Annual Chart Book

Fiscal Year 2005

Texas Children's Health Insurance Program Quality of Care Measures

Prepared by

The Institute for Child Health Policy
University of Florida

The Texas External Quality Review Organization
for Medicaid Managed Care and CHIP

Measurement Period:
September 1, 2004 through August 31, 2005

Submitted:
April 14, 2006

Final Submitted:
September 29, 2006

Table of Contents

Introduction

Assessing the quality of care for all children is essential. In the case of Medicaid Managed Care and the State Children's Health Insurance Program (SCHIP), states are required to have performance goals and measures to evaluate the quality of care provided in the program.[1] There are several conceptual frameworks that can be used to organize quality of care assessments. The Institute of Medicine (IOM) has provided a framework for assessing health care quality that includes assessing (1) the effectiveness of care, (2) the access to and timeliness of care, and (3) the patient-centeredness of care.[2] Effectiveness of care refers to providing care that is based on systematically acquired evidence as to its benefit in producing better outcomes than the alternatives, which include doing nothing. Access to and timeliness of care refers to a person being able to receive needed care without undue delays. Insurance coverage is essential for good access to care, but it is not a guarantee. Geographic barriers, lack of understanding about how to use the health care system, and other factors can contribute to poor access to care, even among the insured. Finally, care should be patient-centered; that is, all patients should be treated with dignity and respect, and they should be involved in the decision-making about their care.

In addition to the preceding aspects of care, the IOM specifically discusses the important relationship between payment polices and the quality of care provided to enrollees. Ensuring that payment is appropriate for the severity of illness or the case-mix seen among the enrolled population is essential to encourage access to care and the delivery of quality care.

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). This update is for September 1, 2004, to August 31, 2005, covering fiscal year 2005. This chart book is a follow-up to the CHIP Annual Chart Book, published in December 2004, which covered quality of care measures for December 1, 2002, to November 30, 2003, and the CHIP Annual Chart Book, published in December 2003, which covered quality of care measures for January 1, 2002, through December 31, 2002. The format of this annual chart book differs from previous annual chart books in that it contains less background information and focuses only on key points. Additionally, recommendations are provided in the narrative of the report under the heading "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 full time frame used to prepare the measures is September 1, 2004, to August 31, 2005. The only exception is the asthma indicator which requires two years of pharmacy data. A three month time lag was used for the claims and encounter data. Prior analyses with Texas data found that, on average, approximately 96 percent of the claims and encounters were complete by that time period. A three month lag was used because the Texas Health and Human Services Commission (HHSC) have requested reports that are as close to the actual time of service delivery as possible.

[1] The National Governors Association, Center for Best Practices. August 2001. *State Efforts to Evaluate the Progress and Success of SCHIP*.
[2] The Institute of Medicine. 2001. *Crossing the Quality Chasm*. Washington, DC: National Academy Press.

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 and Ethnicity

2) Access to Care
   a) Percent of Enrollees with One or More Hospital Stays Due to an Ambulatory Care Sensitive Condition
   b) Percent of Hospitalizations with a Primary Diagnosis of an Ambulatory Care Sensitive Condition
   c) Percent of Enrollees with One or More Emergency Department Visits Due to an Ambulatory Care Sensitive Condition
   d) Percent of Emergency Department Use with a Primary Diagnosis of an Ambulatory Care Sensitive Condition

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 that operates as a traditional MCO. Superior EPO is a separate program which functions as a fee for service model without a gatekeeper. EPO enrollees are permitted to see any provider as long as the provider is in the network. Superior EPO assumed Clarendon's membership when they 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 Physician's 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 in Texas claims and encounter data were compiled for the time period of September 1, 2004, to August 31, 2005. 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, March 2006." 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 national comparisons available for CHIP, there is comparative data from Medicaid programs. National Committee for Quality Assurance (NCQA) gathers data from Medicaid managed care plans nationally and compiles them.[3] 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.[4] NCQA reports the national results 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 2004 mean results are shown and are labeled "HEDIS® Mean 2004" in the graphs. This information is not available for all of the quality of care indicators.

