Serving the Military Population for 13 Years - and Counting!

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

Humana Military has provided health care services to TRICARE beneficiaries since 1996. Our 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, Humana Military 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 (DoD) to communication with its beneficiaries.

In 2004, Humana Military implemented the second generation of the TRICARE program for approximately 2.9 million beneficiaries in the South Region (Arkansas, Alabama, Florida, Georgia, Louisiana, Mississippi, Oklahoma, South Carolina, Tennessee and most of Texas).

Humana Military 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 administer military health care solutions in the true spirit of collaboration with our government partners.

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 \(^{(1)}\).

This IOM committee recommended the report include two dimensions. The first dimension covers patient safety, effectiveness, patient centeredness and timeliness. The second dimension addresses the changing needs of consumers over their life span and includes prevention, getting better, and living with illness \(^{(1)}\).

Using these concepts, Humana Military 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 2008. 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
WHY A HEALTH CARE REPORT CARD?

Profiles, and Quality Compass (HEDIS®) data
- Centers for Disease Control and Prevention (CDC)
- Healthy People 2010
- The Institute for Healthcare Improvement
- AHRQ

According to an article published by RAND Health, health care report cards should include standardized performance measures, such as HEDIS®; should be organized into a framework that groups the data by category to increase usability; and should summarize, analyze, and compare the data (2).

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 also the cost of care:
1. Prevention and Wellness
2. Mental Health
3. Living with Illness
4. Patient Safety and Select Procedures
5. Provider Network
6. Managing Cost
7. Customer Satisfaction and Service

This is the fourth annual Humana Military Report Card. As we gain insight, the Report Card continues to evolve. We again include comparative data for preventive measures and quality indicators for specific diseases, and impact of interventions that were implemented.

A beneficiary reported she was speaking with a Humana Military Beneficiary Service Representative (BSR) when her phone disconnected. The beneficiary stated because the notes the BSR recorded were so thorough, when she called back and got another BSR, she did not have to go over the problem again. The beneficiary noted the BSR “was a very good investigator and got to the root of the problem! She was very attentive, listened well, efficient and just awesome!” The beneficiary also stated she appreciates the fact that she gets great customer service every time she calls. “The supervisors need a pat on the back for hiring the right people and training them so well”.
# Table of Contents

Measures of Healthcare Quality

1) Prevention and Wellness
   a) Health Awareness Letters
   b) Measuring Select Preventive Services
      i) Breast Cancer Screening
      ii) Cervical Cancer Screening
      iii) Colorectal Cancer Screening
      iv) Cholesterol Screening
      v) Influenza Immunizations

2) Mental Health Care
   a) Suicide
   b) Anorexia Nervosa
   c) Access to Mental Health
   d) Case Management Services for Active Duty Service Members with PTSD Diagnosis

3) Living with Illness
   a) Diabetes Mellitus
   b) Heart Failure
   c) Asthma

4) Patient Safety: Adverse and Never Events and Monitoring of Select Procedures
   a) Adverse and Never Events
      i) Accidental Puncture and Laceration
      ii) Infections Related to Medical Care
      iii) Retained Foreign Body
      iv) Mediastinitis Following CABG
      v) Air Embolism
      vi) Blood Incompatibility
      vii) Catheter Associated UTI
      viii) Pressure Ulcers
   b) Select Procedures
      i) Coronary Artery Bypass Graft
      ii) Cholecystectomy
      iii) Hysterectomy
      iv) Back Procedures
      v) Ear Procedures

5) Provider Network
   a) Network Adequacy
   b) Provider Credentialing

6) Managing Cost

7) Customer Satisfaction and Service
   a) Consistently Meeting Beneficiary Needs
   b) Call Quality Monitoring Process
   c) URAC Accreditation
   d) Good News Stories/Quotes

Limitations of Data

Conclusion

Summary Table of Indicators

References
Prevention and Wellness

Chronic preventable diseases account for seven of every ten deaths in the United States (3). Preventive care, reduction of risk factors, and promotion of healthy lifestyles are key strategies in precluding detrimental outcomes from illness and disease. Humana Military actively promotes and measures use of preventive health services.

Health Awareness Letters

Humana Military proactively identifies beneficiaries in need of certain preventive services by utilizing a unique Health Awareness Letters (HAL) system which reminds TRICARE network Prime enrollees 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 identified age and gender groups, and provide safety tips for beneficiaries.

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

Our proactive approach to prevention and wellness increases both awareness and utilization of these important services, as demonstrated in the following sections.

In 2008 Humana Military mailed 293,245 beneficiary letters and 79,630 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 (4). The good news is death rates due to cancer have decreased significantly, primarily due to increased screening, better treatment options, and reduction in smoking (5). Based on this information and the availability of data, the following preventive health services were selected for evaluation:

- Breast Cancer Screening
- Cervical Cancer Screening
- Colorectal Cancer Screening
- Cholesterol Screening
Adherence by TRICARE Prime enrollees to recommended standards of care is measured from administrative claims data using HEDIS® criteria (6). Humana Military adherence rates are understated due to the absence of data for preventive services rendered in military treatment facilities (MTFs).

Beginning October 2008, Humana Military acquired access to the Military Health System Population Health Portal (MHSPHP). This portal allows greater insight into the actual preventive screening rates as it includes data for services rendered within the MTFs. We present MHSPHP rates in addition to Humana Military rates, when available.

**Breast Cancer Screening**

According to the American Cancer Society (ACS), in 2009 approximately 192,370 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 (7).

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 (8).

**Data Parameters and Limitations**

This measure is the percentage of Network Prime enrolled women 40 - 69* [HEDIS® ages] (6) who received a mammogram during the measurement year or year prior. Humana Military data are from claims for women ages 42 - 64 as of December 31 of the measurement year; age 64 is used due to the Humana Military beneficiary population, which excludes Medicare eligible persons. MHSPHP reflects data as of December 31, 2008.

<table>
<thead>
<tr>
<th>Year</th>
<th>MHSPHP Rate</th>
<th>Humana Military Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008</td>
<td>68.3%</td>
<td>62.3%</td>
</tr>
<tr>
<td>2007</td>
<td>61.9%</td>
<td>61.9%</td>
</tr>
<tr>
<td>2006</td>
<td>61.9%</td>
<td>61.9%</td>
</tr>
<tr>
<td>2005</td>
<td>56.7%</td>
<td></td>
</tr>
</tbody>
</table>

NCQA Quality Compass 2009 (9) mean Rate *

$= 64.5$

NCQA QC 25th and 75th percentiles

$= 62.3% - 67.3%$

*NCQA South Central region compares well in geographic distribution to the TRICARE South Region; it includes Alabama, Arkansas, Kentucky, Louisiana, Mississippi, Oklahoma, Tennessee, and Texas. Therefore, these benchmarks are representative of the population we serve (10).

**Cervical Cancer Screening**

The incidence of cervical cancer and its mortality rate have decreased by 67% in the past 30 years. 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. The ACS estimates 11,270 new cases of invasive cervical cancer in 2009. With early detection and treatment, the cure rate for cervical cancer is nearly 100% (11, 12, 13).
Data Parameters and Limitations
This measure is the percentage of Network Prime enrolled women 21 – 64 years who received at least one Pap smear in the last 3 years. Humana Military data are from claims for women ages 24 – 64 as of December 31 of the measurement year. MHSPHP results reflect data as of December 31, 2008.

2008 MHSPHP Cervical Cancer Screening Rate = 73.8%
2008 Humana Military Cervical Cancer Screening Rate = 63.4%
2007 Humana Military Cervical Cancer Screening Rate = 63.9%
2006 Humana Military Cervical Cancer Screening Rate = 61.4%
2005 Humana Military Cervical Cancer Screening Rate = 49.4%
NCQA Quality Compass 2009 (9) mean Rate * = 73.4%
NCQA QC 25th and 75th percentiles = 69.9% - 77.4%

To increase cervical cancer screening, Humana Military has continued its quality improvement initiative that notifies providers of beneficiaries in need of services. It is of interest to note the NCQA mean rate has declined for the past three measurement years (NCQA QC 2007 mean 76.39%, 2008 mean 74.31%, 2009 mean 73.4%).

Colorectal Cancer Screening
According to 2005 CDC data, colorectal cancer ranks fourth in cancer incidence in the United States and primarily affects those age 50 and older (14). 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 (15). When colorectal cancer is found and treated early, the five year survival rate is 90 percent; unfortunately, only 40% of cases are identified at an early stage (11).

