

Annual Chart Book

Fiscal Year 2006

Texas Children's Health Insurance Program Quality of Care Measures

Prepared by

**The Institute for Child Health Policy
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**The Texas External Quality Review Organization
for Medicaid Managed Care and CHIP**

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Table of Contents

Introduction	1
CHIP Descriptive Information	
Chart 1. HEDIS® Total Unduplicated Members by MCO	4
Chart 2. HEDIS® Total Unduplicated Members by Race/Ethnicity and MCO	5
CHIP AHRQ Pediatric Quality Indicators	
Chart 3. AHRQ Pediatric Quality Indicators	6
Chart 4. AHRQ Pediatric Quality Indicators by MCO	8
CHIP Quality of Care	
Chart 5. HEDIS® Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	10
Chart 6. HEDIS® Adolescent Well-Care Visits	12
Chart 7. HEDIS® Use of Appropriate Medications for People with Asthma	14
Chart 8. HEDIS® Follow-Up after Hospitalization for Mental Illness	16
Chart 9. Readmission within 30 Days after an Inpatient Stay for Mental Health	18
Chart 10. HEDIS® Appropriate Testing for Children with Pharyngitis	20

Introduction

Purpose

The purpose of this report is to provide an annual update of the quality of care provided to enrollees in the Texas Children's Health Insurance Program (CHIP) by the participating Managed Care Organizations (MCOs). This update is for September 1, 2005, to August 31, 2006, covering fiscal year 2006. Key points and recommendations are provided in the narrative of the report under the heading "Key Points." Where possible, comparisons between national means and fiscal year 2006 results are provided. Additionally, any significant differences between fiscal years 2005 and 2006 results are noted as key points.

The quality of care measures used in this annual chart book require one year of health care claims and encounter data for their calculations. Therefore, the time frame used to prepare the measures is September 1, 2005, to August 31, 2006. The only exceptions are as follows: 1) The asthma medication indicator requires two years of pharmacy and encounter data to identify a patient as having persistent asthma; and 2) The pharyngitis indicator requires one year of encounter data beginning six months prior to the normal measurement year; thus, the encounter dates of service to identify pharyngitis are March 1, 2005, through February 28, 2006, and the pharmacy dates to check for an antibiotic prescription are January 30, 2005, through March 3, 2006. A four-month time lag was used for the claims and encounter data. Prior analyses with Texas data found that, on average, approximately 97 percent of the claims and encounters were complete by that time period.

This chart book contains the following quality of care indicators grouped under associated headings:

- 1) Descriptive Information
 - a) HEDIS® Total Unduplicated Members
 - b) HEDIS® Total Unduplicated Members by Race/Ethnicity

- 2) AHRQ Pediatric Quality Indicators
 - a) AHRQ Pediatric Quality Indicators

- 3) Quality of Care
 - a) HEDIS® Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life
 - b) HEDIS® Adolescent Well-Care Visits
 - c) HEDIS® Use of Appropriate Medications for People with Asthma
 - d) HEDIS® Follow-Up after Hospitalization for Mental Illness
 - e) Readmission within 30 Days after an Inpatient Stay for Mental Health
 - f) HEDIS® Appropriate Testing for Children with Pharyngitis

This chart book includes data from plans that are designated as Superior and Superior Exclusive Provider Organization (EPO). Superior refers to the Managed Care Organization (MCO) operating as a traditional MCO. Superior EPO is a separate program and refers to the licensed Insurance Company contracted with HHSC that operates like a traditional Managed Care Organization in rural Texas counties. Superior EPO assumed Clarendon's membership when that organization exited the market in September 2004.

Data Sources and Measures

Three data sources were used to calculate the quality of care indicators: (1) person-level enrollment information, (2) person-level health care claims/encounter data, and (3) person-level pharmacy data. The enrollment files contain information about the person's age, gender, the MCO in which the person is enrolled, and the number of months the person was enrolled in the program. The person-level claims/encounter data contain Current Procedural Terminology (CPT) codes, International Classification of Diseases, 9th Revision (ICD-9-CM) codes, place of service (POS) codes, and other information necessary to calculate the quality of care indicators. The person-level pharmacy data contains information about filled prescriptions including the drug name, dose, date filled, and refill information. As previously noted, CHIP claims and encounter data in Texas were compiled for the time period of September 1, 2005, to August 31, 2006. Enrollees who switched health plans during the time period studied were not included in the data analysis. Enrollees switching health plans during the time period comprised approximately one percent of the total pool; therefore, omitting this group does not have a significant impact on the results.

Information regarding the calculation of all measures included in this report can be found in the document "Quality of Care Measures Technical Report Specifications, June 2007." This document, prepared by the Institute for Child Health Policy, provides specifications for both Health Plan Employer Data and Information Set (HEDIS[®]) and other quality of care measures.

Whenever possible, comparisons are provided to national benchmarks. While there are no direct national comparisons available for CHIP, there is comparative data from Medicaid programs. The National Committee for Quality Assurance (NCQA) gathers data from Medicaid managed care plans nationally and compiles them.¹ Submission of HEDIS[®] data to NCQA is a voluntary process; therefore, health plans that submit HEDIS[®] data are not fully representative of the industry. Health plans participating in NCQA HEDIS[®] reporting tend to be older, are more likely to be federally qualified, and are more likely to be affiliated with a national managed care company than the overall population of health plans in the United States.² NCQA reports the national results as a mean and at the 10th, 25th, 50th, 75th, and 90th percentiles for the participating plans. For comparison purposes to the CHIP in Texas findings, NCQA Medicaid Managed Care Plans 2006 mean results are shown and are labeled "HEDIS[®] 2006 Mean" in the graphs. This information is not available for all of the quality of care indicators.

Indicators developed by the Agency for Healthcare Research and Quality (AHRQ) were used to evaluate the performance of CHIP MCOs related to inpatient admissions for various ambulatory care sensitive conditions (ACSCs). The AHRQ considers ACSCs "conditions for which good outpatient care can potentially prevent the need for hospitalization or for which early intervention can prevent complications or more severe disease."³ The Quality Indicators use hospital inpatient discharge data and are measured as rates of admission to the hospital. The incidence of inpatient admissions for ACSCs has been measured in the past for the CHIP Program. However, the use of the AHRQ specifications is new for this annual report. The change to the new AHRQ specifications was made in consultation with HHSC and the STAR and CHIP MCO Medical Directors. Unlike most other measures provided in this chart book, low quality indicator rates are desired as they suggest a better quality of the health care system outside the hospital setting.

¹ The information that NCQA compiles for Medicaid Managed Care Programs can be viewed at www.ncqa.org.

² Beaulieu, N.D., and A.M. Epstein. 2002. "National Committee on Quality Assurance Health-Plan Accreditation: Predictors, Correlates of Performance, and Market Impact." *Medical Care* 40 (4): 325-337.

³ Agency for Healthcare Research and Quality. 2004. *AHRQ Quality Indicators—Guide to Prevention Quality Indicators: Hospital Admission for Ambulatory Care Sensitive Conditions*. Rockville, MD: AHRQ. Revision 4. (November 24, 2004). AHRQ Pub. No. 02-R0203.