In addition to the narrative and graphs contained in this chart book, Excel spreadsheets 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 for each MCO (1) to facilitate ease of presentation and understanding of the material or (2) because the findings were similar for each MCO. However, all of the findings are contained in the Excel spreadsheets. The interested reader can review those spreadsheets for more details. The corresponding reference table is listed beneath each graph.

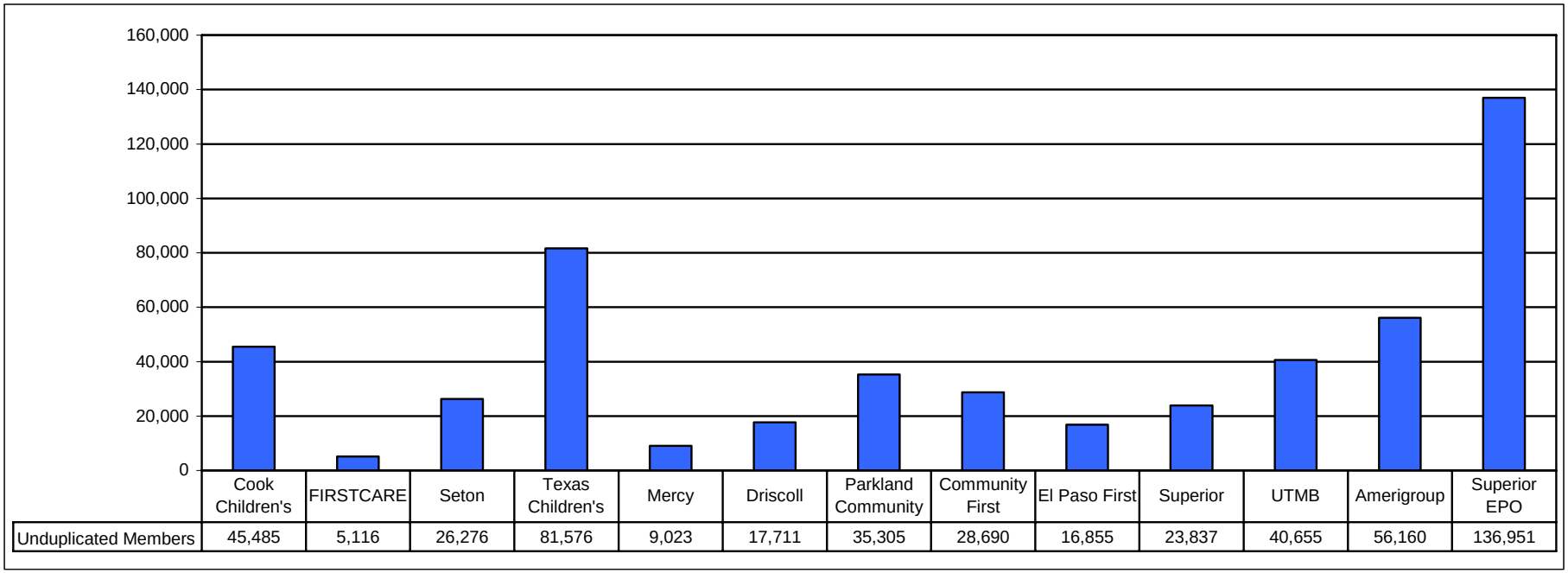
[3] The information that NCQA compiles for Medicaid Managed Care Programs can be viewed at www.ncqa.org

[4] 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.

Chart 1. HEDIS® Total Unduplicated Members

CHIP MCOs - September 1, 2004 to August 31, 2005

CHIP Total Unduplicated Members = 523,640



	Cook Children's	FIRSTCARE	Seton	Texas Children's	Mercy	Driscoll	Parkland Community	Community First	El Paso First	Superior	UTMB	Amerigroup	Superior EPO
Unduplicated Members	45,485	5,116	26,276	81,576	9,023	17,711	35,305	28,690	16,855	23,837	40,655	56,160	136,951

Reference: CHIP Table TX-1

Note: Members who switched plans during the reporting period were not included. This comprised 1.08% of the membership.