Data Parameters and Limitations
Percentage of Network Prime enrolled adults ages 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
- 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 appropriate screening measures. Our rate reflects 50 – 53 months of data and only includes administrative claims data. We anticipate this rate will increase in the coming years with additional data and the expanded TRICARE benefit to include colonoscopy screening.

2008 MHSPHP Colorectal Cancer Screening Rate = 58.4%
2008 Humana Military Colorectal Cancer Screening Rate = 38.2%
2007 Humana Military Colorectal Cancer Screening Rate = 37.7%
2006 Humana Military Colorectal Cancer Screening Rate = 24.0%
2005 Humana Military Colorectal Cancer Screening Rate = 24.0%
NCQA Quality Compass 2009 (9) mean Rate * = 48.0%
NCQA QC 25th and 75th percentiles = 42.5% - 51.1%
In 2007, we added screening for colorectal cancer to our HAL program. In addition to beneficiaries being notified of preventive services, providers are notified of beneficiaries who may be in need of screening for colorectal cancer. In addition, Humana Military has initiated a clinical study to determine which method of notification is more effective in encouraging beneficiaries to receive screening for colorectal cancer. The population for this study was selected and interventions began during the first and second quarter of 2009.

**Cholesterol Screening**

The American Heart Association estimates nearly 80 million Americans have cardiovascular disease (CVD), which includes high blood pressure, coronary heart disease, heart failure, and stroke. Elevated cholesterol is a significant risk factor for persons with CVD; there are nearly 98.6 million adults with total cholesterol levels of over 200 (milligrams per deciliter, or mg/dL). Nearly 34.4 million of these adults have cholesterol levels of 240 and above (16).

Screening for cholesterol is critical as much can be done to prevent and treat this cardiovascular risk factor (17). 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 (18). Modifications in lifestyle can impact cholesterol levels. Eating a healthy diet, reducing saturated fats and cholesterol in the diet, maintaining a healthy weight, and increasing physical activity can significantly influence cholesterol. Medications also effectively 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 50 - 53 months, this is not an accurate reflection of adherence for this measure at this time.

<table>
<thead>
<tr>
<th>Year</th>
<th>Cholesterol Screening Rate</th>
<th>Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008 Humana Military</td>
<td>= 63%</td>
<td>67%</td>
</tr>
<tr>
<td>2007 Humana Military</td>
<td>= 57%</td>
<td>67%</td>
</tr>
</tbody>
</table>

We have no comparative measure for 2005 or 2006. Cholesterol screening remains a focus of HAL preventive letters. This rate has increased over time as more data has become available.

**Influenza Immunizations**

Each year, more than 200,000 people are hospitalized in the United States for illnesses related to influenza (flu) infections; according to the CDC, this number is trending upward. The flu is a contagious respiratory infection and sometimes causes serious, life-threatening complications in certain individuals. To reduce chances of getting the flu, the CDC recommends an annual flu immunization (19).

In an effort to raise awareness of the importance of receiving a flu immunization, Humana Military developed a multi-pronged approach to reach our population. Interventions included the following:

- Humana Military Web Site - flu shot message and links added to www.humana-military.com home page
- Telephone hold recordings included flu message
- TRICARE Service Centers displayed and distributed:
MEASURES OF HEALTH CARE QUALITY

- 11"x17" flu immunization posters
- CDC handouts "Who is at high risk..."
- Email messages in November to Prime households with available e-mail addresses (179,786)
- Reminder e-mail message saying “It’s not too late” in January 2009 (172,474)
- One-time automated outbound calls to Prime households – (183,208 successful contacts)
- Stuffer included in all claims explanation of benefit mailings (1,757,212)
- Articles placed in disease management newsletters
- Article in both beneficiary and provider newsletters

Data Parameters and Limitations
Percentage of Network Prime enrollees, ages 0 - 64, with evidence of a flu immunization during the measurement period (10/1/08 - 3/31/09). Many flu immunizations were likely obtained through health departments and retail settings; they are not captured in these claim counts. We could find no comparable national benchmark data on rate of flu immunization in the overall U.S. population.

2008-2009 Humana Military Flu Immunizations = 17.06%
*2007-2008 Humana Military Flu Immunizations = 14.83%
*2006-2007 Humana Military Flu Immunizations = 12.19%

*Note: Specific procedure codes were omitted from calculations for the two previous years. The rates above reflect the recalculated rates.

Our rate of immunizations for Network Prime enrollees increased by 2.23 percentage points; this reflects an overall increase of 15.03%. Based on this success, Humana Military will continue this initiative for the 2009 - 2010 flu season.

Adherence to Select Preventive Services

<table>
<thead>
<tr>
<th>Preventive Service</th>
<th>2005 Percent Adherence**</th>
<th>2006 Percent Adherence**</th>
<th>2007 Percent Adherence**</th>
<th>2008 Percent Adherence**</th>
<th>2008 MHSPHP NCQA Mean Rate</th>
<th>NCQA 25th and 75th Percentiles</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast Cancer Screening</td>
<td>56.7%</td>
<td>61.9%</td>
<td>61.9%</td>
<td>62.3%</td>
<td>68.3%</td>
<td>64.5%</td>
</tr>
<tr>
<td>Cervical Cancer Screening</td>
<td>49.4%</td>
<td>61.4%</td>
<td>63.9%</td>
<td>63.4%</td>
<td>73.8%</td>
<td>73.4%</td>
</tr>
<tr>
<td>Colorectal Cancer Screening</td>
<td>24.0%</td>
<td>24.0%</td>
<td>37.7%</td>
<td>38.2%</td>
<td>58.4%</td>
<td>48.0%</td>
</tr>
<tr>
<td>Cholesterol Screening</td>
<td>N/A*</td>
<td>N/A*</td>
<td>57.0%</td>
<td>63.3%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Flu Immunizations</td>
<td>N/A*</td>
<td>12.2%</td>
<td>14.8%</td>
<td>17.1%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

*Change in methodology - 2006 comparison not applicable
** Omits services rendered in Military Treatment Facilities, public clinics, and retail settings.

Our MHSPHP screening rates for breast cancer and colorectal cancer exceed the NCQA 75th percentile. Our cervical cancer screening rate is within NCQA 25th and 75th percentiles. Our cholesterol screening rate continues to improve; the long look-back period affects this measure. To address the static rate from
MEASURES OF HEALTH CARE QUALITY

2005 to 2006 in colorectal screening, in 2007 we added screening for colorectal cancer to the HAL Program. We have implemented a clinical study to determine an effective intervention to improve colorectal cancer screening. The flu immunization initiative netted an appreciable increase in our flu immunization rate for the past two years; we will continue this initiative in 2009.

Mental Health

Suicide

According to the National Institute of Mental Health, death by suicide is the 11th most common cause of death in the United States and presents a health crisis \(^{(20)}\). Suicide rates amongst the military population have traditionally been lower than age and gender matched civilian deaths by suicide \(^{(21)}\). However, in recent years the suicide rates within the military population have been increasing steadily. According to Army statistics 2,100 soldiers tried to commit suicide in 2007 compared with 350 in 2002. The Marine Corps also reports an increase in suicides from 33 in 2007 to 41 in 2008 \(^{(21)}\).

Suicide is a major issue facing the public health. Because suicide is preventable, much effort has been made in the civilian sector as well as the military community to educate individuals and providers regarding suicide risk factors, stressors and screening. In response to concern about the rise in suicide among the military population, ValueOptions TRICARE South Behavioral Health implemented several initiatives to identify those at risk and encourage mental health care.

In August of 2008, ValueOptions made available a 24 hour crisis line for military beneficiaries who may have suicidal thoughts. The crisis line is staffed by mental health professionals ready to assist the beneficiary in remaining safe and accessing appropriate mental health care. The ValueOptions award winning Achieve Solutions web site, linked directly from humana-military.com, is available 24/7 to beneficiaries. Achieve Solutions provides up-to-date information on suicide awareness, prevention, and the ability to view two suicide awareness videos regarding available resources and services. The crisis line phone number is displayed during the videos. One video is aimed at military members and the second video is primarily for family members. The videos provide information on depression signs and symptoms and includes a depression self-quiz. Other national suicide and depression resources are also displayed.

Awareness of the rise in military suicides and efforts focused on prevention are essential. Continued interventions that focus on education regarding depression and suicide, reducing the stigma of mental health services, and encouraging beneficiaries to seek appropriate mental health services are necessary for positive outcomes.