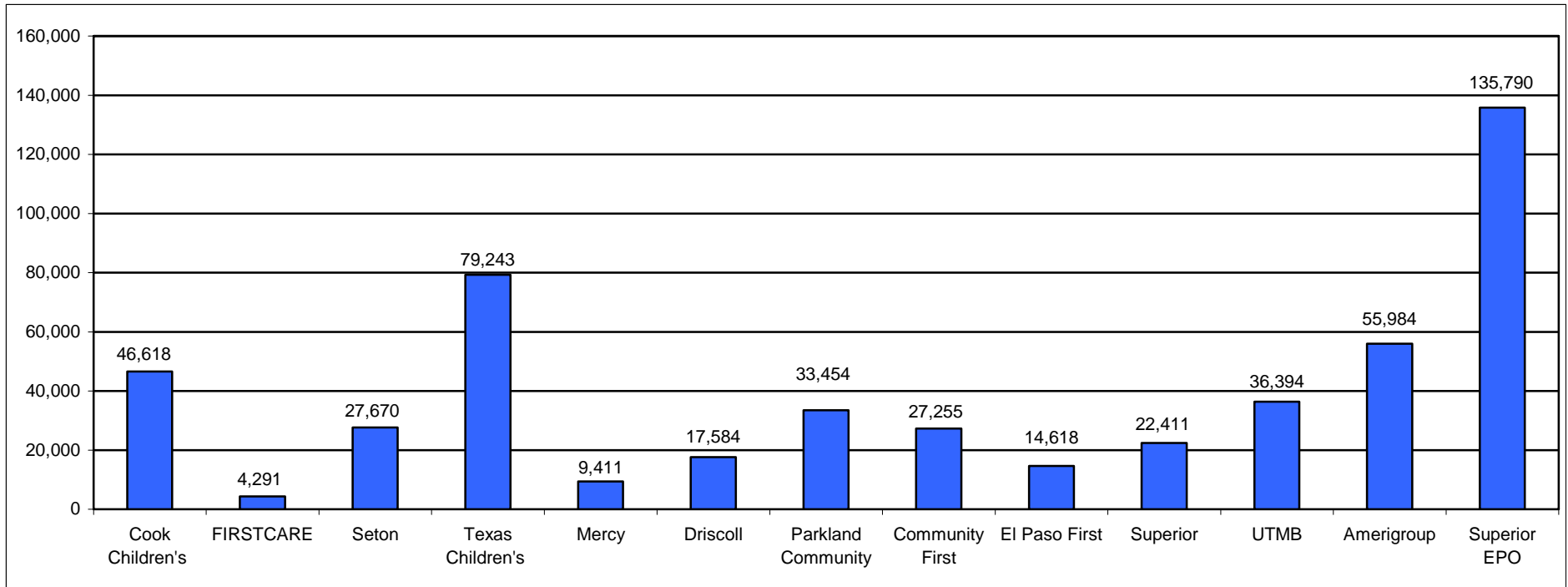
The indicators reported here are called the Pediatric Quality Indicators (PDIs). There are five PDIs measuring the rate of children with ambulatory care sensitive conditions admitted to a hospital for the following conditions: (1) Asthma; (2) Diabetes Short-term Complications; (3) Gastroenteritis; (4) Perforated Appendix; and (5) Urinary Tract Infection. The age eligibility for these measures is 17 years and younger.

In addition to the narrative and graphs contained in this chart book, technical appendices were provided to HHSC that contain all of the key findings. As previously noted, many but not all, of the quality of care indicator results are presented for each MCO. Some results were not displayed at the MCO-level (1) to facilitate ease of presentation and understanding of the material or (2) because the findings were similar between MCOs. However, all of the findings are contained in the technical appendices. The interested reader can review those spreadsheets for more details. The corresponding reference table is listed beneath each graph.

Chart 1. HEDIS® Total Unduplicated Members by MCO

CHIP MCOs - September 1, 2005 to August 31, 2006

CHIP Total Unduplicated Members = 510,723



Reference: CHIP Table TX-1

Note: Members who switched plans during the reporting period were not included; these individuals comprised 1.48 percent of the membership.

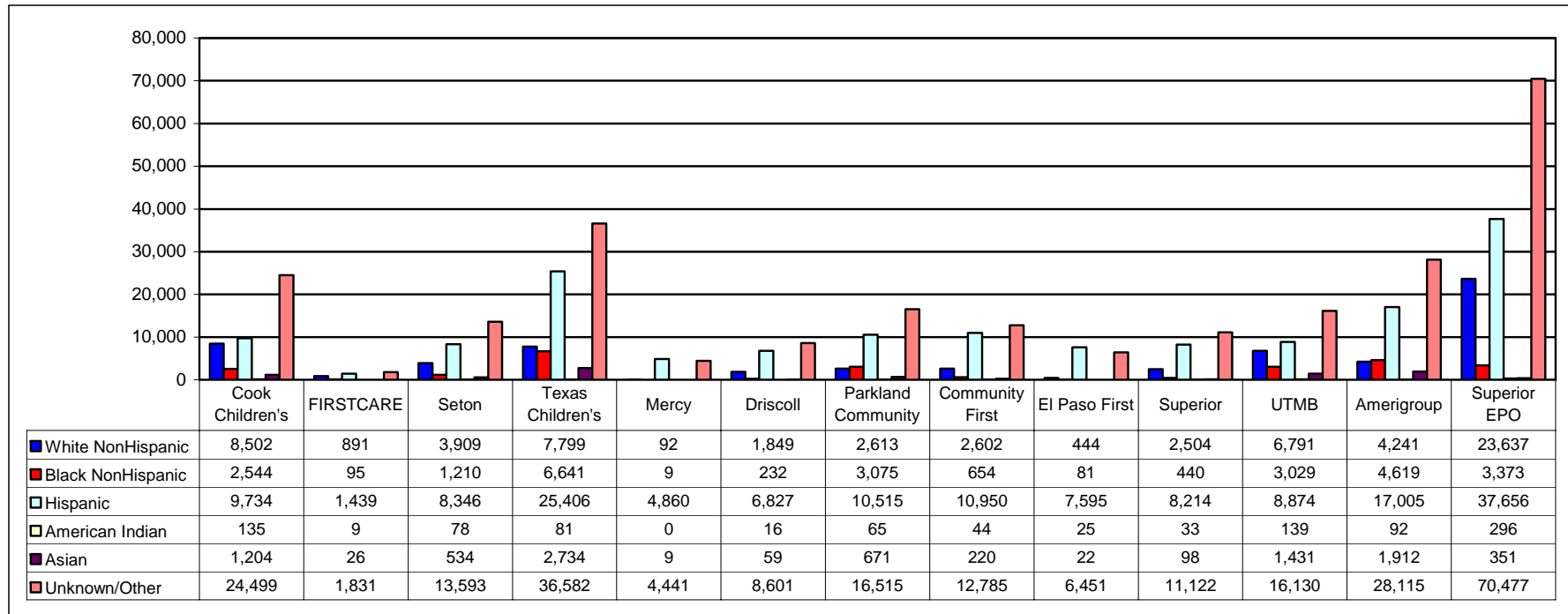
Key Points:

1. There was a decrease in enrollment in the CHIP Program in Texas, primarily attributed to changes in benefits and issues in enrollment/re-enrollment. These have been addressed by HHSC and do not require further recommendations. During fiscal year 2006, there were 510,723 unduplicated members, down from the 523,640 unduplicated members who were enrolled in CHIP during fiscal year 2005.
2. The average age of the membership is 10 years with a standard deviation of 4.81 years. The age distribution of child enrollees is the following: less than one percent of the enrollees are under 12 months old, 18 percent are between 1 and 5 years old, 58 percent are between 6 and 14 years old, and 24 percent are between 15 and 18 years old. Enrollees are almost evenly split between males and females.

