Population Health: How to measure it, How to improve it

Matt Stiefel and Mike Dinneen
Adapted From IHI Presentation
The Triple Aim

- Population Health
- Readiness
- Experience of Care
- Per Capita Cost
## Potential Triple Aim Population Outcome Measures

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Measure</th>
</tr>
</thead>
</table>
| **Population Health**| 1. Health Outcomes:  
- Mortality: Years of potential life lost; Life expectancy; Standardized mortality rates  
- Health/Functional Status: single question (e.g. from CDC HRQOL-4) or multi-domain (e.g. SF-12)  

   Note: Healthy Life Expectancy (HLE) combines life expectancy and health status into a single measure, reflecting remaining years of life in good health  
| 2. Disease Burden: Incidence (yearly rate of onset, avg. age of onset) and/or prevalence of major chronic conditions  
| 3. Risk Status: composite health risk appraisal (HRA) score |
| **Experience of Care** | 1. Standard questions from patient surveys, for example:  
- Global questions from US CAHPS or How’s Your Health surveys  
- Experience questions from NHS World Class Commissioning or CareQuality Commission  
- Likelihood to recommend  
| 2. Set of measures based on key dimensions (e.g., US IOM Quality Chasm aims: Safe, Effective, Timely, Efficient, Equitable and Patient-centered) |
| **Per Capita Cost**   | 1. Total cost per member of the population per month  
| 2. Hospital and ED utilization rate |
Four Questions

- What is population health?
- What influences it?
- How do we measure it?
- How do we improve it?
Population Health

Genetic Endowment

Behavioral Risk Factors

Medical Care

Well-Being

Prevention and Health Promotion

Physiological Risk Factors

Disease and Injury

Health and Function

Socioeconomic Factors

Resilience

Death

Physical Environment

Intermediate Outcomes

States of Health

Quality of Life

Determinants/Factors

Individual Risk Factors

Population Health
Population Health Measures

1. **Health Outcomes**
   - Mortality: For example, Years of potential life lost; Life expectancy; Standardized mortality rates
   - Health/Functional Status (self-reported): Single question or multi-domain (e.g. SF-12)

2. **Disease Burden**: Incidence and/or prevalence of chronic illness

3. **Risk Status**: Composite health risk appraisal (HRA) score
Population Health

1. Risk Status

2. Disease Burden

1. Health Outcomes

1. Risk Status

2. Disease Burden

1. Health Outcomes
Bellin Health: Health Dashboard Measures

Bellin Health Risk Appraisal Scores vs. National Average
(Measured by Healics: increasing score = better health)
CareOregon: Prevalence of Diabetes and Hypertension

- Diabetes only: Feb 2010 (3.2%), May 2010 (3.1%), Aug 2010 (3.2%)
- Hypertension only: Feb 2010 (19.1%), May 2010 (18.8%), Aug 2010 (18.5%)
- Hypertension & Diabetes: Feb 2010 (8.9%), May 2010 (8.2%), Aug 2010 (8.4%)
**KP: Cardiovascular Mortality**

- **Population**
  - 13,000 KP Colorado members with cardiovascular disease
- **Data collection methods**
  - Mortality data from clinical records, vital statistics, Social Security
  - Self-perceived health and health behaviors from member survey
- **Approach to improving results**
  - Clinical Pharmacy Cardiac Risk Service care management program
KP Colorado:
CVD Care Management Reduces Mortality

# MHS Strategic Imperatives Scorecard

<table>
<thead>
<tr>
<th>Strategic Imperative</th>
<th>Exec Sponsor</th>
<th>Performance Measure</th>
<th>Development Status</th>
<th>Previous Performance</th>
<th>Current Performance</th>
<th>Improvement</th>
<th>FY2010 Target</th>
<th>FY2011 Target</th>
<th>FY2012 Target</th>
<th>FY2014 Target</th>
<th>Strategic Initiatives</th>
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<tbody>
<tr>
<td>Improve Individual and Family Medical Readiness</td>
<td>FHPC</td>
<td>Individual Medical Readiness</td>
<td></td>
<td>74%</td>
<td>75%</td>
<td>+1</td>
<td>80%</td>
<td>81%</td>
<td>82%</td>
<td>85%</td>
<td>IMR programs (e.g., addressing dental class 4, overdue PHAs, etc.)</td>
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<td>Enhance Psychological Health &amp; Resiliency</td>
<td>FHPC</td>
<td>PTSD Screening, Referral and Engagement (R/T)</td>
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<td>49%/65%</td>
<td>50%/78%</td>
<td>+1/+13</td>
<td>40%/65%</td>
<td>50%/75%</td>
<td>50%/75%</td>
<td>50%/75%</td>
<td>Psychological Health</td>
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<tr>
<td></td>
<td>FHPC</td>
<td>Depression Screening, Referral &amp; Engagement (R/T)</td>
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<td>64%/67%</td>
<td>65%/83%</td>
<td>+1/+16</td>
<td>40%/65%</td>
<td>50%/75%</td>
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<td>50%/75%</td>
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<tr>
<td>Engage Patients in Healthy Behaviors</td>
<td>CPSC</td>
<td>MHS Cigarette Use Rate (AD 18-24)</td>
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<td>-</td>
<td>9/3</td>
<td>-</td>
<td>25/30</td>
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<td>30/40</td>
<td>30/40</td>
<td>Healthy Behaviors/Lifestyle Programs</td>
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<tr>
<td></td>
<td>CPSC</td>
<td>Overweight/Obesity Documenting (Adults)</td>
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<td>-</td>
<td>17%/54%</td>
<td>-</td>
<td>-</td>
<td>30%/90%</td>
<td>100%/100%</td>
<td>100%/100%</td>
<td>Evidence Based Care</td>
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<tr>
<td></td>
<td>CPSC</td>
<td>Overweight/Obesity Documenting (Children/Adolescents)</td>
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<td>11%/33%</td>
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<td>30%/50%</td>
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<td>50%/100%</td>
<td>Wounded Warrior Programs</td>
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<td></td>
<td>CPSC</td>
<td>Exclusive Breastfeeding</td>
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<td>-</td>
<td>56%</td>
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<td>65%</td>
<td>70%</td>
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<td>Disability Evaluation System Redesign</td>
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<td></td>
<td>CPSC</td>
<td>HEDIS Index: Preventive Screens (DC/PC)</td>
<td></td>
<td>-</td>
<td>9/7</td>
<td>-</td>
<td>10/9</td>
<td>11/12</td>
<td>11/16</td>
<td>Patient Centered Medical Home</td>
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<td>Deliver Evidence-Based Care</td>
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<td>HEDIS Index: Evidence Based Guidelines (DC/PC)</td>
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<td>9/3</td>
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<td></td>
<td>CPSC</td>
<td>Readmission Rate</td>
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<td></td>
<td>CPSC</td>
<td>Patient Safety - Wrong Site Surgery</td>
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<tr>
<td></td>
<td>CPSC</td>
<td>Antibiotic Received Within 1 Hour Prior to Surgical Incision</td>
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<td>92%</td>
<td>94%</td>
<td>+2</td>
<td>95%</td>
<td>100%</td>
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<td>Excel in Wounded, Ill and Injured Care</td>
<td>CPSC</td>
<td>MEBs Completed Within 30 Days (DAR &amp; IDES)</td>
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<td>53%</td>
<td>41%</td>
<td>-12</td>
<td>80%</td>
<td>60%</td>
<td>TBD</td>
<td>TBD</td>
<td>Performance Planning Pilots</td>
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<td></td>
<td>CPSC</td>
<td>Favorable MEB Experience Rating</td>
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<td>52%</td>
<td>51%</td>
<td>-1</td>
<td>45%</td>
<td>65%</td>
<td>70%</td>
<td>75%</td>
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<tr>
<td>Optimize Access to Care</td>
<td>JHOC</td>
<td>Primary Care 3rd Available Appt. (Routine/Acute)</td>
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<td>74%/49%</td>
<td>72%/50%</td>
<td>-2/+1</td>
<td>90%/75%</td>
<td>91%/80%</td>
<td>92%/70%</td>
<td>94%/75%</td>
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<tr>
<td></td>
<td>JHOC</td>
<td>Getting Timely Care Rate</td>
<td></td>
<td>77%</td>
<td>76%</td>
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<td>78%</td>
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<td></td>
<td>JHOC</td>
<td>Potential Recapturable Primary Care Workload for MTF Enrollees</td>
<td></td>
<td>28%</td>
<td>30%</td>
<td>-2</td>
<td>29%</td>
<td>26%</td>
<td>24%</td>
<td>22%</td>
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<tr>
<td>Promote Patient-Centeredness</td>
<td>JHOC</td>
<td>% of Visits Where MTF Enrollees See Their PCM</td>
<td></td>
<td>45%</td>
<td>51%</td>
<td>+6</td>
<td>60%</td>
<td>60%</td>
<td>65%</td>
<td>70%</td>
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<tr>
<td></td>
<td>JHOC</td>
<td>Satisfaction with Health Care</td>
<td></td>
<td>60%</td>
<td>59%</td>
<td>+1</td>
<td>60%</td>
<td>61%</td>
<td>62%</td>
<td>64%</td>
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<tr>
<td>Manage Health Care Costs</td>
<td>CFOIC</td>
<td>Annual Cost Per Equivalent Life (PMPM)</td>
<td></td>
<td>5%</td>
<td>5.8%</td>
<td>-0.8</td>
<td>6.1%</td>
<td>3.1%</td>
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<td>-</td>
<td>EHR Way Ahead</td>
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<td>CFOIC</td>
<td>Enrollee Utilization of Emergency Services</td>
<td></td>
<td>46/100</td>
<td>47/100</td>
<td>-1</td>
<td>35/100</td>
<td>35/100</td>
<td>30/100</td>
<td>25/100</td>
<td>Centers of Excellence</td>
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<tr>
<td>Enable Better Decisions</td>
<td>CPSC</td>
<td>EHR Usability</td>
<td></td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>BRAC / Facility Transformation</td>
<td></td>
</tr>
<tr>
<td>Foster Innovation</td>
<td>CFOIC</td>
<td>Effectiveness in Going from Product to Practice (Translational Research)</td>
<td></td>
<td>-</td>
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<td>Develop Our People</td>
<td>CFOIC</td>
<td>Human Capital Readiness / Build Skills &amp; Currency</td>
<td></td>
<td>-</td>
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<td>-</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>CFOIC</td>
<td>Primary Care Staff Satisfaction</td>
<td></td>
<td>-</td>
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</tbody>
</table>