Anorexia Nervosa

Anorexia Nervosa (AN) is a an eating disorder characterized by low body weight and body image distortion, with an obsessive fear of gaining weight. It is a serious, potentially life threatening condition due to behaviors of self-starvation and excessive weight loss. AN has one of the highest death rates of any
mental health diagnosis, with 5-20% of cases resulting in death \(^{(22)}\). Approximately 90-95% of AN sufferers are female and the condition typically surfaces in early to mid-adolescence \(^{(23)}\).

Anorexia nervosa involves neurobiological, psychological, and sociological components \(^{(24)}\). Due to these complexities, treatment requires coordination across behavioral and medical disciplines. It has been proven that individuals are best served with a multi-disciplinary team approach, including a psychologist or psychiatrist, a registered dietician or nutritionist, and a primary care practitioner or nurse practitioner.

ValueOptions, in an effort to improve health outcomes of individuals with AN, implemented an intensive Case Management (CM) program. This program offers an intense process for early identification, intervention, and coordination of treatment using a team approach. Individuals identified for intervention received initial screening to gather pertinent information, such as height and weight, available lab results, and a standardized eating disorder assessment.

These individuals were then referred to providers with experience and training in eating disorders. These providers have been strongly encouraged to utilize the American Psychiatric Association (APA) guidelines in order to promote consistency and evidence based practice in treatment. Longer acute inpatient stays were authorized in order to improve health status and stability post-discharge and to decrease recidivism.

ValueOptions identified and tracked 81 individuals over the course of calendar year 2008. Twenty-seven of these individuals enrolled in the CM program; significant weight gain was achieved by 11 beneficiaries. One individual did not maintain weight and regressed after their family situation changed.

Overall, beneficiaries participating in the CM program increased their weight from the pre to post-intervention measurement by 17.6%. Feedback from these individuals supports ValueOptions’ hypothesis that intensive CM intervention can impact health outcomes and promote a better quality of life.

The goal of increasing the number of beneficiaries receiving case management was met. Hospitalized beneficiaries had longer stays. Overall outcomes were improved by identification and referral to CM for outreach, and offering a comprehensive program designed to meet the special and complex needs of the AN population.

**Data Parameters and Limitations**

All eligible Prime beneficiaries identified with a diagnosis of anorexia nervosa and agreeing to participate in the intensive CM program during calendar year 2008.

**Access to Mental Health Care**

The need for mental health services for the military members and their families has steadily increased during the conflicts in Iraq and Afghanistan. Extended and repeated deployments present a major stressor to soldiers as well as the significant others in their lives. According to the DoD Mental Health Task Force, of reservists coming back from Iraq, 49% of Army soldiers and 43% of Marines self-reported mental health concerns on the Post Deployment Health Reassessment. The issues identified were relationship problems with spouse and children, depression, abuse of alcohol and problems with anger and aggression \(^{(25)}\).

Not only have the active duty service members been affected by deployments, the significant others in their lives have also seen deleterious effects. According to the Associated Press, there has been a 20% increase from 2007 to 2008 in the number of children of active duty hospitalized for mental health services. The number of outpatient mental health visits for children of
active duty service members doubled between the Iraq invasion of 2003 and 2008 (26, 27).

While the need for mental health services has increased within the military population, the availability of mental health providers across the U.S. is decreasing. Shortages of providers have affected timely access to appointments. In an effort to address the need for access, ValueOptions recruited 1,270 new mental health providers in 2008. ValueOptions also implemented an active duty provider locator and an appointment assistance line, to facilitate locating mental health providers and getting appointments.

The appointment assistance line is for both the active duty service members as well as their eligible family members. During 2008, a total of 6,789 calls were received, of which 3,488 were eligible for the appointment services. Active duty service members (ADSM) who request assistance have appointments scheduled in an average of 5.7 days. For the Active Duty family members, the average was 8.8 days. Callers who use self service to select a provider receive appointments in an average of 9.2 days.

Data Parameters and Limitations
All eligible Prime beneficiaries accessing the appointment assistance line during calendar year 2008.

Case Management Services for Active Duty Service Members with Post Traumatic Stress Disorder
ValueOptions implemented a program in January 2008 to assist ADSMs, diagnosed with Post-Traumatic Stress Disorder (PTSD), and their families.

The goals of the program are:

- Assist ADSM to receive mental health care
- Educate ADSM and family about PTSD and/or Traumatic Brain Injury (TBI)
- Assist the military case manager with questions about benefits and providers. The military case manager remains the primary point of contact for coordination of care and referrals while the beneficiary is on active duty status
- Assist family members with questions about benefits, providers, and authorizations
- Provide information on community resources, Veterans Affairs (VA) benefits and other options to ease the transition for those being medically retired or discharged
- Provide CM services following discharge to ensure uninterrupted care

During 2008, the PTSD CM program had 1,220 referrals, with 101 ADSM accepting services. The program is especially helpful for those transitioning from active duty to civilian life. Participants learn about available care options (such as TRICARE Retired, Traditional Assistance Management Program, VA resources, etc.) and receive needed treatment after retiring.

Living with Illness

Diabetes Mellitus
Diabetes is the seventh leading cause of death in the U.S. and affects over twenty-three million persons; approximately eight percent of the population (28).

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 (29, 30).

Persons with both type 1 and type 2 diabetes are at increased risk for cardiovascular disease, kidney disease, neuropathy, and retinopathy caused by
MEASURES OF HEALTH CARE QUALITY

macro and micro vascular complications associated with this disease (31). 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 (A1C) is a laboratory test that measures the average level of blood glucose over the prior 2-3 months. Expert consensus recommends A1C testing twice a year, and more often if control of blood glucose is not achieved (32).

Associated with the rise in the diabetic population is an increased risk for diabetic kidney (renal) disease. Approximately 10% to 40% of Type 2 diabetics develop end-stage renal disease (ESRD). 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. According to the 2008 American Diabetes Association (ADA) guidelines, screening to assess urine albumin excretion to detect kidney disease in type 2 diabetics should begin at initial diagnosis and continue annually thereafter (32, 33, 34).

Because persons with diabetes tend to have 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 (32).

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 type 2 diabetes have a dilated eye exam at onset of diagnosis, annually thereafter, and more frequently if progression of retinopathy is noted (32).

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.

To help manage this population, Humana Military launched the diabetes disease management program mid 2007. This program monitors beneficiary compliance with A1C, eye screening exams, medication, diet, and many other factors influencing diabetics.

The disease management nurse reviews beneficiary compliance and monitors trends and biometric data. The nurse uses each contact to educate the beneficiary on identified problems and works toward mutually agreed upon goals. Using resources approved by the DoD, the nurse provides guidance on medication adherence, long term effects of the disease, signs and symptoms, when to call the doctor and questions to ask. Healthy lifestyle changes such as good nutrition, exercise, and smoking cessation are encouraged.

Data Parameters and Limitations

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. In addition to claims data, we now include pharmacy data in our evaluation of this indicator. We do not include care rendered in the MTF.
MEASURES OF HEALTH CARE QUALITY

In 2006, NCQA significantly changed their methodology for identifying “medical attention for nephropathy”; appreciably increasing the mean benchmark. We have adjusted our criteria to closely emulate the NCQA HEDIS® criteria. Many of the screening elements can only be identified through medical record review. As our data only reflect claims and pharmacy information, the NCQA benchmark is not entirely applicable to Humana Military findings.

Adherence to Diabetic Indicators of Care

<table>
<thead>
<tr>
<th>Preventive Indicator</th>
<th>2005 Adherence</th>
<th>2006 Adherence</th>
<th>2007 Adherence</th>
<th>2008 Adherence</th>
<th>2008 MHSPHP</th>
<th>NCQA Mean Rate</th>
<th>NCQA 25th and 75th Percentiles</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eye Screening</td>
<td>N/A*</td>
<td>36.4%</td>
<td>39.4%</td>
<td>39.1%</td>
<td>N/A</td>
<td>39.3%</td>
<td>31.3% – 46.5%</td>
</tr>
<tr>
<td>A1C</td>
<td>76.5%</td>
<td>73.0%</td>
<td>73.2%</td>
<td>72.9%</td>
<td>77.8%</td>
<td>83.2%</td>
<td>79.5% – 88.1%</td>
</tr>
<tr>
<td>LDL-C</td>
<td>79.4%</td>
<td>81.4%</td>
<td>81.7%</td>
<td>81.7%</td>
<td>N/A</td>
<td>78.6%</td>
<td>73.7% – 83.8%</td>
</tr>
<tr>
<td>Attention for Nephropathy</td>
<td>N/A</td>
<td>N/A</td>
<td>71.6%</td>
<td>72.1%</td>
<td>N/A</td>
<td>71.3%</td>
<td>61.7% – 81.0%</td>
</tr>
</tbody>
</table>

*Change in our methodology renders 2005, 2006 comparison not applicable.