Chart 2. HEDIS® Total Unduplicated Members by Race/Ethnicity and MCO

CHIP MCOs - September 1, 2005 to August 31, 2006

CHIP Total Unduplicated Members = 510,723



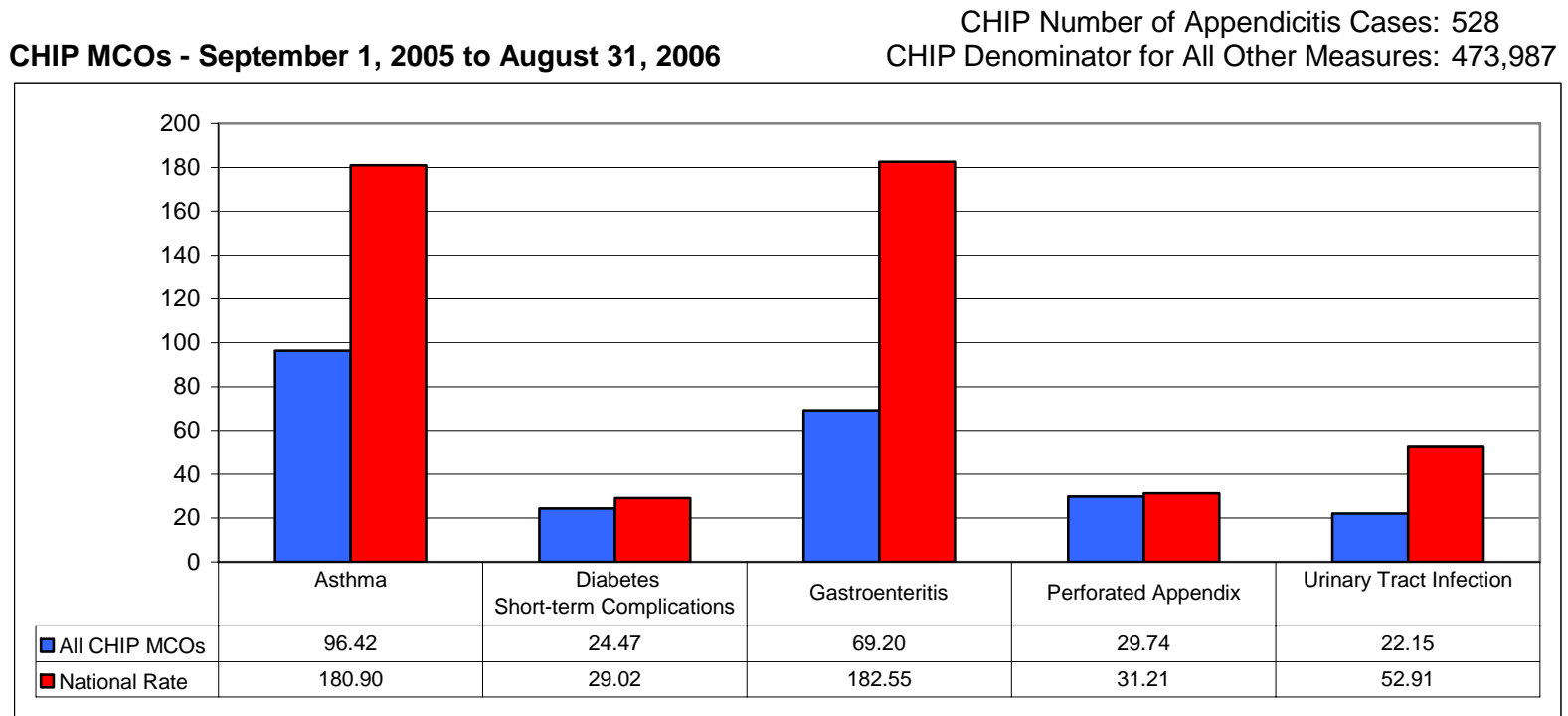
Reference: CHIP Table TX-2

Note: Members who switched plans during the reporting period were not included.

Key Points:

1. Race and ethnicity is unknown for 49 percent of CHIP enrollees. Of those with race/ethnicity available in the enrollment files, 61 percent of CHIP enrollees are Hispanic, 25 percent are White NonHispanic, 10 percent are Black NonHispanic, four percent are Asian, and less than one percent are American Indian.
2. Based on the available data, it is likely that the CHIP population is very diverse. Texas CHIP and the participating MCOs continue to face unique challenges in ensuring access to care and quality of care for groups that are traditionally underserved by the health care delivery system. Current emphasis on delivering culturally competent health care and reducing health disparities between racial/ethnic groups suggests that this information may help health plans target these efforts. Consideration should be given to requiring information regarding an enrollee's race/ethnicity on the enrollment application.

Chart 3. AHRQ Pediatric Quality Indicators



Reference: CHIP Table PI-1

Note: Rates are per 100,000 enrollees ages 17 and younger except for perforated appendix which is per 100 enrollees diagnosed with appendicitis.

Note: Members who switched plans during the reporting period were not included.

Key Points:

1. Chart 3 compares all CHIP MCOs' performance on five pediatric quality indicators developed for the Agency for Healthcare Research and Quality (AHRQ) to national rates. A description of these indicators follows the key points.

2. CHIP PDI rates were comparable to the national rates on two indicators—number of admissions for diabetes short-term complications per 100,000 children and number of admissions for perforated appendix as a share of all admission for appendicitis. However, CHIP PDI rates were significantly lower than the national rates on the remaining three indicators: number of admissions for long-term asthma, number of admissions for pediatric gastroenteritis, and number of admissions for urinary infection (all per 100,000 children).
3. The national rates developed by AHRQ are based on a general community population and not a population of those in a specific insurance program such as CHIP. Even though the pediatric AHRQ measures represent a similar age group, the socioeconomic attributes of the two groups may be quite different. Therefore, caution should be used when comparing CHIP results to national rates. However, comparison between participating MCOs can be valuable until HHSC determines if a specific performance goal is warranted.