**Notes:**
- **Concept Only**: Measure Algorithm Developed
- **Developed and Current Target Approved**: Current Performance Known and Current Target Approved
- **Approved**: Out-Year Targets Approved
- **Funded**: Design Phase
- **As of 01 Apr 2011**
Individual Medical Readiness

We have steadily improved our readiness in both the Active and Reserve Components over the last year two years. Our greatest opportunity for improvement remains to be the Reserve Component.

What are we measuring? This measure is the best-available indicator of the medical readiness of the total force based on requirements in DoDI 6025.19 and as reported by the Services via the DoD IMR Working Group. The elements of IMR are: (1) dental readiness, (2) immunization status, (3) individual medical equipment, (4) medical readiness laboratory studies, (5) no deployment limiting medical condition and (6) periodic health assessment (PHA). The Directive sets a goal of 75% fully medically ready; the IMR working group has set a target of 80% total force medically ready (i.e., fully + partially ready).

Why is it important? This measure provides operational commanders, Military Department leaders, and primary care managers the ability to monitor the medical readiness status of their personnel, ensuring a healthy and fit fighting force medically ready to deploy.

What does our performance tell us? The Total Force medical readiness rate has grown 1% since last quarter to 75%. Active component rates continue to be higher than reserve component rates. We are continuing to work on the drivers of readiness to improve performance. These include: (1) reduced delinquent PHAs, (2) reduced deployment-limiting medical conditions, (3) reduced percentage of delinquent dental exams (Dental Class 4), and (4) reduced percentage of non-deployable dental conditions (Dental Class 3).

Executive Sponsor: FHPC
Working Group: IMR Working Group
Measure Advocate: Col Jose Rodriguez-Vazquez, TMA-FHP&RP; (703) 578-8572
Monitoring: Quarterly
Data Source: Service Data Repositories
Other Reporting: Service Assistant Secretaries (M&RA); Status of the Forces

Status Thresholds:
- Green: ≥ 81%
- Yellow: 71% ~ 80%
- Red: < 70%

Targets:
- 2011: 81%
- 2012: 82%
- 2014: 85%

About the Measure

Total Force

Active Component

Reserve Component

2010 Target: 80%

About the Measure

Data Source: Service Data Repositories
Other Reporting: Service Assistant Secretaries (M&RA); Status of the Forces
PTSD Screening, Referral and Engagement (R/T)
Positive screens have stabilized in the last year while Referrals and Engagements continue to increase.

Positively Screened (P-rate)

Referred (R-rate)

Engaged in Treatment (T-rate)

### About the Measure

#### What are we measuring?
Population is defined as returning deployers with a DD2796 (PDHA) or DD2900 (PDHRA) on file. Those with positive screen or referral on either form are counted. Screen positive percent = those who endorsed 2 or more symptoms on the PC-PTSD screen / form completers. Referral percent = those referred to mental health specialty or primary care, substance abuse, chaplain, or Military One Source / form completers screening positive. Follow up percent = those with mental health-related clinic encounter during 180 days following return / form completers who screened positive and were referred to mental health primary or specialty care.

#### Why is it important?
We monitor our positive screened percentage (p-rate) as this reflects the level of PTSD symptoms in returning deployers. We also monitor the percentage of persons screened positive who were referred for treatment (R-rate) as a reflection of the effectiveness of the process for face to face review. Finally, we monitor the percentage of persons who engaged in treatment (T-rate).

#### What does our performance tell us?
Percentage of Service members returning from OIF/OEF deployments showing PTSD symptoms remains at 10%. For the R-rate, we are now 10% above the goal at 50%. The T-rate is 13% above our goal at 78%. T-rate in Active Component continues to be higher than that in the Reserve Component.

### Total Persons Screened, By Service and Component

<table>
<thead>
<tr>
<th>Service/Component</th>
<th>Q1 '05</th>
<th>Q2 '05</th>
<th>Q3 '05</th>
<th>Q4 '05</th>
<th>Q1 '06</th>
<th>Q2 '06</th>
<th>Q3 '06</th>
<th>Q4 '06</th>
<th>Q1 '07</th>
<th>Q2 '07</th>
<th>Q3 '07</th>
<th>Q4 '07</th>
<th>Q1 '08</th>
<th>Q2 '08</th>
<th>Q3 '08</th>
<th>Q4 '08</th>
<th>Q1 '09</th>
<th>Q2 '09</th>
<th>Q3 '09</th>
<th>Q4 '09</th>
<th>Q1 '10</th>
<th>Q2 '10</th>
<th>Q3 '10</th>
</tr>
</thead>
<tbody>
<tr>
<td>DoD Total</td>
<td>104,348</td>
<td>44,058</td>
<td>53,377</td>
<td>70,063</td>
<td>78,877</td>
<td>44,399</td>
<td>69,599</td>
<td>75,775</td>
<td>49,419</td>
<td>41,671</td>
<td>62,292</td>
<td>73,586</td>
<td>63,873</td>
<td>79,895</td>
<td>54,585</td>
<td>83,211</td>
<td>73,004</td>
<td>67,595</td>
<td>80,611</td>
<td>75,155</td>
<td>73,440</td>
<td>74,718</td>
<td>89,083</td>
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<tr>
<td>Army Active</td>
<td>39,821</td>
<td>9,420</td>
<td>10,135</td>
<td>23,636</td>
<td>35,386</td>
<td>7,782</td>
<td>28,646</td>
<td>47,583</td>
<td>12,375</td>
<td>8,275</td>
<td>13,915</td>
<td>43,280</td>
<td>23,490</td>
<td>27,067</td>
<td>21,808</td>
<td>39,057</td>
<td>32,808</td>
<td>28,546</td>
<td>30,352</td>
<td>38,335</td>
<td>24,796</td>
<td>29,011</td>
<td>46,835</td>
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<td>Army Reserve</td>
<td>33,548</td>
<td>5,093</td>
<td>10,717</td>
<td>32,812</td>
<td>7,266</td>
<td>12,680</td>
<td>8,975</td>
<td>12,242</td>
<td>5,137</td>
<td>6,658</td>
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<td>19,444</td>
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<td>17,110</td>
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<td>8,783</td>
<td>19,767</td>
<td>9,993</td>
<td>21,745</td>
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<td>13,027</td>
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<td>13,520</td>
<td>15,251</td>
<td>8,171</td>
<td>14,514</td>
<td>14,214</td>
<td>15,680</td>
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<td>3,684</td>
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<td>3,269</td>
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<td>3,742</td>
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<td>Marines Active</td>
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<td>631</td>
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<td>2,658</td>
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<td>859</td>
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<td>915</td>
<td>664</td>
<td>849</td>
<td>1,510</td>
<td>707</td>
<td>1,303</td>
<td>1,046</td>
<td>1,010</td>
</tr>
</tbody>
</table>

### Executive Sponsor:
CPSC

### Status Thresholds:
- Green: R-rate > 40% AND T-rate > 65%
- Yellow: R-rate 20%-40% AND T-rate 50-65%
- Red: R-rate < 20% or T-rate < 50%

### Targets:
- 2011: R-rate: 50%, T-rate: 75%
- 2012: R-rate: 50%, T-rate: 75%
- 2014: R-rate: 50%, T-rate: 75%

### Measure Advocate:
Mr. Tim Powers
AFHSC, (301) 319-3242

### Monitoring:
Quarterly

### Data Source:
AFHSC

### Other Reporting:
Well Being of the Force
Depression Screening, Referral and Engagement (R/T)

The referral rate for a positive Depression Screening is 15% higher than PTSD.

