provides an opportunity to provide feedback to associates; and identifies educational opportunities.

Using a twenty question assessment, each Beneficiary Services associate is evaluated for five calls every week. Associates are scored using the following standards:

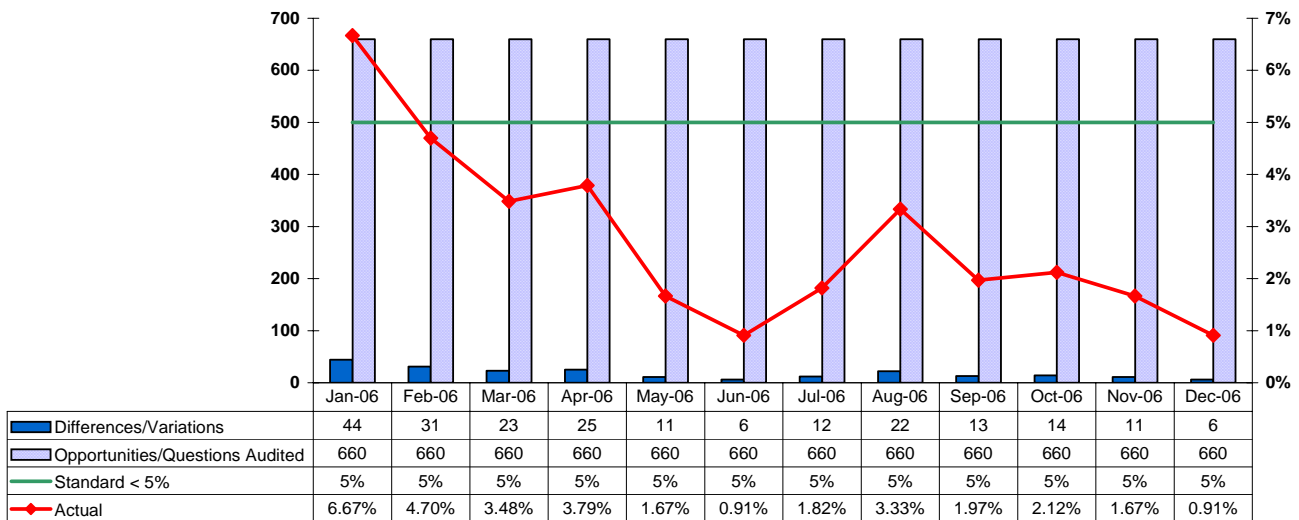
- 95% or > Exceed expectations
- 94.9% - 90% Meet expectations
- Below 90% Not meeting expectations

To further develop the partnership between HMHS and the TRICARE Regional Office- South (TRO-South), HMHS invited representatives from TRO-South to participate in call calibration sessions starting in November 2005. Participation in these sessions has given TRO-South the opportunity to evaluate the HMHS call center scoring criteria, offer perspective into the customer experience, and provide a third party scoring mechanism through call calibration. HMHS has established a formal process to capture the variance in scoring between HMHS and TRO-South. The goal is a variance of 5% or less.

Because the TRO-South evaluators are TRICARE beneficiaries, their assessment also reflects a customer’s perspective. Discussion of findings between HMHS and TRO-South evaluators identifies opportunities to improve customer service and this feedback provides educational opportunities for associates. This process is driving down the rate of findings and improving the agreement in scoring between HMHS and TRO-South.

The graph below represents 2006 data; this process was formalized in Jan 2006.

**Call Quality Calibration Variation**



*"A beneficiary called to say, 'That of all the big companies that I deal with on a day to day basis, TRICARE does a really outstanding job.' He advised that 'HMHS Reps are always helpful and efficient and easy to get a hold of.' He is very appreciative for our assistance with his TRICARE benefits.*

*- Comment from a HMHS BSR*

## URAC Accreditation

HMHS has sought out accreditations to enhance its internal processes and thus improve customer service.

URAC, an independent, nonprofit organization, is a leader in promoting health care quality through accreditation and certification programs. The URAC seal is a widely recognized symbol of quality and a reliable indicator that an organization's operations are conducted in a manner consistent with national standards. These standards promote the adoption of strategies meant to improve care and enhance service.

In August 2006, HMHS was awarded Disease Management Accreditation for its Heart Failure Program and Case Management Accreditation from URAC, a Washington, D.C. - based health care accrediting organization that establishes quality standards for the health care industry.