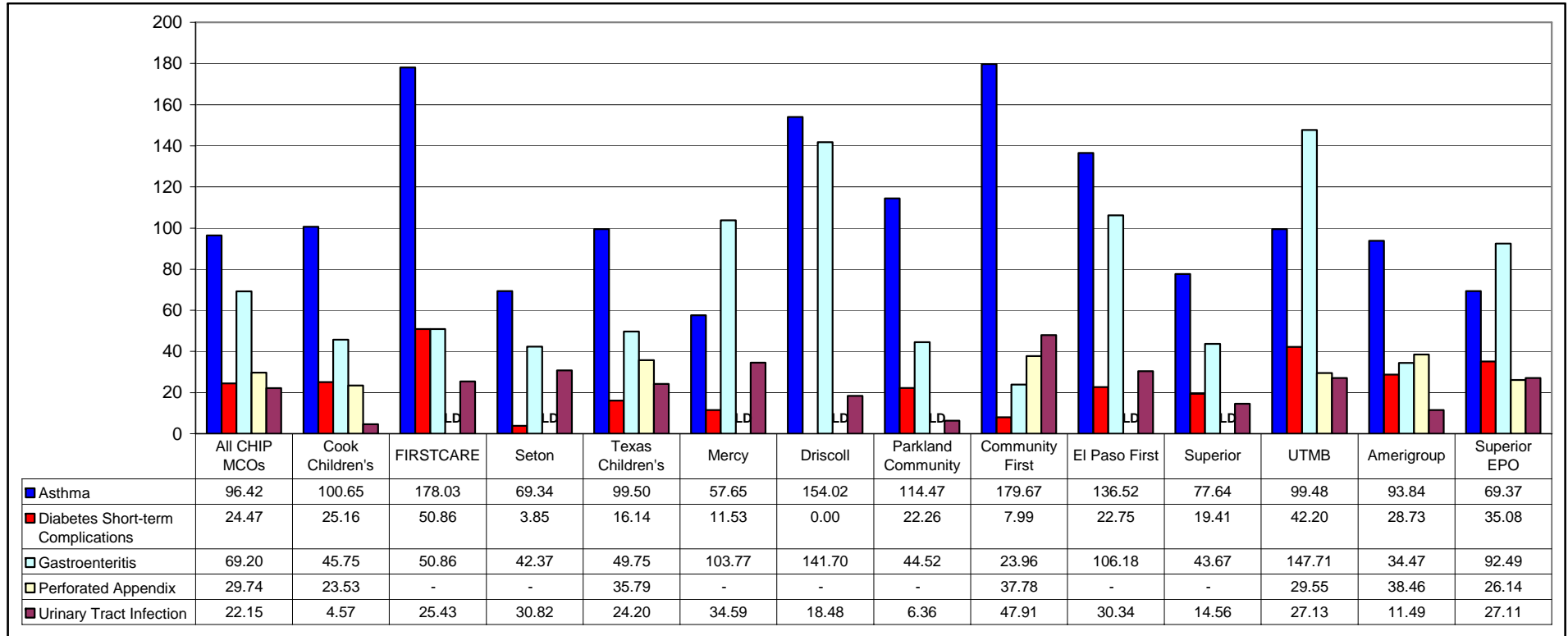
Pediatric Quality Indicators

AHRQ Indicator Number	Indicator Name	Description
PDI 14	Asthma Admission Rate	Number of admissions for long-term asthma per 100,000 population
PDI 15	Diabetes Short-term Complications Admission Rate	Number of admissions for diabetes short-term complications per 100,000 population
PDI 16	Gastroenteritis Admission Rate	Number of admissions for pediatric gastroenteritis per 100,000 population
PDI 17	Perforated Appendix Admission Rate	Number of admissions for perforated appendix as a share of all admissions for appendicitis within an area
PDI 18	Urinary Tract Infection Admission Rate	Number of admissions for urinary infection per 100,000 population

Chart 4. AHRQ Pediatric Quality Indicators by MCO

CHIP Number of Appendicitis Cases: 528
 CHIP Denominator for All Other Measures: 473,987

CHIP MCOs - September 1, 2005 to August 31, 2006



Reference: CHIP Table PI-1

Note: Members who switched plans during the reporting period were not included.

Note: Rates are per 100,000 enrollees ages 17 and younger except for perforated appendix which is per 100 enrollees diagnosed with appendicitis.

Note: LD (Low Denominator) indicates number of members eligible for the measure less than 30 with rate not reported. Eligible members are included in overall CHIP rates.

Key Points:

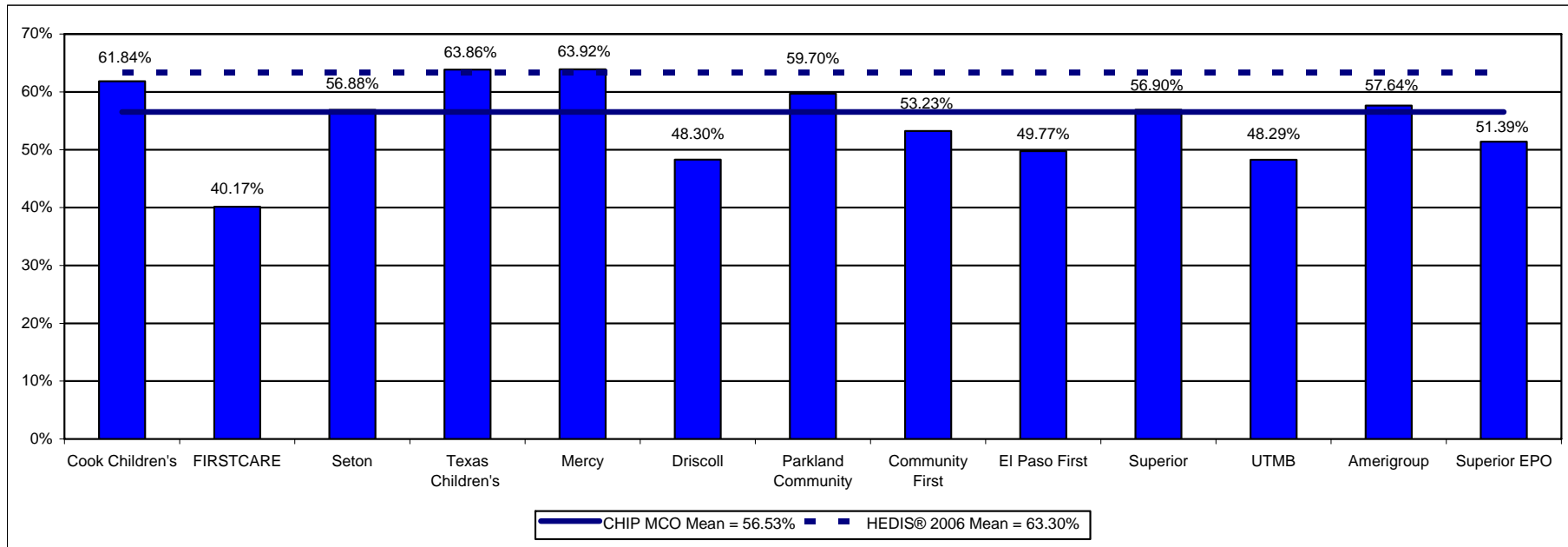
1. Chart 4 compares CHIP MCOs on five pediatric quality indicators (PDIs). There was great variation in MCO performance for every one of the indicators. Although the overall CHIP means were all at or below national means, some individual health plans were above the mean in some of the indicators. These are noted in the key points to follow.

2. For the number of admissions for long-term asthma per 100,000 members, Mercy had the lowest rate and FIRSTCARE and Community First had the highest rates. All MCOs had lower rates than the national mean of 180.90.
3. For the number of admissions for diabetes short-term complications per 100,000 members, Driscoll had no such occurrences while FIRSTCARE had the highest rate. Only three MCOs had rates that were higher than the national mean of 29.02: FIRSTCARE, UTMB, and Superior EPO.
4. For the number of admissions for pediatric gastroenteritis per 100,000 members, Community First had the lowest rate and UTMB had the highest rate. All MCOs had lower rates than the national average of 182.55.
5. For the number of admissions for perforated appendix as a share of every 100 admissions for appendicitis, seven MCOs had fewer than 30 cases of appendicitis among their members; thus, their rates for perforated appendix are not reported here. Of the remaining MCOs, Amerigroup had the highest rate and Cook Children's had the lowest rate.
6. For the number of admissions for urinary tract infections per 100,000 enrollees, Cook Children's and Parkland Community had the lowest rates and Community First had the highest rate. All MCOs had rates lower than the national mean of 52.91.
7. The EQRO recommends referral of these findings to the MCO medical directors for future review. As these are new indicators, HHSC may want to consider additional discussion with the medical directors on the results and their possible relationship to quality of care.