### About the Measure

**What are we measuring?** Population is defined as returning deployers with DD2796 (PDHA) or DD2900 (PDHRA) on file. Those with positive PCL2 screen or referral on either form is counted. Screen positive percent = Those who screened positive for depression / Form completers. Referral percent = Those referred to mental health primary or specialty care, substance abuse, chaplain, OneSource / Form completers screening positive. Follow up percent = Those with mental health-related clinic encounter during 180 days following return / Form completers who screened positive and were referred to mental health primary or specialty care.

**Why is it important?** We must monitor fluctuations in our positive screened percentage (p-rate) as this may suggest more/less stress or increased/reduced stigma associated with depression. We must also monitor the percentage of persons screened positive who were referred for treatment (R-rate) to ensure it is meeting a clinically appropriate level. Finally, monitoring the percentage of persons who engaged in treatment (T-rate) will help us understand how effectively we are serving those who need help.

**What does our performance tell us?** Percentage of Service members returning from OIF/OEF deployments showing PTSD symptoms remains at 9%. For the R-rate, we are now 15% above the goal at 65%. The T-rate is 18% above our goal at 89%. T-rate in Active Component continues to be higher than that in the Reserve Component.

### Positively Screened (P-rate)

<table>
<thead>
<tr>
<th>Service / Component</th>
<th>Q1 '05</th>
<th>Q2 '05</th>
<th>Q3 '05</th>
<th>Q4 '05</th>
<th>Q1 '06</th>
<th>Q2 '06</th>
<th>Q3 '06</th>
<th>Q4 '06</th>
<th>Q1 '07</th>
<th>Q2 '07</th>
<th>Q3 '07</th>
<th>Q4 '07</th>
<th>Q1 '08</th>
<th>Q2 '08</th>
<th>Q3 '08</th>
<th>Q4 '08</th>
<th>Q1 '09</th>
<th>Q2 '09</th>
<th>Q3 '09</th>
<th>Q4 '09</th>
<th>Q1 '10</th>
<th>Q2 '10</th>
<th>Q3 '10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Persons Screened, By Service and Component</td>
<td>104,348</td>
<td>44,058</td>
<td>53,377</td>
<td>70,063</td>
<td>28,646</td>
<td>47,583</td>
<td>12,375</td>
<td>49,419</td>
<td>62,292</td>
<td>73,586</td>
<td>63,873</td>
<td>79,895</td>
<td>54,585</td>
<td>48,194</td>
<td>58,211</td>
<td>73,004</td>
<td>67,595</td>
<td>80,611</td>
<td>75,155</td>
<td>73,440</td>
<td>74,718</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Referred (R-rate)

<table>
<thead>
<tr>
<th>Service / Component</th>
<th>Q1 '05</th>
<th>Q2 '05</th>
<th>Q3 '05</th>
<th>Q4 '05</th>
<th>Q1 '06</th>
<th>Q2 '06</th>
<th>Q3 '06</th>
<th>Q4 '06</th>
<th>Q1 '07</th>
<th>Q2 '07</th>
<th>Q3 '07</th>
<th>Q4 '07</th>
<th>Q1 '08</th>
<th>Q2 '08</th>
<th>Q3 '08</th>
<th>Q4 '08</th>
<th>Q1 '09</th>
<th>Q2 '09</th>
<th>Q3 '09</th>
<th>Q4 '09</th>
<th>Q1 '10</th>
<th>Q2 '10</th>
<th>Q3 '10</th>
</tr>
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<td>Total Persons Screened, By Service and Component</td>
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<td>53,377</td>
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<td>12,375</td>
<td>49,419</td>
<td>62,292</td>
<td>73,586</td>
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<td>80,611</td>
<td>75,155</td>
<td>73,440</td>
<td>74,718</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Engaged in Treatment (T-rate)

<table>
<thead>
<tr>
<th>Service / Component</th>
<th>Q1 '05</th>
<th>Q2 '05</th>
<th>Q3 '05</th>
<th>Q4 '05</th>
<th>Q1 '06</th>
<th>Q2 '06</th>
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<th>Q4 '06</th>
<th>Q1 '07</th>
<th>Q2 '07</th>
<th>Q3 '07</th>
<th>Q4 '07</th>
<th>Q1 '08</th>
<th>Q2 '08</th>
<th>Q3 '08</th>
<th>Q4 '08</th>
<th>Q1 '09</th>
<th>Q2 '09</th>
<th>Q3 '09</th>
<th>Q4 '09</th>
<th>Q1 '10</th>
<th>Q2 '10</th>
<th>Q3 '10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Persons Screened, By Service and Component</td>
<td>104,348</td>
<td>44,058</td>
<td>53,377</td>
<td>70,063</td>
<td>28,646</td>
<td>47,583</td>
<td>12,375</td>
<td>49,419</td>
<td>62,292</td>
<td>73,586</td>
<td>63,873</td>
<td>79,895</td>
<td>54,585</td>
<td>48,194</td>
<td>58,211</td>
<td>73,004</td>
<td>67,595</td>
<td>80,611</td>
<td>75,155</td>
<td>73,440</td>
<td>74,718</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Executive Sponsor:** CPSC

**Working Group:** None

**Measure Advocate:** Mr. Tim Powers

**Data Source:** RESPECT-Mil

**Other Reporting:** None

**Status Thresholds:**
- Green: R-rate > 40% AND T-rate > 65%
- Yellow: R-rate 20% - 40% AND T-rate 50-65%
- Red: R-rate < 20% OR T-rate < 50%

**Targets:**
- 2011: R-rate: 50%, T-rate: 75%
- 2012: R-rate: 50%, T-rate: 75%
- 2014: R-rate: 50%, T-rate: 75%
What are we measuring? We are measuring the incidence of cigarette use among four categories of the MHS beneficiaries. All data have been converted to CAHPS 4.0 for consistency. This is survey self-reported data and is therefore subject to recall bias. Note: This measure currently does not include tobacco products other than cigarettes (e.g. cigars, pipes) and smokeless tobacco products (e.g. dip, chewing tobacco). Data from 4Q ’07 to current was recalculated to conform to CAHPS 4.0, which dropped requirement to indicate when last smoked.

Why is it important? Tobacco smoking among young people aged 18-24 is a particular focus of tobacco cessation efforts because difficult-to-change habits can be formed during these years and because young people aged 18-24 are generally regarded as the group most vulnerable for habit formation. This allows the MHS to assess the success rate of tobacco use cessation programs and other healthy lifestyle/health promotion efforts among specific high risk demographic groups.

What does our performance tell us? In general, tobacco use among Active Duty Service members aged 18-24 has trended upward over the last two years. There has been a 2% drop since the last reporting. Since this data does not include other tobacco products, the actual rate of overall tobacco use is higher.
Overweight & Obese Adults With Documented Problem List

Over 50% of obese patients have obesity-related problems indicated in their medical record.

Executive Sponsor: CPSC
Working Group: CMSP
Measure Advocate: CDR Aileen Buckler
TMA-OCMO: 703-681-6717

Monitoring: Monthly
Data Source: Clinical Data Mart
Other Reporting: CQF

About the Measure

What are we measuring? We are measuring the % of obese and overweight adults that have a weight condition documented in their medical records. The denominator includes all patients who had a Direct Care ambulatory visit(s) at which their height and weight were recorded and their calculated BMI was 25 ≤ BMI ≥29 for overweight or BMI ≥ 30 for obese. The numerator includes all such visits where a weight condition was documented in their problem list. Patients’ BMI was calculated as weight in kilograms divided by height in meters squared or [(weight in lb) x 703] / (height in in²).

Why is it important? Obese and overweight adults are at increased risk for many serious health conditions including coronary heart disease, hypertension, stroke, type 2 diabetes, certain types of cancer, and premature death. According to the Department of Health and Human Services, diseases associated with obesity accounted for 27% of the increases in U.S. medical costs from 1997-2001. This measure is important because it tells us the extent to which MHS is identifying those beneficiaries who are at risk due to their weight, and presumably, communicating with and developing treatment plans for these patients.

What does our performance tell us? Our rate of documentation has been flat for the last 8 quarters. Obese patients are much more likely to have a weight condition documented than patient who are over weight, but both are below target.