"By applying for and receiving Case Management and Disease Management accreditation, Humana Military has demonstrated a commitment to quality health care," said Charles Stellar, URAC Board Chairman. "Quality health care is crucial to our nation's welfare and it is important to have organizations that are willing to

measure themselves against national standards."

In 2006, HMHS was also awarded HIPAA Privacy Accreditation from URAC.

"HMHS is committed to privacy and delivering access to quality health care services to our nation's deserving military community," said David J. Baker, HMHS president and CEO.

HMHS continues to maintain Health Network Accreditation and Health Utilization Management Re-Accreditation from URAC.

## Good News Stories

### *Humana Military and the Armed Services YMCA Team up at Christmas for National Guard and Reserve Families*

Christmas 2006 - Saint Nicholas had a little help from his friends at Humana Military Healthcare Services. More than 600 toys were donated to the Kentucky National Guard's Family Assistance Center in Frankfort as part of an effort between Humana Military Healthcare Services, the Armed Services YMCA, Mattel Toys and Woman's Day Magazine.

HMHS, Armed Services YMCA, Mattel Toys and Woman's Day Magazine conducted similar programs for National Guard families in eleven southern states. More than 7,000 toys and books were delivered in the South region to National Guard and Reserve family members whose loved ones were serving overseas and in need of assistance during the 2006 holiday season.

"Because we handle TRICARE accounts for the National Guard, we deal with soldiers and their families every day of the week," said Julie Ice, Director of Legislative and Public Affairs for Humana Military. "As a result, our employees couldn't help but develop an understanding of what these families were going through, especially during the holidays. We wanted to do something that would make a difference."

More than one third of HMHS employees are military veterans, or have family members connected with the armed forces.

Once again, HMHS showed what the true spirit of the holiday season should be.

## MEASURES OF HEALTH CARE QUALITY

### *Words of Praise for the HF Disease Management Program*

The HF Disease Management program staff received a letter from a retired army officer thanking them for the excellent service provided during his rehabilitation following a heart attack and subsequent cardiac procedures. He praised the “TLC” and expertise provided during his recovery and adjustments, stating that HMHS’s “Heart Failure Disease Management Program worked well for me and I will miss it”. He further noted that he is now quite active and knows much about managing stress and other pitfalls of heart disease.

### *Education Helps Prevent Hospitalization in Asthma DM Program*

During a follow-up call to a beneficiary enrolled in the Asthma Disease Management Program, the beneficiary imparted the value of the education she had received from the DM nurse regarding use of peak flow meters. Because the beneficiary remembered the instructions and recorded the outcomes, she was able to immediately recognize the need for medical care. The beneficiary also commented on the ease of obtaining a timely appointment and subsequent improvement following treatment. The beneficiary stated she now understands the significance of using a peak flow meter for measuring her lung capacity and how it helps prevent hospitalization.

# **Limitations of Data and Conclusion**

PROGRESS  
REPORT CARD



### Limitations of Data

Although the gold standard for data review for quality indicators of care is a combination of both administrative data and chart review, it is not always possible or feasible to do a combined review. Administrative claims data are easily and readily available in large health care plans covering large geographic areas; medical records are difficult to access and costly to obtain and review<sup>(57)</sup>. Administrative data are frequently used to evaluate guidelines; a large study conducted at Johns Hopkins University found use of administrative claims data an effective method for measuring quality indicators<sup>(58)</sup>.

The indicators in the 2007 Report Card are from administrative databases and there are limitations inherent in the use of such data. One limitation is the risk of over-coding, under-coding, as well as miscoding. Another limitation is un-submitted encounter data, whether from utilization at an MTF, public clinic, or other health insurance carrier, and lack of pharmacy data. In several measures, such as cholesterol screening, we lack the necessary time period to complete the measure. Finally, because we have a highly mobile population there is movement in and out of enrollment making it difficult to monitor populations and trends over time. Despite these data limitations, because we have a large beneficiary population and robust data, our results are representative of the care rendered to our consumers.

### Conclusion

Overall, HMHS compares favorably with accepted standards for those indicators measured in the 2006 Report Card. In many measures we exceed nationally or regionally accepted benchmarks.