Chart 5. HEDIS® Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life

CHIP MCOs - September 1, 2005 to August 31, 2006

CHIP Enrollees in Age Group = 16,019



Reference: CHIP Table PI-2

Note: Members who switched plans during the reporting period were not included.

Key Points:

1. Access to preventive care visits is a fundamental component of pediatric health care for both children and adolescents. Preventive care visits that meet the American Academy of Pediatrics (AAP) periodicity schedule are associated with a decrease in avoidable inpatient admissions for infants across various racial and ethnic groups, income levels, and health status.⁴ A decrease in avoidable hospitalizations decreases overall cost as well as increases the overall health and quality of life of the enrollee and their family.
2. The HEDIS® Well-Child Measure includes rates of visits for children in the first 15 months of life. Only 54 children state-wide in CHIP meet the age and enrollment criteria for this measure. All MCOs have fewer than 30 members eligible for this measure.
3. Overall, fewer CHIP enrollees in Texas received at least one well-child visit in their 3rd, 4th, 5th, or 6th year of life than the percentage of child enrollees receiving preventive care for Medicaid health plans reporting to NCQA.

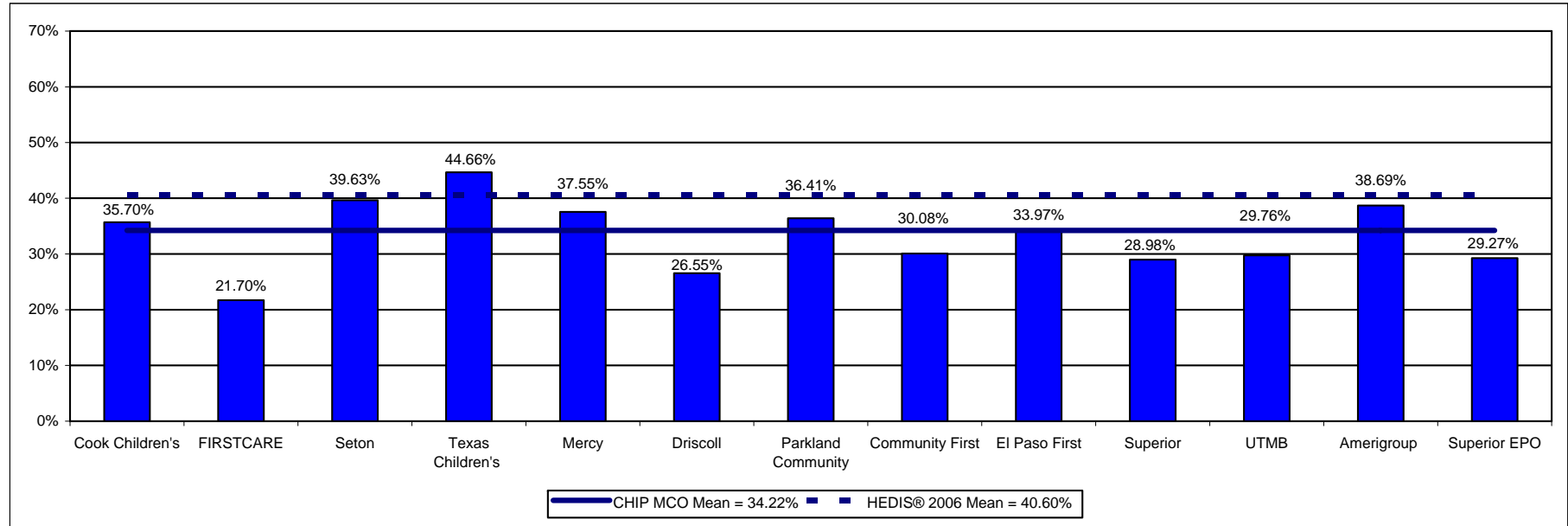
⁴ Hakim, R., and B. Bye. 2001. "Effectiveness of Compliance with Pediatric Preventive Care Guidelines among Medicaid Beneficiaries." *Pediatrics* 108: 90-97.

4. There was some variability among CHIP in Texas plan performance. FIRSTCARE had the lowest percentages of children in the 3rd, 4th, 5th, and 6th years of life receiving a well-child visit. Texas Children's Health Plan and Mercy Health Plan had the highest percentages of children in this age cohort receiving well-child visits and were the only health plans to surpass the national mean of 63 percent.
5. Due to the importance of preventive care in the identification of potential illnesses, special health care needs, and disabilities in children, MCOs should develop strategies to increase provision of preventive care to children in the 3rd, 4th, 5th, and 6th years of life.
6. Out of the four health plans with the lowest percentages, only Driscoll calculates this HEDIS[®] measure as part of their quality assurance program. The other three do not calculate this internally. On the other hand, all three of the health plans with the highest percentages of well-child visits calculate HEDIS[®] measures internally. This suggests that internal calculation and monitoring of the HEDIS[®] measures may have a positive impact on the rates of well-child care. HHSC may want to consider strategies for closer monitoring and reporting of HEDIS[®] measures as a way to improve results.
7. Strategies for facilitating the first encounter with a PCP, which may impact overall rates of well-child care for new enrollees, differed among the worst and best performing health plans as well. FIRSTCARE, which had the lowest percentage of all health plans, and Driscoll, which also performed poorly, did not have any procedures in place to encourage a new enrollee to see their PCP for a well-child visit upon enrolling. UTMB sent a letter with the ID card. In contrast, Texas Children's and Mercy had the highest percentages of children receiving well-child visits followed closely by Cook Children's. Texas Children's sends a welcome letter to new enrollees to encourage them to make an appointment with their child's PCP as soon as possible, and they stress that doctor's appointments not related to an illness are important. Mercy uses welcome calls to inform the parent to make an appointment for their child within 90 days. Mercy also sends out follow-up communications, including a newsletter, that emphasize the importance of the PCP-patient relationship. Cook Children's sends a new member packet and a welcome letter that encourages the parent to make an appointment for their child as soon as possible. The MCO also provides education on this topic for all members when they call the plan's hotline for any reason. HHSC may want to investigate some of these strategies that appear to be successful to increase performance in this area. With the exception of Texas Children's and Mercy, all health plans fall below the HEDIS[®] mean.

Chart 6. HEDIS® Adolescent Well-Care Visits

CHIP MCOs - September 1, 2005 to August 31, 2006

CHIP Enrollees in Age Group = 66,692



Reference: CHIP Table PI-2

Note: Members who switched plans during the reporting period were not included.

Key Points:

1. Overall, 34 percent of CHIP in Texas enrollees received at least one adolescent well-care visit compared to 41 percent of enrollees in Medicaid health plans reporting to NCQA. This year's overall results show some improvement over the 31 percent of adolescent CHIP in Texas enrollees who received at least one preventive care visit as documented in the previous year's annual chart book.
2. There was some marked variability among CHIP in Texas MCO performance. FIRSTCARE had the lowest percentage of enrollees with an adolescent well-care visit. Texas Children's had the highest percentage for adolescent well-care visits and was the only MCO to surpass the HEDIS® mean of 41 percent.