Rates for LDL-C and attention for nephropathy are above the NCQA mean for the South Central Region. Eye screening is slightly below the NCQA mean rate. Screening for A1C remains below benchmark. To address this indicator, Humana Military, in collaboration with the TRICARE Regional Office South, will implement an additional quality improvement initiative in 2009 to notify beneficiaries in need of A1C screening.

Heart Failure

Heart Failure (HF) is one of the major chronic medical conditions in the U.S. According to the National Heart, Lung, and Blood Institute, the prevalence of HF in the United States is approximately five 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 (35).

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, fatigue, and swelling (36, 37).

One of the mainstays in managing HF is the use of medications called angiotensin converting enzyme inhibitors (ACEI) and angiotensin II receptor blockers (ARBs). These drugs have been shown to reduce morbidity and mortality in HF (38, 39, 40, 41).

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 (42). Vaccinations against flu and pneumonia help prevent these illnesses. 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\textsuperscript{(43)}. 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.

Persons enrolled in the Humana Military HF disease management (DM) program are surveyed for use of ACEI or ARB and vaccination for flu and pneumonia. Each disease management nurse interaction with the beneficiary offers an opportunity for education.

\textbf{Data Parameters and Limitations}

The percentage of Network Prime enrolled beneficiaries with a diagnosis of HF, ages 18 - 64, who were dispensed a prescription of ACEI or ARB (based on pharmacy data obtained from the PDTS file). Research could find no national rate of use for ACEI or ARB for persons with HF. The Joint Commission found 85.6\% of patients discharged from a hospital with HF had a written prescription for an ACEI or an ARB\textsuperscript{(44)}. An article in the Journal of the American College of Cardiology, found only 81\% of patients with HF, discharged with a written prescription for an ACEI or ARB, had their prescription filled\textsuperscript{(45)}. This translates to approximately 69\% of HF patients discharged from a hospital who actually filled a prescription. Our data reflects actual prescriptions filled for all Prime enrolled beneficiaries with a diagnosis of HF.

The estimated national rate most likely reflects a higher acuity of HF as these patients were discharged from a hospital. Our rate reflects all Prime enrolled beneficiaries with a diagnosis of HF who had a prescription filled; their acuity level is most likely lower as it includes persons not admitted to the hospital.

\begin{table}[h]
\centering
\begin{tabular}{|c|c|c|c|c|}
\hline
 & 2005 Adherence & 2006 Adherence & 2007 Adherence & 2008 Adherence & Estimated National Rate \\
\hline
HF - ACEI & N/A & N/A & 68.7\% & 64.8\% & 69.3\% \\
\hline
\end{tabular}
\caption{Adherence to ACEI/ARB}
\end{table}

\textbf{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\textsuperscript{(46)}. Achieving good control, to decrease morbidity and mortality, is the primary goal of asthma treatment\textsuperscript{(47)}.

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. Asthma accounts for almost 13 million days missed from school and over 10 million work days missed among adults\textsuperscript{(46, 48)}. 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 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; preferably, inhaled corticosteroids. These medications are effective because they reduce the inflammation associated with asthma. Additionally, development of a written action plan between the health care provider and the patient should be an integral part of asthma management\textsuperscript{(49)}.

Humana Military implemented a disease management program for asthma in September 2006. One of the
mainstays of asthma treatment is to control the symptoms. When Humana Military 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 Humana Military asthma disease management program that receive recommended care for spirometry testing, use of an action plan, and use of long term controller medication during calendar year 2008.

<table>
<thead>
<tr>
<th>Measure*</th>
<th>Baseline</th>
<th>Post-enrollment</th>
<th>Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008 Humana Military Asthma Program Spirometry Testing Rate</td>
<td>73.2%</td>
<td>78.1%</td>
<td>N/A</td>
</tr>
<tr>
<td>2008 Humana Military Asthma Program Action Plan Adherence</td>
<td>26.5%</td>
<td>42.8%</td>
<td>N/A</td>
</tr>
<tr>
<td>2008 Humana Military Asthma Program Long Term Controller Rx Use</td>
<td>60.1%</td>
<td>98.3%</td>
<td>N/A</td>
</tr>
</tbody>
</table>

*These data are beneficiary self-reported

**Patient Safety: Adverse and Never Events and Monitoring of Select Procedures**

**Adverse and Never Events**

Patient safety is defined by the IOM as “avoiding injuries to patients from care that is intended to help them” (1). In 2000, the IOM identified medical errors as the eighth 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 (50).

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 inaccuracies, and system failures (50).

The Centers for Medicare and Medicaid Services (CMS) is exploring ways to reduce and prevent serious, costly medical errors - Never Events. The National Quality Forum (NQF) defines Never Events as “errors in medical care that are clearly identifiable, preventable, and serious in their consequences for patients, and that indicate a real problem in the safety and credibility of a health care facility” (51). Beginning October 2008, CMS stopped paying for care involving eight identified Never Events that are not present on admission. The identified list includes (52):

- Object inadvertently left in after surgery
- Air embolism
- Blood incompatibility
- Catheter associated urinary tract infection
- Pressure ulcer
- Vascular catheter associated infection
MEASURES OF HEALTH CARE QUALITY

- Mediastinitis after coronary artery bypass graft surgery
- Certain types of falls and trauma

For this Report Card, Humana Military has chosen to report on seven of the eight CMS Never Events; additionally, we report on accidental punctures and lacerations. Although Humana Military monitors for falls within a facility, CMS acknowledges there is no method to accurately code claims data for this measure and that falls may or may not be preventable. Therefore, we have elected not to report on this measure.

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 idea that some punctures are not preventable, for example during laparoscopic procedures.

Data Parameters and Limitations
Network Prime enrolled beneficiaries, ages 18 - 64, discharged from a hospital with a diagnosis identifying accidental puncture. The AHRQ incidence includes those over age 64. Rates are expressed per 100,000 per year.

Humana Military Accidental Puncture Rate = 38.6
AHRQ Incidence (Version 3.1-March 2007) (53) = 47.9

Infections Related to Medical Care
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 diagnosis field on a claim form. The AHRQ incidence includes those over age 64. Rates are expressed per 100,000 per year.

Humana Military Medical Care Infection Rate = 2.4
AHRQ Incidence (Version 3.1- March 2007) (53) = 30.8

Retained Foreign Body
This indicator monitors the number of discharges from an inpatient facility with a foreign body; e.g., a retained sponge, 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. The AHRQ incidence includes those over age 64. Rates are expressed per 100,000 per year.

Humana Military Foreign Body Rate = 0.3
AHRQ Incidence (Version 3.1- March 2007) (53) = 1.5

Mediastinitis Following CABG
Mediastinitis is a rare but serious, preventable infection that may occur following...
coronary artery bypass graft (CABG) surgery. Significant morbidity and cost are associated with this complication, as well as a negative impact on long-term survival that is unrelated to the patient’s condition prior to surgery. This indicator monitors the number of discharges from an inpatient facility with a diagnosis of mediastinitis following a CABG procedure.

**Data Parameters and Limitations**
Network Prime enrolled beneficiaries with a discharge from a hospital with select diagnostic codes for mediastinitis following CABG in any secondary diagnosis field on a claim form. This measure applies to persons age 18 - 64. Although research could find no national incidence rate, a large study has shown the percentage of patients identified with mediastinitis following CABG is approximately 1.3%.

**Humana Military Mediastinitis Rate**

\[
\text{Mediastinitis Rate per CABG procedure} = 1.3\%
\]

**Air Embolism**
An air embolism is the introduction of air into a blood vessel following surgery, which can be life-threatening. Air embolism is referred to as a serious reportable event which should not be expected to occur during a hospital admission. This indicator monitors the number of discharges from an inpatient facility identified with an air embolism following a surgical procedure.

**Data Parameters and Limitations**
Network Prime enrolled beneficiaries with a discharge from a hospital with select diagnostic codes for air embolism in any secondary diagnosis field on a claim form. This measure applies to persons age 18 - 64. Research found no national incidence rate. Per CMS, this event is extremely rare; in FY2006, there were only 45 reported cases among Medicare patients. Rates are expressed per 100,000 per year.