Key Points:

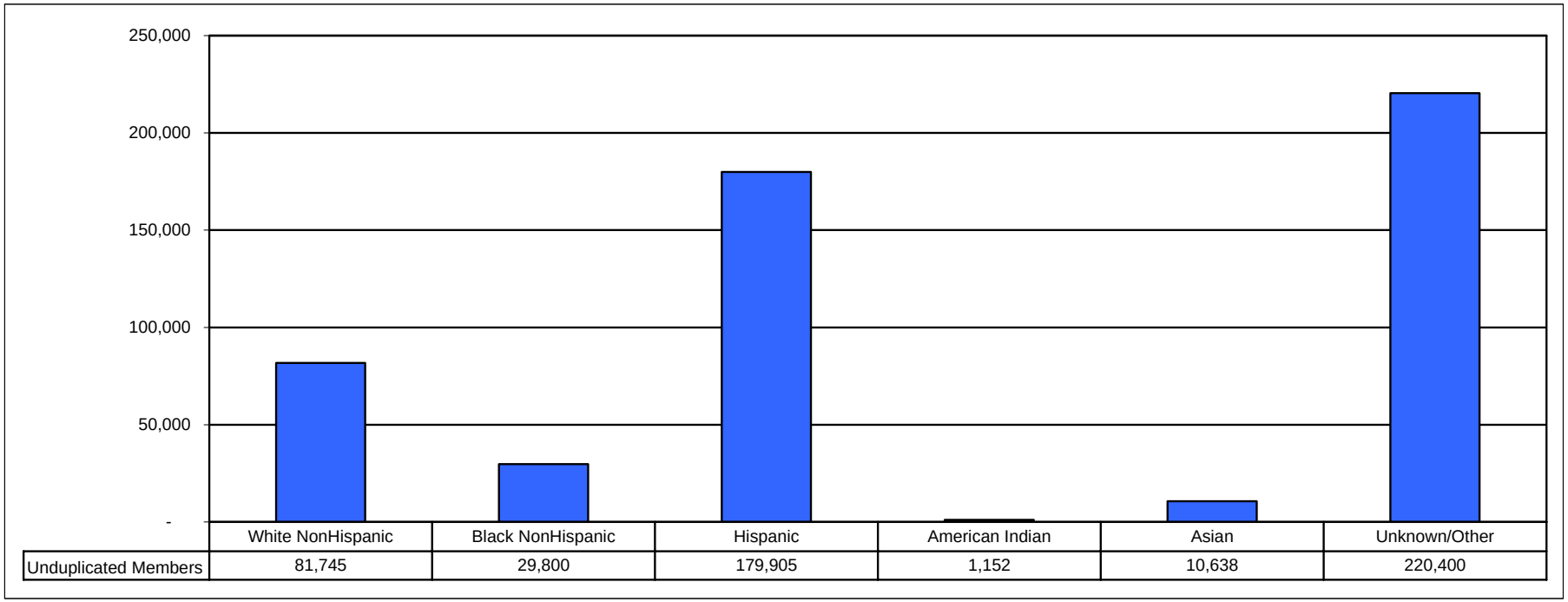
1. During the time period from September 1, 2004, to August 31, 2005 (SFY05), there were 523,640 unduplicated members in CHIP in Texas. This represents a 24 percent decrease from the 688,914 unduplicated members who were enrolled in CHIP during the time period of the previous annual chart book from December 1, 2002, to November 30, 2003. This decrease can be attributed to several policy changes implemented by Texas. These policy changes and their impact on enrollment are more fully described in the report, "An Analysis of Disenrollment Patterns in the Child Health Insurance Program in Texas," submitted in October 2004.

2. The average age of the membership is 10 years (± 4.84 years). The age distribution of enrollees is similar to that reported in the previous annual chart book. Less than one percent of the enrollees are under 12 months old, 19 percent are between 1 and 5 years old, 58 percent are between 6 and 14 years old, and 23 percent are between 15 and 18 years old.