<table>
<thead>
<tr>
<th>Visits</th>
<th>Overweight Persons</th>
<th>Overweight Rate</th>
<th>Documented Problem List Persons</th>
<th>Documented Problem List Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Army</td>
<td>418,184</td>
<td>167,588</td>
<td>40%</td>
<td>31,530</td>
</tr>
<tr>
<td>Navy</td>
<td>263,268</td>
<td>108,864</td>
<td>41%</td>
<td>15,146</td>
</tr>
<tr>
<td>Air Force</td>
<td>327,809</td>
<td>130,591</td>
<td>40%</td>
<td>23,422</td>
</tr>
<tr>
<td>MHS</td>
<td>1,009,261</td>
<td>407,043</td>
<td>40%</td>
<td>70,098</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Visits</th>
<th>Obesity Persons</th>
<th>Obesity Rate</th>
<th>Documented Problem List Persons</th>
<th>Documented Problem List Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Army</td>
<td>117,989</td>
<td>28%</td>
<td>66,107</td>
<td>56%</td>
</tr>
<tr>
<td>Navy</td>
<td>62,833</td>
<td>24%</td>
<td>31,028</td>
<td>49%</td>
</tr>
<tr>
<td>Air Force</td>
<td>83,567</td>
<td>25%</td>
<td>44,875</td>
<td>54%</td>
</tr>
<tr>
<td>MHS</td>
<td>264,389</td>
<td>26%</td>
<td>142,010</td>
<td>54%</td>
</tr>
</tbody>
</table>

Executive Sponsor: CPSC
Working Group: CMSP
Measure Advocate: CDR Aileen Buckler
TMA-OCMO: 703-681-6717

Status Thresholds (Overweight):
- Green: ≥ 30%
- Yellow: 27-29%
- Red: < 27%

Status Thresholds (Obesity):
- Green: ≥ 75%
- Yellow: 70-74%
- Red: < 70%

Targets (Overweight):
- 2011: 30%
- 2012: 50%
- 2014: 100%

Targets (Obesity):
- 2011: 75%
- 2012: 90%
- 2014: 100%
What are we measuring? We are measuring the % of obese and overweight children/adolescents that have a weight condition documented in their medical records. The denominator includes all patients who had a Direct Care ambulatory visit(s) at which their height and weight were recorded and their BMI was calculated. Using height and weight, BMI is calculated as weight in kilograms divided by height in meters squared or \((\text{weight in lb}) \times 703\) / \((\text{height in in})^2\). For children/adolescents (ages 2–19), BMI values are plotted on the CDC growth chart to determine the corresponding BMI-for-age percentiles and then the percentile ranges are used to determine an individual child/adolescent’s weight status. Children/adolescents with BMIs between the 85th and 95th percentile are considered overweight and those in the 95th percentile or greater are considered obese.

Why is it important? Childhood and adolescent obesity and being overweight is one of the most serious health problems in the U.S. and the problem is worsening rapidly. Overweight and obese children are at risk for cardiovascular diseases, diabetes, and other serious health problems. This measure is important because it tells us the extent to which MHS is identifying those beneficiaries who are at risk due to their weight, and presumably, communicating with and developing treatment plans for these patients.

What does our performance tell us? Our rate of documentation has been flat for the last 8 quarters. Obese patients are much more likely to have a weight condition documented than patients who are over weight, but both are below target.

About the Measure

<table>
<thead>
<tr>
<th>Army</th>
<th>Navy</th>
<th>Air Force</th>
<th>Direct Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>82,126</td>
<td>45,583</td>
<td>48,925</td>
<td>176,634</td>
</tr>
<tr>
<td>12,362</td>
<td>6,679</td>
<td>6,840</td>
<td>25,881</td>
</tr>
<tr>
<td>15%</td>
<td>15%</td>
<td>14%</td>
<td>15%</td>
</tr>
<tr>
<td>1,328</td>
<td>554</td>
<td>972</td>
<td>2,854</td>
</tr>
<tr>
<td>11%</td>
<td>8%</td>
<td>14%</td>
<td>11%</td>
</tr>
</tbody>
</table>

**Executive Sponsor:** CPSC  
**Working Group:** CMSP  
**Measure Advocate:** CDR Aileen Buckler  
**TMA-OCMO:** 703-681-6717

**Status Thresholds (Overweight):**  
- Green: \(\geq 50\%\)  
- Yellow: 27-29%  
- Red: < 27%

**Status Thresholds (Obesity):**  
- Green: \(\geq 50\%\)  
- Yellow: 45-49%  
- Red: < 45%

**Targets (Overweight):**  
- 2011: 50%  
- 2012: 50%  
- 2014: 100%

**Targets (Obesity):**  
- 2011: 50%  
- 2012: 75%  
- 2014: 100%
What are we measuring?
We are measuring % of mothers who are exclusively breastfeeding (no formula) during the newborn’s hospitalization. The numerator is number of newborns that were fed breast milk only since birth and denominator is total number of newborns discharged from the hospital. The Joint Commission currently suggests the following sources for collecting data on this measure: discharge summary, feeding flow sheets, individual treatment plans, intake and output sheets, nursing notes, and physician progress notes. Definition of exclusive breast milk feeding is: “a newborn receiving only breast milk and no other liquids or solids except for drops or syrups consisting of vitamins, minerals, or medicines.” Breast milk feeding includes expressed mother’s milk as well as donor human milk.

Why is it important?
Exclusive breast milk feeding for the first 6 months of neonatal is a goal of World Health Organization, the Department of Health and Human Services (DHHS), and the American Academy of Pediatrics and American College of Obstetricians and Gynecologists. The benefits of breastfeeding extend well beyond basic nutrition. Containing all the vitamins and nutrients for infants, breast milk contains disease-fighting substances that protect infants from illness. Some studies have shown that breastfed infants are less likely to be obese as they mature and mothers achieve health benefits when they breastfeed their infants.

What does our performance tell us?
The direct care system is exceeding the national standard for supporting exclusive breastfeeding. We are doing a good job of documenting and promoting the healthy choice of breastfeeding to improve the health of our infants and mothers. In order to improve this measure, it will be helpful to review reasons for not breastfeeding.

About the Measure

Executive Sponsor: CPSC
Working Group: Clinical Quality Forum
Measure Advocate: Ms. Theresa Hart TMA-OCMO; (703) 681-7518
Monitoring: Quarterly
Data Source: HEDIS, TJC
Other Reporting: None

Status Thresholds:
- Green: ≥ 65%
- Yellow: 55% - 64%
- Red: < 55%

Targets:
- 2011: 65%
- 2012: 70%
- 2014: 80%

MHS is exceeding the national average by 16%.
What are we measuring? We are measuring compliance with HEDIS on 3 preventive screenings. Breast cancer screening assesses the percentage of women 42 - 69 who have had at least one mammogram in past 2 years. Cervical cancer screening measures the percentage of women 24 - 64 who have had at least one pap test during the past 3 years. The well child visits measure assesses the percentage of children with 6 Primary Care Provider well child visits during the first 15 months of life. The rate of performance for each Service and an aggregated for direct care are converted to percentile rankings based on civilian benchmarks. The percentile rankings are captured in an MHS Index (0 to 5) to determine overall performance.

The maximum index score for this measure set is 15 points.

Why is it important? The selected measures support an evidence-based approach to population health and quality assessment. It also provides a direct comparison with civilian health plans and a means of tracking improvements in preventive screening. Improved scores in this measure should translate directly to a healthier beneficiary population, reduced acute care needs, and appropriate use of health system resources.

What does our performance tell us? Service performance in Breast Cancer Screening and Cervical Cancer Screening was fairly consistent over the past 3 months. The Navy has reached the 90th percentile for Cervical Cancer Screening. The Well Child Visits measure is a new measure recently made available to providers. New measures need a maturation period of 6-12 months to assess and address administrative and clinical processes to better understand variables affecting performance.
About the Measure

What are we measuring? We are measuring compliance with HEDIS on 4 preventive screenings. Breast cancer screening assesses the percentage of women 42 - 69 who have had at least one mammogram in past 2 years. Cervical cancer screening measures the percentage of women 24 - 64 who have had at least one pap test during the past 3 years. Colorectal cancer screening assesses whether adults 50 - 75 have had "appropriate" screening for colorectal cancer. The well child visits measure assesses the percentage of children with 6 Primary Care Provider well child visits during the first 15 months of life. The rate of performance for each Region and an aggregated for purchase care are converted to percentile rankings based on civilian benchmarks. The percentile rankings are captured in an MHS Index (0 to 5) to determine overall performance. The maximum index score for this measure set is 20 points.

Why is it important? The selected measures support an evidence-based approach to population health and quality assessment. It also provides a direct comparison with civilian health plans and a means of tracking improvements in preventive screening. Improved scores in this measure should translate directly to a healthier beneficiary population, reduced acute care needs, and appropriate use of health system resources.

What does our performance tell us? Region performance for breast and cervical cancer screening remain consistent for past quarter while colorectal cancer screening and well child visits measures are improving. Access to measures data recently improved with deployment of enhanced Population Health Portal functionality.

Executive Sponsor: CPSC Working Group: Clinical Quality Forum Measure Advocate: Dr. John Kugler, TMA-OCMO; (703) 681-0064 Monitoring: Quarterly Data Source: Population Health Portal Other Reporting: None

Status Thresholds:
- Green: ≥ 16 Points with all Regions at or above 75th percentile
- Yellow: 15 – 12 Points
- Red: < 12 Points

Targets:
- 2011: 9
- 2014: 16
HEDIS Index – Evidence Based Guidelines (Direct Care)

Performance has remained relatively flat for the last year.

About the Measure

What are we measuring? We are measuring compliance with HEDIS on 4 sets of effectiveness of care measures including diabetes care; cholesterol management for cardiovascular conditions; follow-up after hospitalization for mental illness; and antidepressant medication management. These graphs focus on the diabetic care measure set. We evaluate 4 measures for members 18-75 with diabetes: (1) A1c screening; (2) A1c control (< 9.0%) (3) LDL-C screening, and LDL-C level < 100mg/dl. Service and an aggregated rate for direct care are converted to percentile rankings based on civilian benchmarks. The percentile rankings are captured in an MHS Index (0 to 5) to determine overall performance. The maximum index score for 4 sets of effectiveness of care measures is 20 points with the maximum of 5 for this subset measure set.