3. Annual results for adolescents continue to fall short of the national average of plans reporting to NCQA. Because preventive care is very important throughout adolescence, MCOs should develop strategies to increase provision of preventive care to adolescents ages 12 to 21. The same health plans that performed well for the younger age group (See Chart 5) also performed well in adolescent preventive care. Many of the same strategies identified to improve performance rates in the younger group may also be used with adolescents. In addition, studies have found that one common barrier to adolescents receiving high-quality preventive care is the lack of privacy in the interaction between adolescent patients and their physicians.⁵ HHSC may want to encourage health plans to collaborate with providers and parents to provide more opportunities for adolescents to see clinicians without their parents present at the time of the visit.^{6,7}

⁵ Chung, P.J., T. C. Lee, J. L. Morrison, and M. A. Schuster. 2006. "Preventive Care for Children in the United States: Quality and Barriers." *Annual Review of Public Health* 27: 491-515.

⁶ Bethell, C., J. Klein, and C. Peck. 2001. "Assessing Health System Provision of Adolescent Preventive Services: The Young Adult Health Care Survey." *Med. Care* 39: 478-490.

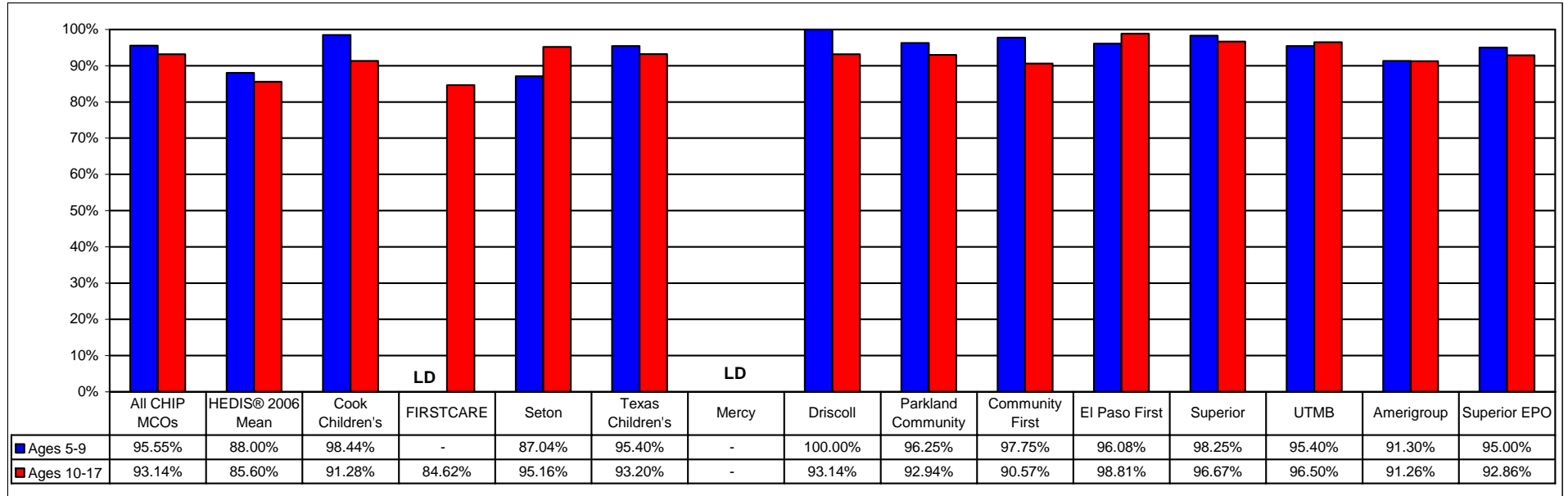
⁷ Bravender, T., C. N. Price, and A. English. 2004. "Primary Care Providers' Willingness to See Unaccompanied Adolescents." *Journal of Adolescent Health* 34: 30-36.

Chart 7. HEDIS® Use of Appropriate Medications for People with Asthma

CHIP MCOs - September 1, 2005 to August 31, 2006

CHIP Enrollees in Age Group: Children = 1,191

Adolescents = 2,098



Reference: CHIP Table PI-4

Note: Members who switched plans during the reporting period were not included.

Note: HEDIS® age groups are Children (5 to 9 years old) and Adolescents (10 to 17 years old). Ages 18 and 19 fall in the Adult category.

Note: LD (Low Denominator) indicates number of members with persistent asthma eligible for the measure is less than 30 with rate not reported.

Key Points:

1. In 2005, an estimated 22.2 million Americans (7.7 percent of the population) had asthma. Children (younger than 18 years) represent a substantial number of asthma cases in the United States, accounting for 6.5 million Americans with asthma.⁸ Asthma is the third leading cause of hospitalizations among children under the age of 15 and is the leading cause of chronic illness among children.⁹ Despite major advances in understanding asthma, the development of new therapies to control symptoms and prevent exacerbations, and use of clinical guidelines developed by The National Institute of Health and National Heart, Lung and Blood Institute, effective therapies are not uniformly used in the pediatric health care community.¹⁰

⁸ Centers for Disease Control and Prevention (CDC). 2007. "Asthma Prevalence, Health Care Use and Mortality: United States, 2003-05." [Accessed on August 17, 2007]. Available at <http://www.cdc.gov/nchs/products/pubs/pubd/hestats/asthma03-05/asthma03-05.htm>.

⁹ National Center for Health Statistics. *National Hospital Discharge Survey and National Health Interview Survey*.

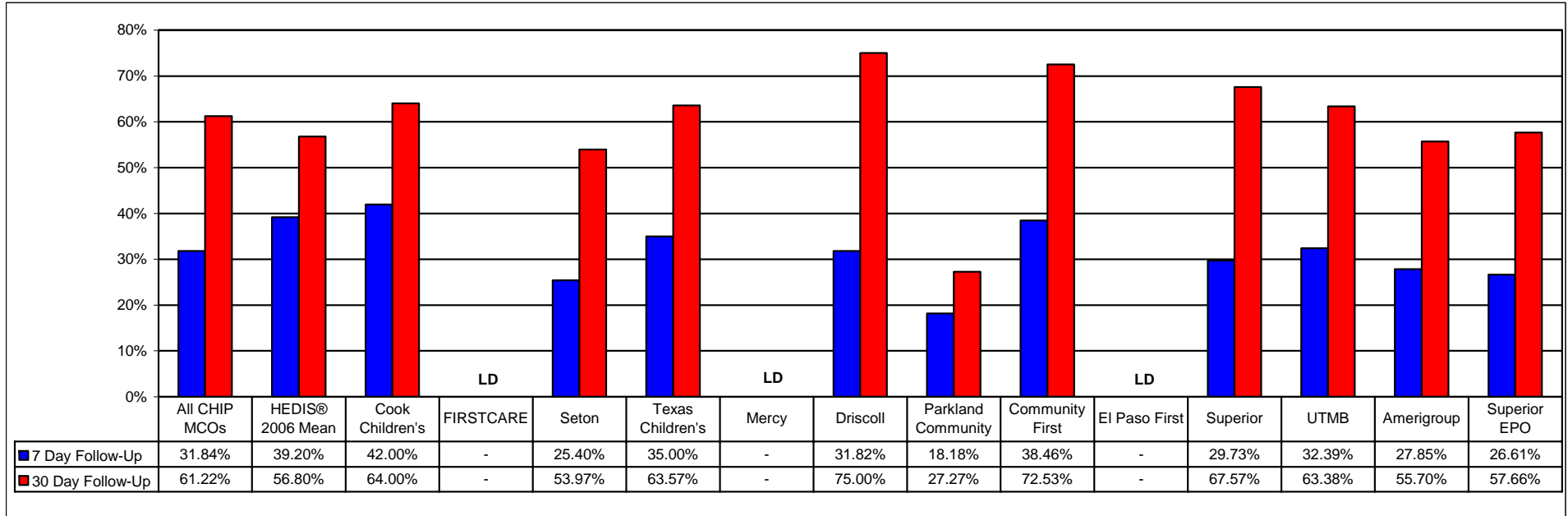
¹⁰ Swartz, M. K., N. C. Banasiak, and M. Meadows-Oliver. 2005. "Barriers to Effective Pediatric Asthma Care." *Journal of Pediatric Health Care* 19 (2): 71-79.