**Humana Military Air Embolism Rate**

\[
\text{CMS Air Embolism Rate} = 0
\]

(45 incidents per yr / 39,210,604 Medicare beneficiaries)

**Blood Incompatibility**
AHRQ defines transfusion reaction as a reaction to blood or blood by-products after a blood transfusion. Reactions, due to hypersensitivity, occur in one to two percent of transfusions. However, reactions also occur as a result of errors on the part of health care workers in the administration of blood products or in the process of cross-matching the blood. To minimize the chance of an adverse reaction during a transfusion, health care practitioners take precautions such as cross-matching, to ensure the blood is compatible.

**Data Parameters and Limitations**
Network Prime enrolled beneficiaries with a discharge from a hospital with select diagnostic codes for transfusion reaction in any secondary diagnosis field on a claim form. This measure applies to persons age 18 - 64. AHRQ incidence includes those over age 64. Rates are expressed per 100,000 per year.

**Humana Military Blood Incompatibility Rate**

\[
\text{AHRQ Incidence (Version 3.1- March 2007)} = 0.1
\]

**Catheter Associated UTI**
Many hospitalized patients require the placement of an indwelling urinary catheter. Although a minority of these patients develop urinary tract infections (UTI), the frequency of use of urinary catheters produces
substantial overall morbidity \(^{(59)}\). This indicator monitors the number of discharges from an inpatient facility with a diagnosis of catheter associated UTI.

**Data Parameters and Limitations**
Network Prime enrolled beneficiaries with a discharge from a hospital with select diagnostic codes for catheter associated UTI. This measure applies to beneficiaries age 0 - 64. CDC incidence of 564,667 in FY 2002 includes those over age 64 \(^{(60)}\). Rates are expressed per 100,000 per year.

\[
\text{Humana Military Catheter Associated UTI Rate} = 0.5 \\
\text{CDC Catheter Associated UTI Rate} = 194.7 \\
\text{(564,667 incidents per year/ 2002 U.S. population 288,368,698 \(^{(61)}\))}
\]

**Pressure Ulcers**
Pressure ulcers, or decubitus ulcers, occur when the blood supply is diminished to the skin. Most pressure ulcers, about 95%, occur in the more vulnerable bony areas of the lower body, such as the tailbone and heels. This indicator monitors the number of discharges from an inpatient facility with a third or fourth degree pressure ulcer acquired in a facility \(^{(62)}\).

**Data Parameters and Limitations**
Using AHRQ criteria, we measure Network Prime enrolled beneficiaries, ages 0 - 64, discharged from a hospital with select diagnostic codes for third and fourth degree pressure ulcer. Rates are expressed per 100,000 per year.

\[
\text{Humana Military Pressure Ulcer Rate} = 1.0 \\
\text{CMS Pressure Ulcer Rate} \(^{(55)}\) = 733.9 \\
\text{(322,946 incidents per year/39,210,604 Medicare Beneficiaries \(^{(56)}\))}
\]

**Summary of Adverse and Never Event Rates**

<table>
<thead>
<tr>
<th>Event</th>
<th>Age Range</th>
<th>National Incidence Rate</th>
<th>Humana Military Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accidental Puncture</td>
<td>18 - 64</td>
<td>47.9</td>
<td>38.6</td>
</tr>
<tr>
<td>Infection due to Medical Care</td>
<td>0 - 64</td>
<td>30.8</td>
<td>2.4</td>
</tr>
<tr>
<td>Foreign Body</td>
<td>18 - 64</td>
<td>1.5</td>
<td>0.3</td>
</tr>
<tr>
<td>Mediastinitis</td>
<td>18 - 64</td>
<td>1.25</td>
<td>0.0</td>
</tr>
<tr>
<td>Air Embolism</td>
<td>18 - 64</td>
<td>0.12</td>
<td>0.0</td>
</tr>
<tr>
<td>Blood Incompatibility</td>
<td>18 - 64</td>
<td>0.1</td>
<td>0.0</td>
</tr>
<tr>
<td>UTI Infection</td>
<td>0 - 64</td>
<td>194.7</td>
<td>0.5</td>
</tr>
<tr>
<td>Pressure Ulcer</td>
<td>0 - 64</td>
<td>733.9</td>
<td>1.0</td>
</tr>
</tbody>
</table>

Humana Military compares favorably to benchmark incidence rates for all events studied; our patient safety measures are substantially better than national rates.
MEASURES OF HEALTH CARE QUALITY

Select Procedures

Coronary Artery Bypass Graft
Coronary Artery Bypass Graft 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 (53).

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 (64). 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; errors related to technical skill may cause myocardial infarction, stroke, or death (65). Therefore, this measure should also assess the number of deaths per 100 discharges for a CABG.

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, we measure the percent discharged with a status of death. The CABG rate is per 100,000 population; CABG death rate is per 100 CABG procedures. Of note, the AHRQ incidence includes adults over age 64.

Rates are expressed per 100,000 per year.

Humana Military CABG Rate = 134.81
AHRQ Incidence (Version 3.1- March 2007) (53) = 234.59

Humana Military CABG Death Rate = 1.80 per 100 procedures
AHRQ Incidence (Version 3.1- March 2007) (53) = 3.07 per 100 procedures

Cholecystectomy
Nationally, seventy-five percent of uncomplicated cholecystectomies (gallbladder removal) are performed laparoscopically with a steady upward trend. Laparoscopic cholecystectomy, for symptomatic gallstones, is the gold standard for removal of the gallbladder and has proven to be more cost effective than an open procedure. 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 (66, 67, 68).

Humana Military monitors the percentage of all cholecystectomies performed as closed (laparoscopic) procedures. The desired outcome is a high proportion of closed cholecystectomy 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.

Humana Military Number Open Cholecystectomy = 122 procedures
Humana Military Number Closed Cholecystectomy = 2381 procedures
Humana Military Closed Cholecystectomy Rate = 95.13 per 100 procedures
AHRQ Incidence (Version 3.1-March 2007) (53) = 77.41 per 100 procedures
Hysterectomy
One-third of women in the U.S. have had hysterectomies by the age of 60 (69). 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 (70). Use of this technique generally reduces the complication rate, length of stay, and time to return to normal activity (71). Hysterectomy, as with any surgery, involves risk and possible long-term complications. 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% (72). There is a potential for overuse of this procedure.

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 the need (73, 74).

**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 members per year.

<table>
<thead>
<tr>
<th>Humana Military Vaginal Hysterectomy Rate age (15-44)</th>
<th>= 3.32</th>
</tr>
</thead>
<tbody>
<tr>
<td>NCQA QC 2008 mean Benchmark South Central Region (9)</td>
<td>= 3.84</td>
</tr>
<tr>
<td>NCQA QC 25th and 75th percentiles</td>
<td>= 2.91-4.57</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Humana Military Vaginal Hysterectomy Rate ages (45-64)</th>
<th>= 2.35</th>
</tr>
</thead>
<tbody>
<tr>
<td>NCQA QC 2008 mean Benchmark South Central Region (9)</td>
<td>= 3.38</td>
</tr>
<tr>
<td>NCQA QC 25th and 75th percentiles</td>
<td>= 2.74-4.02</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Humana Military Abdominal Hysterectomy Rate ages (15-44)</th>
<th>= 5.07</th>
</tr>
</thead>
<tbody>
<tr>
<td>NCQA QC 2008 mean Benchmark South Central Region (9)</td>
<td>= 5.24</td>
</tr>
<tr>
<td>NCQA QC 25th and 75th percentiles</td>
<td>= 4.29-6.36</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Humana Military Abdominal Hysterectomy Rate ages (45-64)</th>
<th>= 5.25</th>
</tr>
</thead>
<tbody>
<tr>
<td>NCQA QC 2008 mean Benchmark South Central Region (9)</td>
<td>= 5.90</td>
</tr>
<tr>
<td>NCQA QC 25th and 75th percentiles</td>
<td>= 5.16-6.56</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age</th>
<th>Hysterectomies</th>
<th>Female Population</th>
<th>Rate/1000/yr</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Abdominal</td>
<td>Vaginal</td>
<td></td>
</tr>
<tr>
<td>15-44</td>
<td>690</td>
<td>452</td>
<td>8.40</td>
</tr>
<tr>
<td>45-64</td>
<td>556</td>
<td>249</td>
<td>7.60</td>
</tr>
<tr>
<td>Subtotal</td>
<td>1,246</td>
<td>701</td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>1,947</td>
<td>241,853</td>
<td>8.05</td>
</tr>
</tbody>
</table>

A recent article published in *Clinical Obstetrics and Gynecology* shows the rate of hysterectomy differs markedly by geographic region; with a rate as high as nine per thousand per year in the Southern U.S.(73). Our overall rate of hysterectomy of 8.05 per 1,000 per year, is below the rate reported for the Southern U.S.
Back Procedures

Spinal procedures have significantly advanced in recent years, from disc reduction procedures to more complex spinal reconstruction and stabilization procedures. Back procedure use, including laminectomy, shows wide variation between regions and has a potential for overuse. According to the National Quality Measures Clearinghouse, several studies have shown approximately 23 to 38% of laminectomies were performed for inappropriate indications (75). 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 20 - 64 with a procedure code for back procedures as defined by NCQA HEDIS® criteria (6). For calendar year 2007, NCQA significantly changed the methodology for calculating this indicator; this change, which eliminated numerous procedure codes, appreciably reduced the rate for this indicator. Rates are expressed per 1,000 members per year.