Why is it important? The selected measures evaluate the effectiveness of care, the extent to which we follow evidence-based guidelines in caring for our population. It also provides a direct comparison with civilian health plans and a means of tracking improvements in treating common chronic conditions. Improved scores in this measure should translate directly to a healthier beneficiary population, reduced acute care needs, and appropriate use of health system resources.

What does our performance tell us? Current performance has remained stable over past quarter. The focus for improvement needs to be on increasing the screening rates as enrollees with no test on record will be assumed to be above the control level for both A1c and LDL-C.

Executive Sponsor: CPSC
Working Group: Clinical Quality Forum
Measure Advocate: Dr. John Kugler, TMA-OCMO; (703) 681-0064
Monitoring: Quarterly
Data Source: Population Health Portal
Additional Reporting: None

Status Thresholds:
- Green: ≥ 16 Points with all Services at or above 75th percentile
- Yellow: 15 – 12 Points
- Red: < 12 Points

Targets:
- 2011: 10
- 2012: 12
- 2014: 16
**HEDIS Index – Evidence Based Guidelines (Direct Care) Continued**

*LDL Screening is performing below the 10<sup>th</sup> percentile and LDL Control is in the 25<sup>th</sup> percentile.*

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**About the Measure**

**What are we measuring?** We are measuring compliance with HEDIS on 4 sets of effectiveness of care measures including diabetes care; cholesterol management for cardiovascular conditions; follow-up after hospitalization for mental illness; and antidepressant medication management. These graphs focus on the cholesterol management measure set. The cholesterol management for patients with cardiovascular conditions measures include patients age 18-75 who were discharged alive for AMI, CABG, or PTCA or who had a diagnosis of IVD. The measures assess the percentage of enrollees with a LDL-C screening and LDL-C level is below 100 mg/dL. The rate of performance for each Service and an aggregated for direct care are converted to percentile rankings based on civilian benchmarks. The percentile rankings are captured in an MHS Index (0 to 5) to determine overall performance. The maximum index score for 4 sets of effectiveness of care measures is 20 points with the maximum of 5 for this subset measure set.

**Why is it important?** The selected measures support an evidence-based approach to population health and quality assessment. It also provides a direct comparison with civilian health plans and a means of tracking improvements in preventive screening. Improved scores in this measure should translate directly to a healthier beneficiary population, reduced acute care needs, and appropriate use of health system resources.

**What does our performance tell us?** The cholesterol management measure set is a new measure recently made available to providers. New measures need a maturation period of 6-12 months to assess and address administrative and clinical processes to better understand variables affecting performance. Current performance has remained stable over past quarter.

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**Executive Sponsor:** CPSC  
**Working Group:** Clinical Quality Forum  
**Measure Advocate:** Dr. John Kugler, TMA-OCMO; (703) 681-0064  
**Monitoring:** Quarterly  
**Data Source:** Population Health Portal  
**Other Reporting:** None
**About the Measure**

**What are we measuring?** We are measuring compliance with HEDIS on 4 sets of effectiveness of care measures including diabetes care; cholesterol management for cardiovascular conditions; follow-up after hospitalization for mental illness; and antidepressant medication management. These graphs focus on the mental health follow-up and antidepressant medication management measure sets. The mental health follow-up measures assess the percentage of patients enrolled to MTFs who received follow-up within 7 and 30 days of discharge mental health hospitalization. The antidepressant medication management measures percentage of newly diagnosed and treated members who remained on an antidepressant medication for at least 84 (acute) and 180 (continuation) days. The rate of performance for each Service and an aggregated for direct care are converted to percentile rankings based on civilian benchmarks. The percentile rankings are captured in an MHS Index (0 to 5) to determine overall performance. The maximum index score for 4 sets of effectiveness of care measures is 20 points with the maximum of 5 for each of this subset measure sets.

**Why is it important?** The selected measures support an evidence-based approach to population health and quality assessment. Improved scores in this measure should translate directly to a healthier beneficiary population, reduced acute care needs, and appropriate use of health system resources.

**What does our performance tell us?** These are new measures recently made available to providers. New measures need a maturation period of 6-12 months to assess and address administrative and clinical processes to better understand variables affecting performance.

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**Executive Sponsor:** CPSC  
**Working Group:** Clinical Quality Forum  
**Measure Advocate:** Dr. John Kugler, TMA-OCMO; (703) 681-0064  
**Monitoring:** Quarterly  
**Data Source:** Population Health Portal  
**Other Reporting:** None

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**HEDIS Index – Evidence Based Guidelines (Direct Care) Continued**

The greatest improvement can be made in Antidepressant Medication Mgmt for Continuation Phase, performing in the 25th percentile.

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### Mental Health 30-Day Follow-Up After Hospitalization

<table>
<thead>
<tr>
<th>Service</th>
<th>Screens</th>
<th>Total</th>
<th>Rate</th>
<th>Index</th>
</tr>
</thead>
<tbody>
<tr>
<td>Army</td>
<td>5,402</td>
<td>6,650</td>
<td>82.7%</td>
<td></td>
</tr>
<tr>
<td>Navy</td>
<td>2,409</td>
<td>3,085</td>
<td>80.9%</td>
<td></td>
</tr>
<tr>
<td>Air Force</td>
<td>2,410</td>
<td>3,233</td>
<td>74.1%</td>
<td></td>
</tr>
<tr>
<td>Direct Care</td>
<td>10,689</td>
<td>12,988</td>
<td>80.1%</td>
<td></td>
</tr>
</tbody>
</table>

### Mental Health 7-Day Follow-Up After Hospitalization

<table>
<thead>
<tr>
<th>Service</th>
<th>Screens</th>
<th>Total</th>
<th>Rate</th>
<th>Index</th>
</tr>
</thead>
<tbody>
<tr>
<td>Army</td>
<td>5,402</td>
<td>6,571</td>
<td>92.8%</td>
<td></td>
</tr>
<tr>
<td>Navy</td>
<td>2,457</td>
<td>3,029</td>
<td>81.1%</td>
<td></td>
</tr>
<tr>
<td>Air Force</td>
<td>2,385</td>
<td>3,202</td>
<td>74.5%</td>
<td></td>
</tr>
<tr>
<td>Direct Care</td>
<td>10,373</td>
<td>12,902</td>
<td>80.2%</td>
<td></td>
</tr>
</tbody>
</table>

### Antidepressant Medication Management (Acute Phase)

<table>
<thead>
<tr>
<th>Service</th>
<th>Screens</th>
<th>Total</th>
<th>Rate</th>
<th>Index</th>
</tr>
</thead>
<tbody>
<tr>
<td>Army</td>
<td>4,400</td>
<td>6,550</td>
<td>66.2%</td>
<td></td>
</tr>
<tr>
<td>Navy</td>
<td>2,396</td>
<td>3,065</td>
<td>66.5%</td>
<td></td>
</tr>
<tr>
<td>Air Force</td>
<td>1,758</td>
<td>3,233</td>
<td>54.0%</td>
<td></td>
</tr>
<tr>
<td>Direct Care</td>
<td>8,183</td>
<td>12,988</td>
<td>63.0%</td>
<td></td>
</tr>
</tbody>
</table>

### Antidepressant Medication Management (Continuation Phase)

<table>
<thead>
<tr>
<th>Service</th>
<th>Screens</th>
<th>Total</th>
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<tbody>
<tr>
<td>Army</td>
<td>11,938</td>
<td>15,007</td>
<td>79.5%</td>
<td></td>
</tr>
<tr>
<td>Navy</td>
<td>5,880</td>
<td>9,031</td>
<td>64.4%</td>
<td></td>
</tr>
<tr>
<td>Air Force</td>
<td>8,883</td>
<td>12,193</td>
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<tr>
<td>Direct Care</td>
<td>26,914</td>
<td>40,331</td>
<td>65.4%</td>
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Note: Y-Axis Set at Non-Zero

**MHS Index**


<table>
<thead>
<tr>
<th>6</th>
<th>&gt;= 90th %</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>&lt; 75th %</td>
</tr>
<tr>
<td>3</td>
<td>&lt; 50th %</td>
</tr>
<tr>
<td>2</td>
<td>&lt; 25th %</td>
</tr>
<tr>
<td>1</td>
<td>&lt; 25th %</td>
</tr>
<tr>
<td>0</td>
<td>&lt; 10th %</td>
</tr>
</tbody>
</table>

---

**Commercial HEDIS Audit Percentiles**

- **Mental Health Follow-Up:** 70.3%, 64.3%, 63.5%, 63.3%, 60.3%
- **Mental Health Follow-Up:** 70.3%, 64.3%, 63.5%, 63.3%, 60.3%
- **Antidepressant Medication Mgmt (Acute):** 65.7%, 65.5%, 65.3%, 64.8%, 64.4%
- **Antidepressant Medication Mgmt (Continuation):** 66.4%, 66.3%, 66.1%, 66.0%, 65.9%
What are we measuring? We are measuring compliance with HEDIS on 4 sets of effectiveness of care measures including diabetes care; cholesterol management for cardiovascular conditions; follow-up after hospitalization for mental illness; and antidepressant medication management. These graphs focus on the diabetic care and cholesterol management measure sets. We evaluate 2 measures for members 18-75 with diabetes: (1) A1c screening and LDL-C screening. The cholesterol management for patients with cardiovascular conditions measure assess the percentage of enrollees with a LDL-C screening for patients age 18-75 who were discharged alive for AMI, CABG, or PTCA or who had a diagnosis of IVD. Region and an aggregated rate for purchase care are converted to percentile rankings based on civilian benchmarks. The percentile rankings are captured in an MHS Index (0 to 5) to determine overall performance. The maximum index score for 4 sets of effectiveness of care measures is 20 points with the maximum of 5 for each of this subset measure sets.