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

CHIP MCOs - September 1, 2004 to August 31, 2005

CHIP Total Unduplicated Members = 523,640



	White NonHispanic	Black NonHispanic	Hispanic	American Indian	Asian	Unknown/Other
Unduplicated Members	81,745	29,800	179,905	1,152	10,638	220,400

Reference: CHIP Table TX-2

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

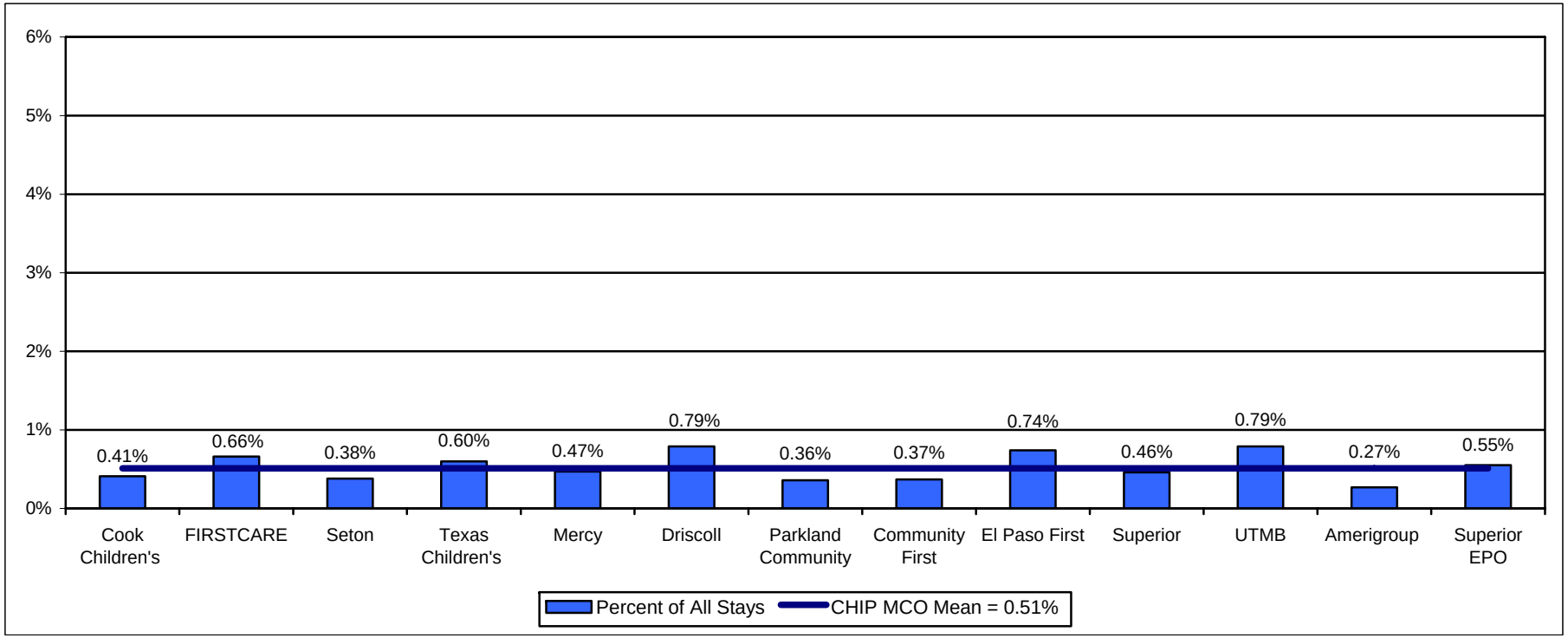
Key Points:

1. Thirty-four percent of CHIP enrollees are Hispanic, 16 percent are White non-Hispanic, six percent are Black non-Hispanic, two percent are Asian, and less than one percent are American Indian. Race and ethnicity is unknown for 42 percent of CHIP enrollees. This distribution is similar to that reported in previous chart books.

2. Despite the missing values for race and ethnicity for 42 percent of CHIP enrollees, 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. Currently, MCOs are not required to submit information regarding an enrollees' race or ethnicity. Consideration should be given to requiring MCOs to submit this information.