Humana Military Back Procedures (F 20-44) = 2.71
NCQA QC 2008 mean Benchmark South Central Region (9) = 3.13
NCQA QC 25th and 75th percentiles = 2.54-3.77

Humana Military Back Procedures (F 45-64) = 6.91
NCQA QC 2008 mean Benchmark South Central Region (9) = 6.46
NCQA QC 25th and 75th percentiles = 5.21-7.60

Humana Military Back Procedures (M 20-44) = 4.56
NCQA QC 2008 mean Benchmark South Central Region (9) = 3.02
NCQA QC 25th and 75th percentiles = 2.64-3.67

Humana Military Back Procedures (M 45-64) = 6.89
NCQA QC 2008 mean Benchmark South Central Region (9) = 6.37
NCQA QC 25th and 75th percentiles = 5.56-7.43

Our rates for back procedures are below benchmarks or within the 25th and 75th percentiles for all females and males ages 45 - 64. Our rate for back procedures for males between the ages of 20 – 44 is above the 75th percentile and may represent an opportunity for improvement.

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. (76). 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 (77, 78). 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 beneficiary adults age 0 - 19 with a procedure code for ear procedures as defined by NCQA HEDIS® measures (6). Rates are expressed per 1,000 members per year.

Humana Military Ear Procedure Rate Ages 0-4 = 44.64
NCQA QC 2008 mean Benchmark South Central Region (9) = 85.46
**MEASURES OF HEALTH CARE QUALITY**

*NCQA QC 25th and 75th percentiles*  
= 67.92-104.89

**Humana Military Ear Procedure Rate Ages 5-19**  
= 3.17

*NCQA QC 2008 mean Benchmark South Central Region* \((^9)\)  
= 4.87

*NCQA QC 25th and 75th percentiles*  
= 4.04-5.95

Our rates of ear procedures are favorable to benchmarks.

**Summary of Monitoring Select Procedures**  
2008

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Age Range</th>
<th>Gender</th>
<th>Benchmark*</th>
<th>Humana Military Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>CABG</td>
<td>40 - 64</td>
<td>All</td>
<td>278.8</td>
<td>134.8</td>
</tr>
<tr>
<td>CABG death rate</td>
<td>40 - 64</td>
<td>All</td>
<td>3.4</td>
<td>1.8</td>
</tr>
<tr>
<td>Cholecystectomy Closed Rate/100 total</td>
<td>18 - 64</td>
<td>All</td>
<td>75.6</td>
<td>95.1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Age Range</th>
<th>Gender</th>
<th>Mean Benchmark**</th>
<th>Humana Military Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hysterectomy/Vag</td>
<td>15 - 44</td>
<td>F</td>
<td>3.84</td>
<td>3.32</td>
</tr>
<tr>
<td>Hysterectomy/Vag</td>
<td>45 - 64</td>
<td>F</td>
<td>3.38</td>
<td>2.35</td>
</tr>
<tr>
<td>Hysterectomy/Abd</td>
<td>15 - 44</td>
<td>F</td>
<td>5.24</td>
<td>5.07</td>
</tr>
<tr>
<td>Hysterectomy/Abd</td>
<td>45 - 64</td>
<td>F</td>
<td>5.9</td>
<td>5.25</td>
</tr>
<tr>
<td>Back Surgery</td>
<td>20 - 44</td>
<td>F</td>
<td>3.13</td>
<td>2.71</td>
</tr>
<tr>
<td>Back Surgery</td>
<td>45 - 64</td>
<td>F</td>
<td>6.46</td>
<td>6.91</td>
</tr>
<tr>
<td>Back Surgery</td>
<td>20 - 44</td>
<td>M</td>
<td>3.02</td>
<td>4.56</td>
</tr>
<tr>
<td>Back Surgery</td>
<td>45 - 64</td>
<td>M</td>
<td>6.37</td>
<td>6.89</td>
</tr>
<tr>
<td>Ear Procedures</td>
<td>0 - 4</td>
<td>All</td>
<td>85.46</td>
<td>44.64</td>
</tr>
<tr>
<td>Ear Procedures</td>
<td>5 - 19</td>
<td>All</td>
<td>4.87</td>
<td>3.17</td>
</tr>
</tbody>
</table>

*Benchmark = AHRQ  
**Benchmark = NCQA

Humana Military has a favorable comparison to benchmarks in rates of CABG, CABG mortality, percent of cholecystectomies performed laparoscopically, hysterectomy, and ear procedure rates. Our rate of back surgery in younger men is above the 75th percentile.

**Provider Network**

**Network Adequacy**

It is Humana Military’s 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 scope 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 time standards.

The chart above depicts the relative size of our beneficiary population and provider network density. Although our beneficiary population has remained relatively stable, our provider participation in the TRICARE network has increased year over year in the South Region.

**Provider Credentialing**

Credentialing is the process of obtaining and reviewing the documentation (licensure, education, certifications, malpractice insurance, etc.) of health professionals to validate their qualifications. 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 Humana Military Credentialing Committee for determining initial and ongoing participation in the network.

Humana Military providers are credentialed in accordance with URAC Health Network Standards, Version 5.0, as well as TRICARE and Humana, Inc. requirements. Humana Military monitors potential provider issues, such as access, attitude, and quality of care. To ensure quality networks, the Clinical Quality Management Department works in conjunction with the Credentialing Department to evaluate providers identified with issues.

During 2008, Humana Military delegated authority to credential and recredential a portion of providers to 90 contracted groups. All delegated groups are audited on-site annually in order to determine their continued ability to perform credentialing and recredentialing in accordance with Humana Military standards.

**2008 Credentialing**

<table>
<thead>
<tr>
<th>Action Type</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initially Credentialed</td>
<td>4,667</td>
<td>6,194</td>
<td>6,379</td>
<td>7,333</td>
</tr>
<tr>
<td>Recredentialed</td>
<td>5,557</td>
<td>7,261</td>
<td>9,268</td>
<td>9,431</td>
</tr>
</tbody>
</table>

Increased provider participation in the TRICARE network directly impacts credentialing activities. Credentialing and recredentialing activities have increased year over year, ensuring a robust and quality
Managing Cost

According to the National Coalition on Health Care (NCHC), health care costs are rising at twice the rate of inflation for other goods and services and are expected to continue to rise over the next ten years (79). Factors contributing to this rapid rise are new technology and drugs coupled with increased utilization due to aging baby boomers, demand for new treatments and testing, and challenges caused by lifestyles, such as obesity, substance abuse, and sedentary routines (80). Factors unique to the military health system compounding the cost trend are migration of the population to Network Prime, decrease in MTF Prime, and continuing shift of services out of MTFs in response to the stresses on the military health system.

Each year, Humana Military works with the government to formulate a cost target for managing health care. 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. Although costs continue to rise, Humana Military has limited the percent increase from year to year. The annual per member per month (PMPM) percent increase from calendar year 2006 to 2007 was 11.8%, down from 14.2% the year before. This year we again noted a decrease in trend; the PMPM increase from 2007 to 2008 was 9.5%. The graph below illustrates the incurred claims PMPM for the calendar years 2006, 2007, and 2008.
Customer Satisfaction and Service

Humana Military is committed to beneficiary and customer satisfaction. Humana Military measures numerous customer interactions that allow us to understand and evaluate 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 overall customer satisfaction. These efforts allow Humana Military to focus on the needs of beneficiaries.