Why is it important? The selected measures evaluate the effectiveness of care, the extent to which we follow evidence-based guidelines in caring for our population. Improved scores in this measure should translate directly to a healthier beneficiary population, reduced acute care needs, and appropriate use of health system resources.

What does our performance tell us? Current performance has remained stable over past quarter. T3 includes incentives to improve the diabetes measures. The cholesterol management measure set is a new measure recently made available to providers. New measures need a maturation period of 6-12 months to assess and address administrative and clinical processes to better understand variables affecting performance.

Executive Sponsor: CPSC
Working Group: Clinical Quality Forum
Measure Advocate:
Dr. John Kugler, TMA-OCMO; (703) 681-0064
Monitoring: Quarterly
Data Source: Population Health Portal
Other Reporting: None

Status Thresholds:
- Green: > 12 Points with all Services at or above 75th percentile
- Yellow: 9 – 11 Points
- Red: < 11 Points

Targets:
- 2011: 6
- 2012: 8
- 2014: 12
**What are we measuring?**
We are measuring compliance with HEDIS on 4 sets of effectiveness of care measures including diabetes care; cholesterol management for cardiovascular conditions; follow-up after hospitalization for mental illness; and antidepressant medication management. These graphs focus on the mental health follow-up and antidepressant medication management measure sets. The mental health follow-up measures assess the percentage of patients enrolled to MTFs who received follow-up within 7 and 30 days of discharge mental health hospitalization. The antidepressant medication management measures percentage of newly diagnosed and treated members who remained on an antidepressant medication for at least 84 (acute) and 180 (continuation) days. The rate of performance for each Region and an aggregated for purchase care are converted to percentile rankings based on civilian benchmarks. The percentile rankings are captured in an MHS Index (0 to 5) to determine overall performance. The maximum index score for 4 sets of effectiveness of care measures is 20 points with the maximum of 5 for each of this subset measure sets.

**Why is it important?**
The selected measures evaluate the effectiveness of care, the extent to which we follow evidence-based guidelines in caring for our population. Improved scores in this measure should translate directly to a healthier beneficiary population, reduced acute care needs, and appropriate use of health system resources.

**What does our performance tell us?**
These are new measures recently made available to providers. New measures need a maturation period of 6-12 months to assess and address administrative and clinical processes to better understand variables affecting performance.

---

**Executive Sponsor:** CPSC  
**Working Group:** Clinical Quality Forum  
**Measure Advocate:** Dr. John Kugler, TMA-OCMO; (703) 681-0064  
**Monitoring:** Quarterly  
**Data Source:** Population Health Portal  
**Other Reporting:** None
Wrong Site Surgery
There is room for improvement with the goal of lengthening the time between events.

What are we measuring? WSS should never occur! We are measuring the time between incidents of wrong site surgeries/procedures (WSS) in the Direct Care setting from reports from the Patient Safety Reporting System (PSR) and Root Cause Analysis (RCA) databases.

Why is it important? All of graphs are T-Charts. T-Charts measure time between incidents, while frequency charts display counts. Therefore, the higher the line/peaks, the longer the time between incidents, which is better. Additionally with a T-Chart, identification of trends are easier and statistically relevant, whereas frequency graphs are dependent on counts, which are highly variable. For the T-Charts, the red circles indicate one aspect of special cause variation, where the time between incidents is statistically significant meaning the DoD was performing at an extraordinarily high level to achieve such a large time between incidents.

Identification of goals and benchmarks are easier with the T-Chart UCL. Any point or line above the UCL indicates exceptional performance and is part of the special cause variation. With frequency graphs, the maximum count is often used (or a percentage of it), which may lead to unreasonable goals. Following simple criteria for special cause variation, it is easier to identify trends in a T-Chart. Furthermore, changes in process improvements are better gauged with a T-Chart.

What does our performance tell us? There is room for improvement as WSS continues to happen too frequently.

About the Measure

| What are we measuring? WSS should never occur! We are measuring the time between incidents of wrong site surgeries/procedures (WSS) in the Direct Care setting from reports from the Patient Safety Reporting System (PSR) and Root Cause Analysis (RCA) databases. |
| Why is it important? All of graphs are T-Charts. T-Charts measure time between incidents, while frequency charts display counts. Therefore, the higher the line/peaks, the longer the time between incidents, which is better. Additionally with a T-Chart, identification of trends are easier and statistically relevant, whereas frequency graphs are dependent on counts, which are highly variable. For the T-Charts, the red circles indicate one aspect of special cause variation, where the time between incidents is statistically significant meaning the DoD was performing at an extraordinarily high level to achieve such a large time between incidents. Identification of goals and benchmarks are easier with the T-Chart UCL. Any point or line above the UCL indicates exceptional performance and is part of the special cause variation. With frequency graphs, the maximum count is often used (or a percentage of it), which may lead to unreasonable goals. Following simple criteria for special cause variation, it is easier to identify trends in a T-Chart. Furthermore, changes in process improvements are better gauged with a T-Chart. |
| What does our performance tell us? There is room for improvement as WSS continues to happen too frequently. |
| Executive Sponsor: PSP, PSPCC |
| Measure Advocate: LTC Donald Robinson |
| Monitoring: Quarterly |
| Data Source: PSR, RCA Database |
| Other Reporting: |
| Status Thresholds: |
| • Green: ≥ 90 days |
| • Yellow: 65 days – 90 days |
| • Red: ≤ 65 days |
| Targets: |
| • 2012: 0 WSS Events |
| • 2013: 0 WSS Events |
| • 2014: 0 WSS Events |
Antibiotic Received Within 1 Hour Prior to Surgical Incision

MHS has shown consistent improvement for two years.

What are we measuring? We are measuring the percentage of surgical patients who received prophylactic antibiotics within 1 hour prior to surgical incision. The measure is included in the Joint Commission (TJC) National Hospital Quality Measure sets. Studies show a strong association of reduced incidence of post-operative infection with administration of antibiotics within the one hour prior to surgery; however, after the incision is closed, prolonged administration of prophylaxis with antibiotics may increase the risk of infections at no additional benefit to the patient. Our overall measure rate includes our performance for colon surgery, hip and knee arthroplasty, abdominal and vaginal hysterectomy, cardiac surgery (including coronary artery bypass grafts (CABG)) and vascular surgery.

Why is it important? This measure educates providers about evidence based practice, improves the quality of surgical procedures, and is part of TJC accreditation process requirements. We can reduce the risk of wound infection after surgery by providing the right medicines at the right time on the day of surgery. If we are able to demonstrate that we are achieving very high levels of adherence with best clinical practices, we will earn beneficiary trust, and more people will wish to come to our hospitals for their care.

What does our performance tell us? All Services are showing an upward trend. Army is showing the most consistent performance improvement and Navy had the most improvement since the last reporting (5% increase).

About the Measure

Executive Sponsor: CPSC
Working Group: Clinical Quality Forum
Measure Advocate: Dr. John Kugler
TMA-OCMO; (703) 681-0064
Monitoring: Quarterly
Data Source: Inpatient Chart Extractions
Other Reporting: Joint Commission

Status Thresholds:
- Green: > 95%
- Yellow: 90% - 94%
- Red: < 90%

Targets:
- 2011: 100%
- 2012: 100%
- 2014: 100%
About the Measure

**What are we measuring?** We are measuring percentage of MEB cases completed in less than 30 days. Case processing begins when a provider dictates a Clinical Narrative Summary (NARSUM) and ends when the case file is received by the PEB. New requirements policy (effective in Oct 08) for an impartial medical provider and official rebuttal of the MEB findings may affect processing timelines.

**Why is it important?** Our goal is to improve the quality and efficiency of the disability evaluation process. Although the process begins well before the NARSUM is dictated and continues well after the MEB report is completed, this part of the process is largely under the control of military health care system and has established targets. If we optimize this part of the process we will avoid some delays that contribute to dissatisfaction and rework.

**What does our performance tell us?** Overall MHS rate decreased by 19% from last FY10 quarter. All three Services are showing decreased performance, with Army showing the most (decreased 21%).