Chart 3. Percent of Enrollees with One or More Hospital Stays Due to an Ambulatory Care Sensitive Condition

CHIP MCOs - September 1, 2004 to August 31, 2005 CHIP Enrollees = 523,640

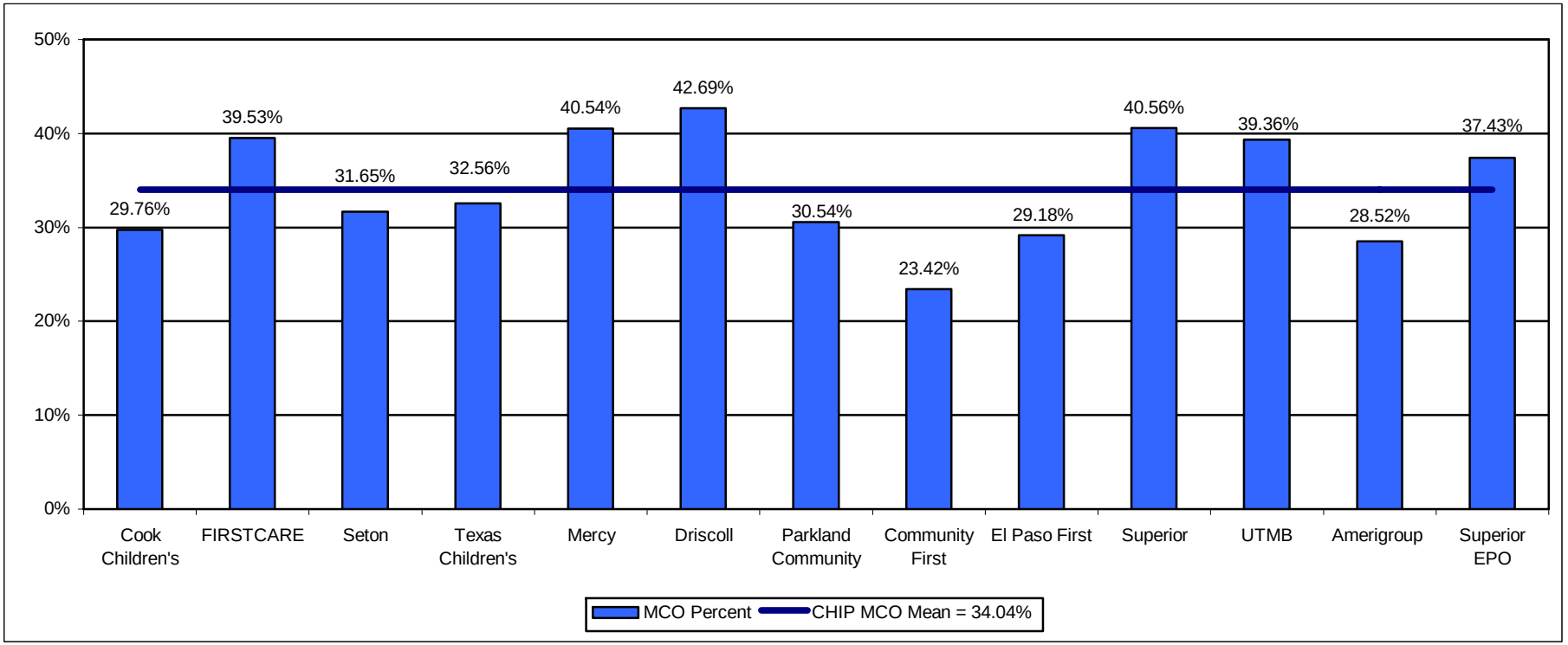


Reference: CHIP Tables PI-1 and TX-1

Note: Charts 3 and 4 need to be viewed together. The key findings about hospital stays for ambulatory care sensitive conditions are summarized following Chart 4.

Chart 4. Percent of Hospitalizations with a Primary Diagnosis of an Ambulatory Care Sensitive Condition

CHIP MCOs - September 1, 2004 to August 31, 2005 CHIP Hospitalizations = 8,849



Reference: CHIP Table PI-1

Key Points:

1. Ambulatory Care Sensitive Conditions (ACSCs) are those conditions (such as angina, bacterial pneumonia, congenital syphilis, specific types of congestive heart failure, specific types of hypertension, and immunization-preventable conditions) that should not result in an inpatient stay or an emergency room visit if there is good access to care in the outpatient setting.