Measuring Customer Satisfaction

Humana Military provides opportunities for beneficiaries to provide feedback. One is a survey located on the Humana Military web site. The survey is voluntary and can be utilized when beneficiaries interact with Humana Military. 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, detailed on the previous page, reflect consumer satisfaction. In 2008, there were 12,460 respondents.

<table>
<thead>
<tr>
<th>Question</th>
<th>2006 Annual Weighted Average</th>
<th>2007 Annual Weighted Average</th>
<th>2008 Annual Weighted Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>I would recommend my TRICARE health plan to a friend.</td>
<td>3.97</td>
<td>4.05</td>
<td>4.13</td>
</tr>
<tr>
<td>I am able to get the health care I need.</td>
<td>3.90</td>
<td>3.93</td>
<td>3.99</td>
</tr>
<tr>
<td>My doctor's staff is helpful.</td>
<td>4.04</td>
<td>4.04</td>
<td>4.07</td>
</tr>
<tr>
<td>When contacting Humana Military, I am able to get the information I need</td>
<td>3.80</td>
<td>3.72</td>
<td>3.92</td>
</tr>
</tbody>
</table>

Customer satisfaction improved in 2008, reflected by an increase in scores for all survey questions.

Meeting and Exceeding Beneficiary Service Standards

In 2008 Humana Military has continuously been close, met, or exceeded the standards pertaining to beneficiary services. Telephone metrics such as answer speed, hold time, abandonment rate (disconnected calls), and follow-up calls (questions not answered will have a follow up call within two working days) met or exceeded standards in 2008. Humana Military 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. Additionally, the TSC standard of 100% of walk in inquiries acknowledged within ten minutes was continuously met throughout 2008.

Below we present the rate for call answer timeliness.

**Data Parameters and Limitations**

All calls answered through the Humana Military enterprise 1-800 numbers for calendar year 2008. Numerator is all calls not exceeding 30 second hold time. Total hold time begins when the caller makes a selection and the automated response unit places the caller on hold if the selection is not readily available.

- **Humana Military Call Answer Timeliness** = 97.70
- **NCQA QC 2008 mean Benchmark South Central Region** = 79.92
- **NCQA QC 25th and 75th percentiles** = 79.76-82.93

Humana Military consistently exceeds South Central Region mean benchmark for call answer timeliness.

**Call Quality Monitoring Process**

The Call Quality Monitoring Process was established by our call center leadership to ensure Humana Military provides exceptional customer service to our beneficiaries and providers. This process evaluates accuracy, tone, clarity, and responsiveness; provides an opportunity to give 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 Humana Military and the TRICARE Regional Office - South (TRO-South), Humana Military invited representatives from TRO-South to participate in call calibration sessions starting in November 2005. This process was formalized in Jan 2006. Participation in these sessions has given TRO-South the opportunity to evaluate the Humana Military call center scoring criteria, offer perspective into the customer experience, and provide a third party scoring mechanism through call calibration. Humana Military has established a formal process to capture the variance in scoring between Humana Military 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 Humana Military and TRO-South evaluators identifies opportunities to improve customer service and this feedback provides educational opportunities for associates.

The graph on the following page represents 2008 data.
As illustrated in the above graph, the Call Monitoring Process shows consistently low disagreement in scoring between Humana Military and TRO-South.

**URAC Accreditation**

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.

Humana Military continues to maintain URAC accreditation in Health Network; Health Utilization Management; HIPAA Privacy; Case Management; Disease Management, Heart Failure, and Asthma; and for the Humana Military Health Web Site, www.humana-military.com. By applying for and receiving these accreditations, Humana Military has demonstrated a commitment to quality health care. Charles Stellar, URAC Board Chairman stated “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.”

**Good News Stories**

**Contact Center World Names Two Humana Military Healthcare Services’ Associates as Winners in World Awards**

Two Humana Military associates received honors at the 2008 Contact Center World Awards held December 2-4, 2008 in Las Vegas, Nevada. Named “Best Support Professional for IT in the Americas,” Humana Military’s Director of Customer Service Systems also received the Silver in the World Awards.
In addition, the Director of Beneficiary Services, named “Best Contact Center Leader in the Americas,” brought home the Bronze in the World Awards. This prestigious awards program recognizes professionals making significant contributions to the overall success of their contact center and organization.

Delegates at the Contact Center’s World Awards completed a written submission to be judged by their peers and presented to the conference delegates, setting it apart from other awards programs of its kind. Representatives from over 22 countries attended to learn from the very best in the call center industry.

Contact Center World is a global support organization for contact centers. They have extensive experience in the industry and strive to provide fast access to the latest industry information so that executives can make informed business decisions within their contact center.

Humana Military and the Valero Texas Open Announce Partnership to “Honor Our Heroes”

In October 2008 Humana Military partnered with the Military Warrior Support Foundation (MWSF) and Golf San Antonio to honor service members recovering from illness or injury, at the Valero Texas Open in San Antonio. Through this relationship, a Warrior Hospitality Suite accommodated approximately 75 injured warriors and their families each day of the tournament.

Golf is a popular game among many service members and gives Humana Military the opportunity to thank our veterans and support our military while providing them with a memorable experience and quality of life outings during their recovery process,” said Dave Baker, President and CEO of Humana Military. “For some of these heroes, it is a once-in-a-lifetime opportunity to attend a PGA TOUR event and we are excited to be a part of it.”

The event gave injured warriors and their families the opportunity to visit with PGA tour players, senior Department of Defense officials, Lt. Gen (ret) Leroy Sisco and other military leaders.

MinuteClinics Offer Innovative Services for South Region TRICARE Beneficiaries

In the fall of 2008, Humana Military announced an innovative service available to beneficiaries. The addition of MinuteClinics to the Humana Military network increased access for TRICARE beneficiaries, while providing services in a timely and convenient setting. The clinics are located in Florida, Georgia, Oklahoma, South Carolina, Tennessee, and Texas.

MinuteClinic health care centers are located inside CVS pharmacies and staffed by board-certified nurse practitioners specializing in family health care, with physician oversight. They are trained to diagnose, treat and write prescriptions for common illnesses and provide vaccinations. In addition, the clinics administer a series of wellness services designed to help beneficiaries identify lifestyle changes needed to improve their current and future health. Beneficiaries are able to receive services that are TRICARE covered benefits.

“We are excited to offer our beneficiaries this new resource in obtaining accessible health care services,”
said Dave Baker, President and CEO of Humana Military. “MinuteClinic is aligned with our mission of delivering high quality and cost effective health care. We are confident the clinics will provide convenience and quality care in a timely manner to our beneficiaries.”

**Humana Military and Atlanta’s Shepherd Center Partner to Complement Care for Wounded U.S. Military Members Who Served in Iraq and Afghanistan**

In late 2008, Humana Military and the Shepherd Center, an Atlanta-based hospital specializing in the medical care and rehabilitation of people with spinal cord and brain injuries, announced a partnership with Home Depot co-founder Bernie Marcus. This partnership assists military service members wounded in Operation Iraqi Freedom and Operation Enduring Freedom, as well as their families, in obtaining additional care that will aid in their recovery from combat related injuries.

The SHARE Initiative began in January 2008. SHARE’s vision is to enrich the hope and recovery for wounded men and women of the military. The partnership with Shepherd Center, (one of the nation’s leading rehabilitation hospitals), will provide health care that may not be covered by TRICARE or other health insurance. Services may include specialized rehabilitation and community reintegration for spinal cord or TBI survivors who sustained injuries while serving in Iraq and Afghanistan.

“Humana Military is pleased to be a part of this initiative,” said Dave Baker, President and CEO of Humana Military. “The courageous men and women of the military deserve the finest of care when they return home with injuries. I am happy we are partnering with Mr. Marcus and the Shepherd Center to complement the quality care they are already receiving.”

**New Features Available on the Web to Assist Service Members and Families**

In August 2008 ValueOptions, Inc., the South Region subcontractor for behavioral health, and Humana Military announced new educational features on the AchieveSolutions® behavioral health portal at www.humana-military.com. AchieveSolutions®, a web-based behavioral health care tool developed by ValueOptions, offers South Region beneficiaries a private, safe environment to seek information, educational materials and self-assessment tools on behavioral health, addiction and recovery, life events, and daily living skills. New enhancements to the site included: Life Manager, Teen Life, and Suicide Awareness videos.