2. The findings for this indicator are positive. Overall, CHIP MCOs exceeded the HEDIS[®] Medicaid 2006 mean for both children and adolescents. Ninety-six percent of CHIP enrollees ages five through nine with asthma received appropriate asthma medications compared to 88 percent of enrollees with asthma of Medicaid plans reporting to NCQA. Ninety-three percent of adolescents with asthma ages 10 through 17 received appropriate medications compared to the national average of 86 percent.
3. Overall, CHIP MCOs performed well, at or above the national HEDIS[®] Medicaid 2006 mean. Because the Texas CHIP Program had higher rates of appropriate asthma treatment than the national means, no recommendations are suggested.

Chart 8. HEDIS® Follow-Up after Hospitalization for Mental Illness

CHIP MCOs - September 1, 2005 to August 31, 2006

CHIP Mental Health Hospitalizations = 980



Reference: CHIP Table PI-5

Note: Members who switched plans during the reporting period were not included.

Note: LD (Low Denominator) indicates number of hospitalizations eligible for the measure is less than 30 with rate not reported. Eligible hospitalizations are included in overall CHIP rates.

Key Points:

1. Ensuring continuity of care and providing follow-up in the community after inpatient stays for mental illness has been shown to reduce enrollees' health care costs and to improve their outcomes of care.¹¹ Appropriate follow-up is particularly important for children who have serious emotional disturbance due to the complexity of their healthcare needs. HEDIS® contains a measure designed to assess outpatient follow-up at seven days and 30 days after an inpatient stay for mental illness.

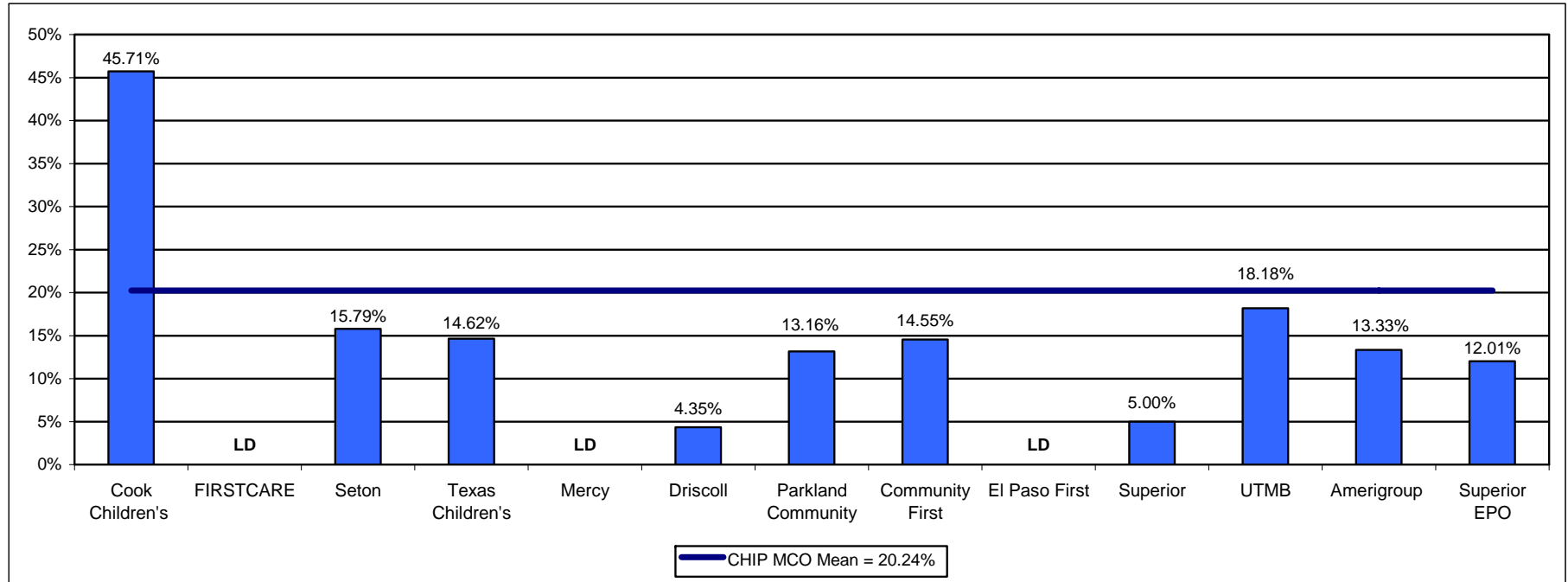
¹¹ Fortney, J. G. Sullivan, K. Williams, C. Jackson, S. C., Morton, and P. Kogel. 2003. "Measuring Continuity of Care for Clients of Public Mental Health Systems." *Health Services Research* 38 (4): 1157-1175.

2. The HEDIS[®] measure includes follow-up visits with a mental health provider only. Due to difficulty in identifying provider type in the claims and encounter data, the measure reported for CHIP includes follow-up visits for a mental health diagnosis with any medical provider. Therefore, rates reported for Texas would be expected to be somewhat higher than the HEDIS[®] reported rates.
3. The percentage of CHIP enrollees who had an outpatient follow-up within seven days of an inpatient admission for mental illness is lower than the HEDIS[®] 2006 mean for outpatient follow-up (39 percent). On the other hand, the percentage of CHIP enrollees who had a follow-up within 30 days of their inpatient admissions was higher than the 57 percent average for Medicaid Programs reporting to NCQA.
4. Although the overall CHIP rate for follow-up after seven days is slightly lower and the rate for follow-up after 30 days is slightly higher than the national mean, it is important to note the variation by MCO. For example, Parkland Community lags behind the performance of other health plans with approximately 18 percent of the enrollees having an outpatient follow-up within seven days of discharge and only 27 percent having an outpatient follow-up within 30 days of discharge. HHSC should consider sharing results with each MCO, and successful aftercare strategies developed by MCOs should be analyzed and disseminated.

Chart 9. Readmission within 30 Days after an Inpatient Stay for Mental Health

CHIP MCOs - September 1, 2005 to August 31, 2006

CHIP Inpatient Mental Health Stays = 1,250



Reference: CHIP Table PI-6

Note: Members who switched plans during the reporting period were not included.