2. While preventable hospitalizations and emergency room visits are costly and do not reflect good quality of or access to care for enrollees, this measure can only identify those occurrences that may have been preventable. Additional analysis would be required to confirm whether an individual occurrence was indeed preventable.

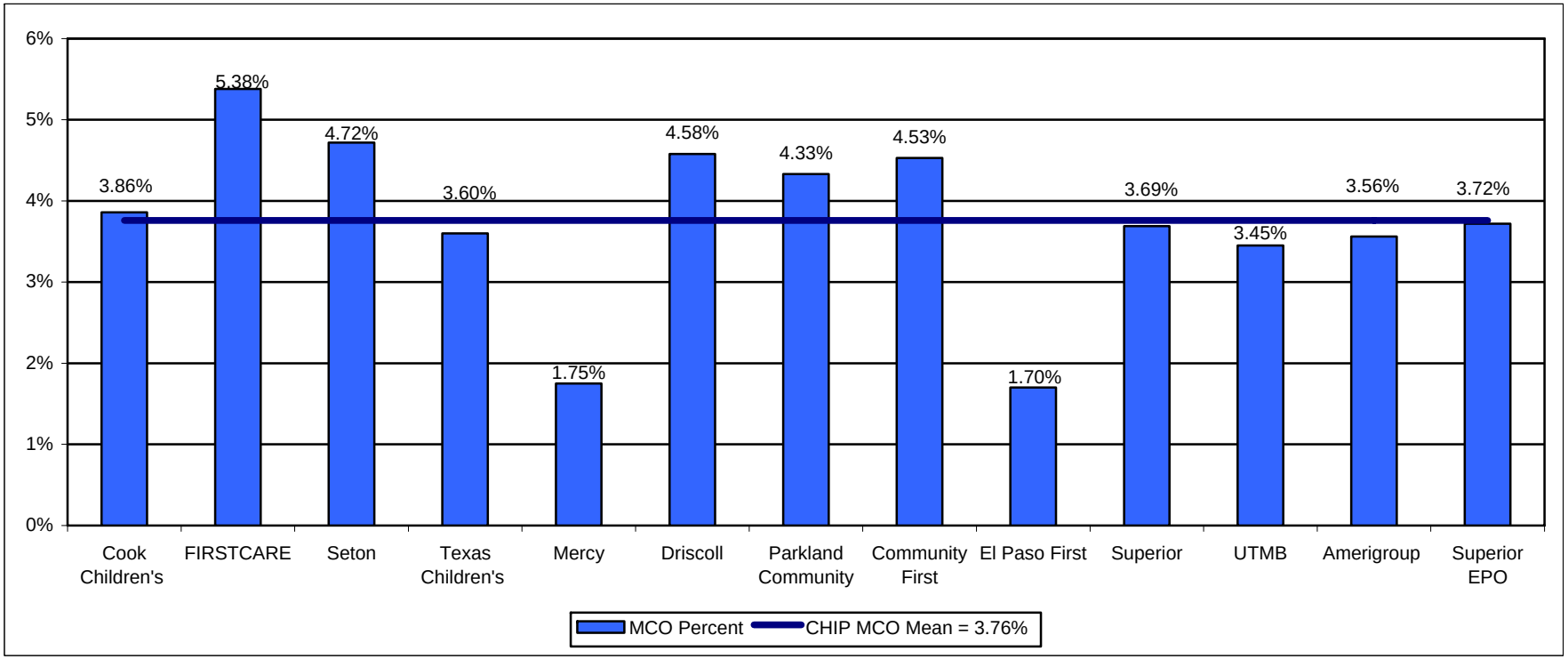
3. Less than one-half of a percent of CHIP in Texas enrollees in seven out of 13 health plans experienced one or more hospital stays due to an ACSC during the reporting period (see Chart 3).

4. Admissions for ACSCs accounted for the 34 percent of CHIP in Texas enrollee hospitalizations. This can be compared to the 26 percent of ACSC-related admissions reported in the previous annual chart book. There was variability in the hospitalizations with Driscoll having the highest percentage of hospitalizations for ACSCs at 43 percent, and Amerigroup and Community First having the lowest percentage of ACSC hospitalizations at 29 percent and 23 percent, respectively.