*Life Manager* is a web-based instrument bringing together TRICARE resources, benefit information, and services to assist members and their families with their individual needs. This tool helps beneficiaries assess mood, focus on concerns, and identify solutions to life’s challenges. *Teen Life* provides a variety of tools and resources to help teens and their parents tackle challenging life issues.

*A beneficiary called to compliment a Beneficiary Service Representative who was "very helpful, pleasant, and informative". The caller also wanted to compliment Humana Military for the service we provide. Every time she calls she speaks with someone who gives correct information, gets the job done, and always seems pleased to speak with her.*
Limitations of Data and Conclusion

Limitations of Data
Although the gold standard for review for quality of care indicators 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 health care plans covering large geographic areas; medical records are difficult to access and costly to obtain and review (81). Administrative data are frequently used to evaluate guidelines and the quality of health care (82). A large study conducted at Johns Hopkins University found use of administrative claims data an effective method for measuring quality indicators (83).

The indicators in the 2008 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. 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, Humana Military compares favorably with accepted standards for those indicators measured in the 2008 Report Card. In many measures we exceed nationally or regionally accepted rates.

- Humana Military takes a proactive approach to preventive services through use of the HAL program, which notifies beneficiaries of needed services and monitors results. Humana Military initiated monitoring for colorectal cancer through our HAL program; our rate has increased significantly from 2007 to 2008. Our influenza immunization rate increased appreciably as has our cholesterol screening rate. Our breast cancer screening rate has increased slightly. Our cervical cancer screening rate has decreased minimally, consistent with national norms.
- Rates for LDL-C, eye screening, and attention for nephropathy in diabetics are at or above the national mean. Screening for A1C in diabetics remains below benchmark and offers an opportunity for improvement. To address this

A beneficiary called to compliment a Beneficiary Service Representative (BSR) on an outstanding job. The BSR took the time to help; spent an hour on the phone helping the beneficiary resolve a referral issue for his daughter who has a tumor. The BSR utilized all available resources. The beneficiary who called was very emotional; to the point of having trouble speaking because of the relief he felt at the end of his call.
Humana Military will implement a quality improvement initiative in 2009.

- Adverse events and patient safety indicators have remained stable and below the national norms, as has utilization for select procedures. Our rate of back procedures in younger males is higher than the national norm, which may present an opportunity to improve care.
- Our provider network is robust and continues to grow.
- Customer satisfaction has improved year over year, reflected by overall increase in scores for survey questions.
- Our year over year cost trend declined in 2008.
Beneficiary stated to the Disease Management nurse that the Heart Failure program has helped him through a rough time and he is glad to be a part of the program. He is keeping follow up visits with his cardiologist and is compliant with all medications.

<table>
<thead>
<tr>
<th>Preventive Service*</th>
<th>Benchmark</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast Cancer Screening</td>
<td>64.5%</td>
<td>56.7%</td>
<td>61.9%</td>
<td>61.9%</td>
<td>62.3%</td>
</tr>
<tr>
<td>Cervical Cancer Screening</td>
<td>73.4%</td>
<td>49.4%</td>
<td>61.4%</td>
<td>63.9%</td>
<td>63.4%</td>
</tr>
<tr>
<td>Colorectal Cancer Screening</td>
<td>48.0%</td>
<td>24.0%</td>
<td>24.0%</td>
<td>37.7%</td>
<td>38.2%</td>
</tr>
<tr>
<td>Cholesterol Screening</td>
<td>67%</td>
<td>N/A</td>
<td>N/A</td>
<td>57.0%</td>
<td>63.3%</td>
</tr>
<tr>
<td>Influenza Immunizations</td>
<td>N/A</td>
<td>N/A</td>
<td>12.2%</td>
<td>14.8%</td>
<td>17.1%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Living with Illness</th>
<th>Benchmark</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes Care-Eye Screening</td>
<td>39.3%</td>
<td>N/A</td>
<td>36.4%</td>
<td>39.4%</td>
<td>39.1%</td>
</tr>
<tr>
<td>Diabetes Care-A1C</td>
<td>83.2%</td>
<td>76.5%</td>
<td>73.0%</td>
<td>73.2%</td>
<td>72.9%</td>
</tr>
<tr>
<td>Diabetes Care-LDL-C</td>
<td>78.6%</td>
<td>79.4%</td>
<td>81.4%</td>
<td>81.7%</td>
<td>81.7%</td>
</tr>
<tr>
<td>Diabetes Care-Nephropathy</td>
<td>71.3%</td>
<td>N/A</td>
<td>N/A</td>
<td>71.6%</td>
<td>72.1%</td>
</tr>
<tr>
<td>HF - ACEI &amp;/or ARB</td>
<td>69.3%</td>
<td>N/A</td>
<td>N/A</td>
<td>68.7%</td>
<td>64.8%</td>
</tr>
<tr>
<td>Asthma – Spirometry Testing</td>
<td>N/A</td>
<td>N/A</td>
<td>79.6%</td>
<td>85.5%</td>
<td>78.1%</td>
</tr>
<tr>
<td>Asthma – Action Plan</td>
<td>N/A</td>
<td>N/A</td>
<td>36.2%</td>
<td>46.9%</td>
<td>42.8%</td>
</tr>
<tr>
<td>Asthma – Long Term Controller Rx</td>
<td>N/A</td>
<td>N/A</td>
<td>81.5%</td>
<td>99.2%</td>
<td>98.3%</td>
</tr>
</tbody>
</table>

*These preventive services require 3 - 10 yr. data. This report reflects only 50 – 53 months of data; thus, our true rates are likely higher.
## SUMMARY TABLE OF INDICATORS

### Monitoring Patient Safety and Select Procedures

<table>
<thead>
<tr>
<th>Patient Safety</th>
<th>Incidence Rate*</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accidental Puncture</td>
<td>47.9</td>
<td>38.6</td>
</tr>
<tr>
<td>Infection due to Medical Care</td>
<td>30.8</td>
<td>2.4</td>
</tr>
<tr>
<td>Foreign Body</td>
<td>1.5</td>
<td>0.3</td>
</tr>
<tr>
<td>Mediastinitis</td>
<td>1.3</td>
<td>0.0</td>
</tr>
<tr>
<td>Air Embolism</td>
<td>0.1</td>
<td>0.0</td>
</tr>
<tr>
<td>Blood Incompatibility</td>
<td>0.1</td>
<td>0.0</td>
</tr>
<tr>
<td>UTI Infection</td>
<td>194.7</td>
<td>0.5</td>
</tr>
<tr>
<td>Pressure Ulcer</td>
<td>733.9</td>
<td>1.0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Select Procedures</th>
<th>Incidence*</th>
</tr>
</thead>
<tbody>
<tr>
<td>CABG death rate</td>
<td>3.07</td>
</tr>
<tr>
<td>Cholecystectomy Closed Rate/100</td>
<td>77.41</td>
</tr>
<tr>
<td>Hysterectomy/Vag age 15 - 44</td>
<td>3.84</td>
</tr>
<tr>
<td>Hysterectomy/Vag age 45 - 64</td>
<td>3.38</td>
</tr>
<tr>
<td>Hysterectomy/Abd age 15 - 44</td>
<td>5.24</td>
</tr>
<tr>
<td>Hysterectomy/Abd age 45 - 64</td>
<td>5.90</td>
</tr>
<tr>
<td>Back Procedures F ages 20 - 44</td>
<td>3.13</td>
</tr>
<tr>
<td>Back Procedures F ages 45 - 64</td>
<td>6.46</td>
</tr>
<tr>
<td>Back Procedures M ages 20 - 44</td>
<td>3.02</td>
</tr>
<tr>
<td>Back Procedures M ages 45 - 64</td>
<td>6.37</td>
</tr>
<tr>
<td>Ear Procedures – ages 0 - 4</td>
<td>85.46</td>
</tr>
<tr>
<td>Ear Procedures – ages 5 - 19</td>
<td>4.87</td>
</tr>
</tbody>
</table>

* Please see detailed discussions for units of measure.
References


REFERENCES


   Counter=3041&intNumPerPage=10&checkDate=&checkKev=&srcchType=1&numDays=3500&srchOpt=0&srchData=&keywordType=All&chkNewsType=1%2C2%2C3%2C4%2C+5&intPage=&showAll=&pYear=&year=&des=false&cboOrder=date.


REFERENCES