Note: LD (Low Denominator) indicates number of members eligible for the measure less than 30 with rate not reported. Eligible members are included in overall CHIP rates.

Key Points:

1. With the increase of managed care in mental health services, there is an increasing emphasis placed on time-limited treatment in both inpatient and outpatient psychiatric settings. Some have argued that while decreased length of stay does help contain mental health care costs, quality of care can be compromised.^{12,13} For that reason, mental health readmissions are frequently used as a measure of an adverse outcome.¹⁴
2. National comparison data is not available for this measure; however, one small study conducted in a regional managed care company showed that 17.6 percent of patients discharged from any of seven psychiatric hospitals in the region were readmitted to a hospital during the six-month follow up period. About seven percent of the readmissions occurred within 30 days of discharge.¹⁵
3. Twenty percent of CHIP enrollees who were hospitalized for a mental health problem were readmitted to an inpatient facility within 30 days of discharge, an increase from the 13 percent of the previous annual chart book. There was great variability in plan performance with Driscoll and Superior having four and five percent of enrollees, respectively, readmitted to an inpatient facility within 30 days and Cook Children's Health Plan having 46 percent of enrollees readmitted to a hospital within 30 days.
4. There are multiple factors that can influence readmission to a psychiatric hospital, including patient severity, family resources, after care planning, and community supports. HHSC should consider a focus study to identify whether interventions used by plans that perform well on this indicator can be implemented to improve other plans' performance or whether the differences can be attributed to the diagnoses or demographics of the eligible populations for each plan.

¹² Lieberman, P. B., S. Wiitala, B. Elliott, et al. 1998. "Decreasing Length of Stay: Are There Effects on Outcomes of Psychiatric Hospitalization?" *American Journal of Psychiatry* 155: 905–909.

¹³ Pincus H. A., D. Zarin, and J. West. 1996. "Peering into the 'Black Box'. Measuring Outcomes of Managed Care." *Archives of General Psychiatry* 53: 870–877.

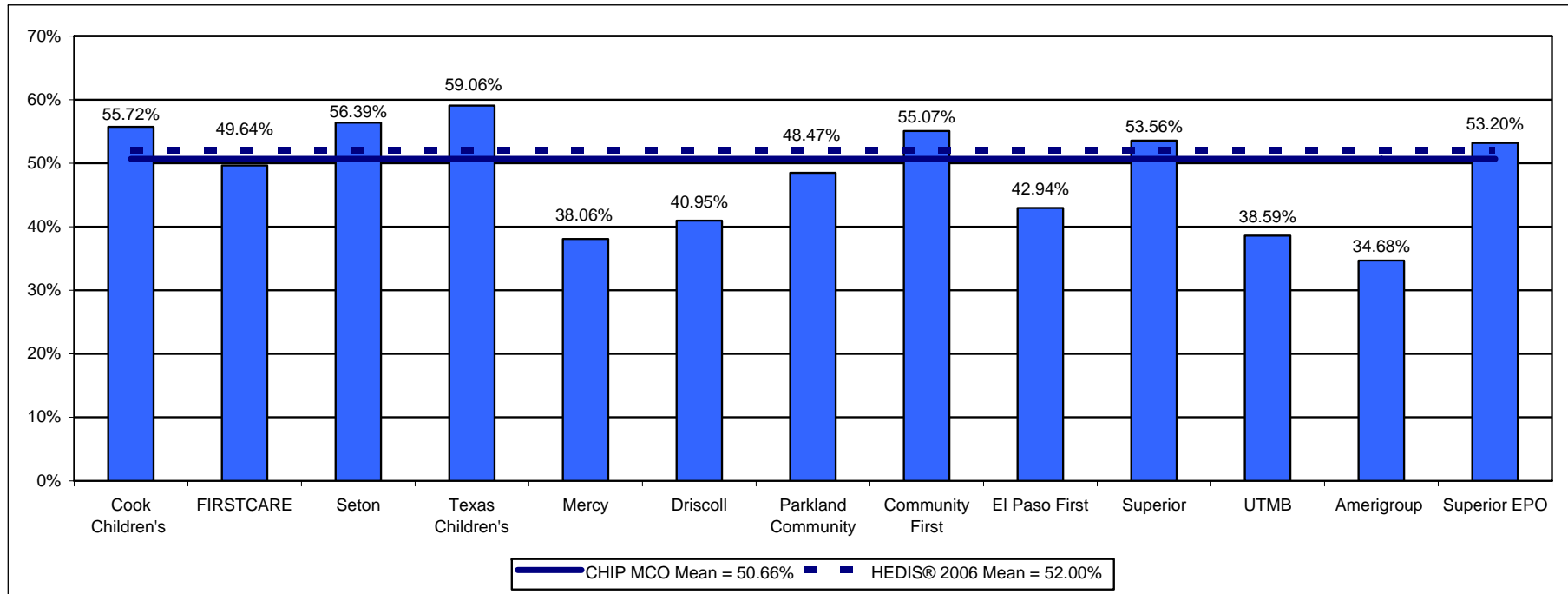
¹⁴ Figueroa, R., J. Harman, and J. Engberg. 2004. "Use of Claims Data to Examine the Impact of Length of Inpatient Psychiatric Stay on Readmission Rate." *Psychiatric Services* 55 (5): 560-5.

¹⁵ Lyons, J., M. O'Mahoney, S. Miller, J. Neme, J. Kabat, and F. Miller. 1997. "Predicting Readmission to the Psychiatric Hospital in a Managed Care Environment: Implications for Quality Indicators." *American Journal of Psychiatry* 154 (3): 337-40.

Chart 10. HEDIS® Appropriate Testing for Children with Pharyngitis

CHIP MCOs - September 1, 2005 to August 31, 2006

CHIP Eligible Children = 18,619



Reference: CHIP Table PI-14

Note: Members who switched plans during the reporting period were not included.

Key Points:

1. Sore throat is one of the most common reasons for a child to visit their Primary Care Provider.¹⁶ While most children with a sore throat have an infectious cause (pharyngitis), fewer than 20 percent have a clear indication for antibiotic therapy (i.e., group A beta-hemolytic streptococcal infection).¹⁷ Due to concerns with antibiotic resistance and inappropriate use of antibiotic medications, testing of children presenting to their Primary Care Provider with sore throats is warranted.
2. Overall, the percentage of CHIP enrollees with pharyngitis who received appropriate Group A streptococcus testing is very close to the HEDIS® 2006 mean of 52 percent.

¹⁶ Gerber, M.A. 1998. "Diagnosis of Group A Streptococcal Pharyngitis." *Pediatric Annals* 27: 269-73.

¹⁷ Vincent, M.T. 2004. "Pharyngitis." *American Family Physician* 69: 1465-70.

3. Findings for this reporting period continue to show a great deal of variability among CHIP MCOs. At 59 percent, Texas Children's Health Plan had the highest percentage of children receiving appropriate testing for the fiscal year. At 35 percent, Amerigroup had the lowest percentage of enrollees who received appropriate testing for the fiscal year.
4. Consideration should be given to assessing whether MCOs with better performance, such as Texas Children's, Seton, Cook Children's, and Community First, have specific strategies in place that may contribute to that performance. HHSC should also share results with other MCOs that have been less successful to increase awareness of the importance of this practice.