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**Executive Sponsor:** CPSC  
**Working Group:** Disability Advisory Council  
**Measure Advocate:** Kathie McCracken  
**HA-C&PP:** 703-681-1716  
**Monitoring:** Monthly  
**Data Source:** Data call to Services  
**Other Reporting:** DES Report to USD(P/R)  
**Status Thresholds:**  
- Green: > 60% MEB Completed in 30 Days or Less  
- Red: < 60% MEB Completed in 30 Days or Less  
**Targets:**  
- 2011: 60%  
- 2012: TBD  
- 2014: TBD
About the Measure

**Status Thresholds:**
- **Green:** > 60% MEB Completed in 30 Days or Less
- **Red:** < 60% MEB Completed in 30 Days or Less

**Targets:**
- 2011: 60%
- 2012: TBD
- 2014: TBD

**What are we measuring?**
We are measuring percentage of MEB cases completed in less than 30 days. Case processing begins when a provider dictates the Clinical Narrative Summary (NARSUM) and ends when the board has made a final decision. New requirements policy (effective in Oct 08) for impartial medical provider review and official rebuttal of MEB findings may change processing timelines.

**Why is it important?**
Our goal is to improve the quality and efficiency of the disability evaluation process. Although the process begins well before the NARSUM is dictated and continues well after the MEB report is completed. This part of the process is largely under the control of the military health care system and has established targets. If we optimize this part of the process we will avoid some delays that contribute to dissatisfaction and rework.

**What does our performance tell us?**
Both the Active and Reserve Component performances have dipped below our desired level of performance. We are approximately 6-7 percentage points below our new FY2011 target for the Active and Reserve Components. We have realized a steady downward trend in performance since 3rd quarter, FY09, which may be linked to expansion of the IDES expansion. Roll out of the new process across the MHS continues.
**Favorable Medical Evaluation Board Experience Rating**

*We have ended FY2010 at 51%, 6 percentage points above our goal.*

### What are we measuring?
This measure comes from a monthly telephonic survey that began in May 2007. It initially surveyed 100% of all Service members returning from operational deployment via aeromedical evacuation, but was expanded in Q3 FY08 to include 100% follow-up of all aerovac patients and 100% of referrals to the VA resulting in a claim. It expanded again in Q4 FY08 to a substantial sample (nearing 100%) of Service members who completed a PDHA or PDHRA one year prior and were recommended for referral to the PEB. It does not measure all Service members undergoing MEB/PEB. The survey uses a 5-point scale to assess patients’ self-reported experience with the medical and physical evaluation board process with a 25% yield and 41% adjusted response rate of eligibles. The question is: “Please think about your Medical Evaluation Board (MEB) experience. Using a scale of 1 to 5, with 1 being “Poor” and 5 being “Outstanding”, how would you rate your experience with the MEB process?”

### Why is it important?
Our goal is to improve the disability evaluation process. This measure provides direct feedback from Wounded Warriors on their initial satisfaction with the medical board portion of the process. Many things can influence satisfaction but, we believe some of the factors that positively influence satisfaction include having an individualized care plan, open communication, and efficient administrative processes (access, referrals, MEB timeliness). These factors are all addressed in the DES reengineering initiative. Other than the war itself, there is no more important mission than caring for these service members.

### What does our performance tell us?
Since the last report on FY10 Q2, we have experienced a 10% decrease in satisfaction rating and have achieved our FY2010 goal. We will continue to monitor for additional improvement to see if it correlates to expansion of DES improvement initiatives beyond the pilots.

### Status Thresholds:
- **Green:** > 45%
- **Yellow:** 40% - 44%
- **Red:** < 40%

### Targets:
- **2011:** 65%
- **2012:** 70%
- **2014:** 75%

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### About the Measure

**Executive Sponsor:** CPSC  
**Working Group:** Tri-Service Survey Work Group  
**Measure Advocate:** Dr. Rich Bannick, TMA-HPA&E; (703) 681-3636  
**Monitoring:** Monthly  
**Data Source:** Service Member Survey  
**Other Reporting:** None
Primary Care 3rd Available Appointment (Routine/Acute)

Routine 3rd available appointments has improved by 3% since last quarter.

What are we measuring? This is a prospective daily measure from a point in time when one looks for an appointment to when the third appointment is available for an acute appointment. Rate is a ratio of the # of clinics that meet the ATC standard compared to the total number of clinics having the particular ATC category.

Why is it important? We want it to be as convenient as possible for people to make appointments. Our hypothesis is that if we have constructed our appointment templates appropriately and have adequate staffing, then appointments will be available when people call. If one finds 3 appointments within the access standards one should be able to give beneficiaries some choice further improving satisfaction. This measure reflects the ability of a clinic to maintain availability for the 3rd available appointment.

What does our performance tell us? We are making progress to eliminate variation in appointing templates and processes across the Services. During this quarter, we have increased the availability of appointments for routine by 3% since last quarter, but have decreased by 1% in acute. As more MTFs implement the PCMH, we expect this to fuel improvement across the enterprise. Air Force uses 4th level MEPRS to show access at the team level and Navy is moving to this model. This may initially result in an overall downward trend before we see an improvement.

Executive Sponsor: JHOC

Working Group: None

Measure Advocate: Dr. Mike Dinneen
HA-OSM; (703) 681-1712

Monitoring: Weekly

Data Source: TOC/CHCS/AHLTA

Other Reporting: None

Status Threshold for Routine:
- Green: ≥ 91%
- Yellow: 80% - 90%
- Red: < 80%

Routine Targets:
- 2011: 91%
- 2012: 92%
- 2014: 94%

Status Threshold for Acute:
- Green: > 68%
- Yellow: 57% - 67%
- Red: < 57%

Acute Targets:
- 2011: 53%
- 2012: 56%
- 2014: 55%
Getting Timely Care Rate

Satisfaction with access appears to be improving.

Those seeking care from the Health Care Support Contractors report a higher satisfaction with getting timely care.

About the Measure

What are we measuring? We are measuring beneficiary satisfaction rate with getting timely care through a composite of two questions from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey 4.0. The questions are: In the last 12 months, (1) When you needed care right away, how often did you get care as soon as you thought you needed? (2) Not counting the times you needed care right away, how often did you get an appointment for your health care at a doctor’s office or clinic as soon as you thought you needed? Responses of ‘Usually’ and ‘Always’ are counted positive.

Why is it important? We believe that if patients are able to access care more quickly, they will avoid harmful delays, reduce the likelihood of progression of illness and be more satisfied with the care experience.

What does our performance tell us? Army and Navy have shown improvements, but Air Force experienced a drop from last quarter. MSCS continues to report higher performance than the Services. We anticipate implementation of the PCMH efforts will improve access across the enterprise.

Executive Sponsor: JHOC

Working Group: Tri-Service Survey Work Group

Measure Advocate: Dr. Rich Bannick, TMA-HPA&E; (703) 681-3636

Monitoring: Quarterly

Data Source: Health Care Survey of DoD Beneficiaries

Status Thresholds:
- Green: ≥ 78%
- Yellow: 73% - 77%
- Red: ≤ 72%

Targets:
- 2011: 78%
- 2012: 80%
- 2014: 82%

Other Reporting: None
Potential Recapturable Primary Care Workload for MTF Enrollees

For the most recent quarter MTF enrollees are receiving on average 30% of their primary care from other venues.

About the Measure

What are we measuring? We are measuring the amount of workload for MTF Prime enrollees that could be prevented or redirected to the enrollment site, including a) primary care delivered at any site other than the enrollment site, both direct care (DC) and purchased care (PC); b) Urgent care workload for DC and PC; and c) ER workload for DC and PC. This methodology purposely over-estimates the workload that could be returned to the primary care setting or prevented. In addition, experts from Kaiser Permanente reported that efforts to identify only inappropriate workload to an ER were unsuccessful; they advised that we count all ER workload and simply try to reduce the total over time.

Why is it important? The MHS has embraced the Patient Centered Medical Home (PCMH) as the delivery model for primary care. The goal of this model is for enrolled patients to receive the majority of their care from their primary care manager or team. Measuring the amount of primary care that is delivered outside of the enrollment site will enable MTFs to make practice adjustments to increase continuity for enrollees.

What does our performance tell us? Over the past year, 30% of primary care for MTF enrollees was done in places other than their enrollment MTF. As more MTFs implement the medical home model, we believe it will have a positive impact on this measure.
About the Measure

**What are we measuring?** We are measuring the percentage of visits that MTF prime enrollees see their primary care manager (PCM). Numerator is # of appointments where patients saw their assigned PCM and denominator is Total number of appointments. Note: This measure no longer filters out visits where the patient’s PCM is not in clinic.

**Why is it important?** We believe PCM continuity improves patient-provider communication and trust, which leads to more activated patients and a positive impact on every aspect of the Quadruple Aim. Our hypothesis is that this rate will be positively influenced as MHS continues to implement the medical home model.

**What does our performance tell us?** Starting in 2010 July, PCM continuity has increased, with the MHS as a whole reaching 51%, its highest rate in 2 years.