- HMHS takes a proactive approach to preventive services through use of the HAL program which notifies beneficiaries of needed services and monitors results. We have noted improvement for breast cancer and cervical cancer screening. Because many of the preventive measures require review of both administrative data and chart review, our rates probably understate adherence. HMHS will evaluate effectiveness of the addition of colorectal cancer screening to the HAL Program.
- Our 30-Day acute readmission rate for mental health has remained stable as has the evaluation post diagnosis of new episode of major depression.
- Based on findings for diabetic screening in the 2005 Report Card, HMHS notified beneficiaries in need of screening for nephropathy; we have noted improvement for this indicator. Our disease management programs for heart failure and asthma show significant improvement in adherence for indicators monitored. We expect our Disease Management Program will enhance screening for A1c and retinopathy in diabetic patients.
- Adverse events have remained stable and below the national norms, as has utilization for procedures.
- Our provider network is robust and continues to grow.
- Customer satisfaction is strong and improved year over year, with improved scores for each survey question.
- We have consistently maintained health care cost below target.
- HMHS has continued URAC accreditation for Health Network and Utilization Management and has recently attained URAC accreditation for HIPAA Privacy, Case Management, and Disease Management for Heart Failure.

*“A beneficiary wanted TRICARE to know how the representatives here make them feel confident and comfortable with the way their health care is handled and they feel special every time they call and are greeted with a pleasant and friendly voice.”*

*- Comment from a HMHS BSR*

# **Table of Indicators**





**Summary Table of Indicators**

**Preventive Services/Living with Illness Indicators**

<b>Preventive Service*</b>	<b>Benchmark</b>	<b>2005</b>	<b>2006</b>
Breast Cancer Screening	64.4%	56.7%	61.9%
Cervical Cancer Screening	76.4%	49.4%	61.4%
Colorectal Cancer Screening	48.5%	24.0%	24.0%
Cholesterol Screening	67.0%	N/A	69.0%
<b>Living with Illness</b>	<b>Benchmark</b>	<b>2005</b>	<b>2006</b>
Diabetes Care-Eye Screening	43.7%	N/A	36.4%
Diabetes Care-A1c	84.3%	76.5%	73.0%
Diabetes Care-LDL-C	80.2%	79.4%	81.4%
Diabetes Care-Nephropathy Screening	76.9%	29.9%	34.1%
HF - Influenza Vaccine	26%	51%	61.6%
HF - Pneumonia Vaccine	16%	51%	52.3%
HF - ACEI &/OR ARB	65%	65%	70.8%
Asthma – Spirometry Testing	N/A	N/A	79.6%
Asthma – Action Plan	N/A	N/A	36.2%
Asthma – Long Term Controller Rx	N/A	N/A	81.5%
Mental Health 30 day readmit	10%	11%	11%
Mental Health Tx within 30 days	80%	76.1%	76.1%

*\*These Preventive services require 3 - 10 yr data. This report reflects only 26 – 29 months of data; thus, our true rates are likely higher.*

**Monitoring Patient Safety and Select Procedures**

<b>Patient Safety</b>	<b>Benchmark</b>	<b>2006</b>
Puncture	47.8	39.5
Infection	30.8	20.5
Foreign Body	1.5	0.7
<b>Select Procedures</b>	<b>Benchmark</b>	<b>2006</b>
CABG death rate	3.39	1.76
Cholecystectomy Closed Rate/100	75.55	94.03
Hysterectomy/Vag age 15 - 44	4.00	4.31
Hysterectomy/Vag age 45 - 64	4.44	3.28
Hysterectomy/Abd age 15 - 44	5.33	4.50
Hysterectomy/Abd age 45 - 64	6.74	4.85
Back Procedures F ages 20 - 44	16.74	14.30
Back Procedures F ages 45 - 64	33.03	26.74
Back Procedures M ages 20 - 44	12.61	15.89
Back Procedures M ages 45 - 64	26.16	20.68
Ear Procedures – ages 0-4	78.41	42.00
Ear Procedures – ages 5-19	4.65	2.81

A stack of several books is shown on a wooden surface. The top book has an orange cover and features a large, realistic illustration of a red apple. A yellow pencil with a silver eraser and a sharp lead tip lies diagonally across the top book. The word "References" is printed in a large, white, serif font across the center of the image, overlapping the pencil and the apple illustration. Below the orange book, the spines of other books in various colors (light green, grey, and patterned) are visible.

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