**Executive Sponsor:** JHOC

**Status Thresholds:**
- Green: ≥ 60%
- Yellow: 40% - 59%
- Red: ≤ 39%

**Working Group:** None

**Measure Advocate:** TBD

**Monitoring:** TBD

**Data Source:** CHCS

**Targets:**
- 2011: 60%
- 2012: 65%
- 2014: 70%

---

*Percentage of Visits Where MTF Enrollees See Their PCM*

*Since the last reporting, PCM continuity maintained its positive upward trend, increasing by 6 percentage points.*

---

**2011 Target = 60%**

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Y

**Percentage of Visits Where Patients Saw Their Assigned PCM**

<table>
<thead>
<tr>
<th>Facility</th>
<th>Percent of Apps</th>
<th>Number of Apps</th>
<th>Total Number of Appointments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Army</td>
<td>50.96%</td>
<td>463</td>
<td>569</td>
</tr>
<tr>
<td>US Army Health Clinic-McCord AFB</td>
<td>79.33%</td>
<td>1,180</td>
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</tr>
<tr>
<td>DNH Jahn AHC</td>
<td>71.96%</td>
<td>1,581</td>
<td>2,197</td>
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<tr>
<td>AMC Hamden</td>
<td>70.21%</td>
<td>535</td>
<td>762</td>
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<tr>
<td>AMC Kaiserslautern</td>
<td>69.13%</td>
<td>674</td>
<td>975</td>
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<td>LA Pointe Health Clinic</td>
<td>23.93%</td>
<td>656</td>
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<tr>
<td>NISQUALLY Family Medicine Clinic-Ft. I</td>
<td>22.41%</td>
<td>1,040</td>
<td>4,640</td>
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<tr>
<td>US Army Camp Casey</td>
<td>20.52%</td>
<td>134</td>
<td>653</td>
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<td>US Army Camp Humphreys</td>
<td>16.14%</td>
<td>167</td>
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<tr>
<td>Aviation Medicine Clinic</td>
<td>7.59%</td>
<td>42</td>
<td>553</td>
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Navy

<table>
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<th>Number of Apps</th>
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<tr>
<td>NHC Quantico</td>
<td>77.92%</td>
<td>2,230</td>
<td>2,862</td>
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<tr>
<td>NBHC NTC San Diego</td>
<td>76.75%</td>
<td>2,185</td>
<td>2,847</td>
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<td>NH Oak Harbor</td>
<td>73.45%</td>
<td>2,028</td>
<td>2,761</td>
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<tr>
<td>NBHC MoD Parris Island</td>
<td>71.11%</td>
<td>540</td>
<td>753</td>
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<td>BMC MCAS Miramar</td>
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<td>1,246</td>
<td>1,766</td>
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<tr>
<td>NBHC Bancroft Hall</td>
<td>18.13%</td>
<td>299</td>
<td>1,649</td>
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<tr>
<td>NBHC NSA Bahrain</td>
<td>15.08%</td>
<td>163</td>
<td>1,081</td>
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<tr>
<td>NBHC Albany</td>
<td>15.08%</td>
<td>79</td>
<td>524</td>
</tr>
<tr>
<td>NBHC NAS Jacksonville</td>
<td>9.80%</td>
<td>107</td>
<td>1,092</td>
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<tr>
<td>NBHC Key West</td>
<td>6.00%</td>
<td>66</td>
<td>692</td>
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Air Force

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<th>Facility</th>
<th>Percent of Apps</th>
<th>Number of Apps</th>
<th>Total Number of Appointments</th>
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<tbody>
<tr>
<td>45th Medical Group</td>
<td>81.50%</td>
<td>2,374</td>
<td>2,910</td>
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<tr>
<td>470 Medical Flight</td>
<td>79.52%</td>
<td>426</td>
<td>533</td>
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<tr>
<td>579th Medical Group</td>
<td>78.41%</td>
<td>1,318</td>
<td>1,681</td>
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<tr>
<td>36th Medical Group</td>
<td>77.89%</td>
<td>620</td>
<td>796</td>
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<tr>
<td>61st Medical Group</td>
<td>75.42%</td>
<td>1,126</td>
<td>1,493</td>
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<td>5th Medical Group</td>
<td>40.99%</td>
<td>990</td>
<td>2,415</td>
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<tr>
<td>27th Special Operations Medical Gro</td>
<td>40.26%</td>
<td>1,104</td>
<td>2,742</td>
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<td>10th Medical Group</td>
<td>40.02%</td>
<td>1,296</td>
<td>3,238</td>
</tr>
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<td>40th Medical Group</td>
<td>36.92%</td>
<td>1,058</td>
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<tr>
<td>Mike O'Callaghan Federal Hospital</td>
<td>35.27%</td>
<td>2,695</td>
<td>7,641</td>
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</tbody>
</table>

*Only includes facilities with 500 or more appointments.*
Satisfaction with Health Care
Satisfaction in the private sector continues to be higher than that in the direct care system.

About the Measure

What are we measuring? We are measuring beneficiary satisfaction with overall health care using the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey 4.0. Beneficiaries are asked: Using any number from 1 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care in the last 12 months? Responses of 8, 9, or 10 indicate patient satisfaction. The benchmark comes from CAHPS average of 250 health plans.

Why is it important? More satisfied beneficiaries are more likely to follow our advice regarding health choices and are more likely to come to our providers for health services.

What does our performance tell us? First quarter in FY11 performance is relatively flat from the FY2010 with more improvement showing in HCSC.

Executive Sponsor: JHOC
Working Group: Tri-Service Survey Work Group
Measure Advocate: Dr. Rich Bannick, TMA-HPA&E; (703) 681-3636
Monitoring: Quarterly
Data Source: Health Care Survey of DoD Beneficiaries
Other Reporting: Status of Forces

Status Thresholds:
- Green: ≥ 61%
- Yellow: 55% - 60%
- Red: < 54%

Targets:
- 2011: 61%
- 2012: 62%
- 2014: 64%
Annual Cost Per Equivalent Life (PMPM)
The rate of increase is still below that of the Kaiser Family Foundation, but is on an upward trend from the last quarter.

What are we measuring? The average percent Defense Health Program annual cost per equivalent life increase compared to average civilian sector premium increase.

Why is it important? This metric looks at how well the Military Health System manages the care for those individuals who have chosen to enroll in a health maintenance organization-type of benefit. It is designed to capture aspects of three major management issues: (1) how efficiently the Military Treatment Facilities (MTF) provides care; (2) how efficiently the MTF manages the demand of its enrollees; and (3) how well the MTF determines which care should be produced inside the facility versus that purchased from a managed care support contractor.

What does our performance tell us? OPPS has considerably reduced the rate of increase for Managed Care enrollees and to a lesser extent MTF enrollees. However, Direct Care for Inpatient and Outpatient are still increasing significantly faster than PSC rates. Additionally, there has been a rise in outpatient utilization. The challenge for the Direct Care as we begin to report FY11 data will be to lower costs since the FY11 target using the Kaiser Family Foundation rate and adjusted for our population is set at 3.1%.

About the Measure

Executive Sponsor: CFOIC
Working Group: None
Measure Advocate: Dr. Bob Opsut, HA-HBB&FP; (703) 681-1724
Monitoring: Monthly
Data Source: M2
Other Reporting: Services, Well Being of the Force

Status Thresholds:
- Green: < +6.1%
- Yellow: +6.1% - 8.1%
- Red: > +8.1%

Targets:
- 2011: 3.1%
- 2012: N/A
- 2014: N/A

Note: 4th quarter, FY10 data is preliminary.
Enrollee Utilization of Emergency Services
Utilization rate is more than 2 times the national benchmark for MHS beneficiaries.

About the Measure

What are we measuring? This measure is derived using E&M codes 99281 through 99285. Purchased care is limited to the non-institutional program indicator code and place of service being an emergency room or hospital outpatient treatment. Direct care parameters were limited to the MEPRS3 code BIA (emergency room). Enrollees were restricted to those in region’s North, South, West and Alaska. The expected rate of utilization is based on the National Hospital Ambulatory Care Survey (2006) Emergency Department Utilization, adjusted for the MHS population constituting each Service.

Why is it important? Measuring emergency room utilization enables us to determine if our enrollees are appropriately using this service or is this being used as a fall back because of access issues. Since the MHS has embraced the Patient Centered Medical Home (PCMH) as the delivery model for primary care, our belief is this measure will improve as access improves.

What does our performance tell us? Utilization of ER services among TRICARE Prime enrollees is increasing over time. Prime enrollees are using these services 2 times more than the national utilization rate. Direct Care ER services may currently be an alternative to Primary Care and thus increasing the utilization rate.

Executive Sponsor: CPSC
Working Group: None
Measure Advocate: Dr. Bob Opsut
HA-HB&FP; (703) 681-1724
Monitoring: Monthly
Status Thresholds:
- Green: < 35 Visits Per 100
- Yellow: 35 - 40 Visits Per 100
- Red: ≥ 40 Visits Per 100
Targets:
- 2011: 35/100
- 2012: 30/100
- 2014: 25/100

Data Source: M2
Other Reporting: None