5. National comparison data are not available for this measure.

Chart 5. Percent of Enrollees with One or More Emergency Department Visits Due to an Ambulatory Care Sensitive Condition

CHIP MCOs - September 1, 2004 to August 31, 2005 CHIP Enrollees = 523,640

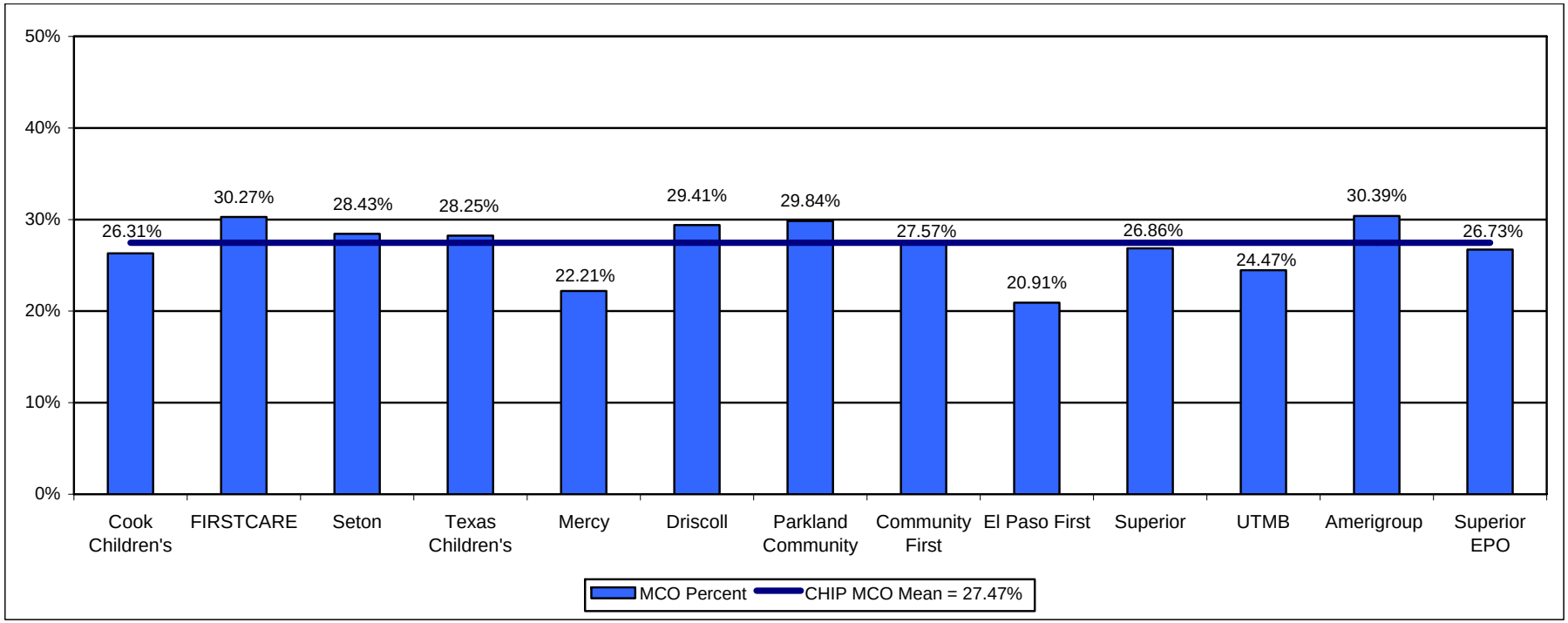


Reference: CHIP Tables PI-1 and TX-1

Note: Charts 5 and 6 need to be viewed together. The key findings about emergency department visits for ambulatory care sensitive conditions are summarized following Chart 6.

Chart 6. Percent of Emergency Department Use with a Primary Diagnosis of an Ambulatory Care Sensitive Condition

CHIP MCOs - September 1, 2004 to August 31, 2005 CHIP ED Visits = 85,868



Reference: CHIP Table PI-1

Key Points:

1. Four percent of CHIP in Texas enrollees experienced one or more emergency department (ED) visits due to an ACSC during the reporting period (see Chart 5).

2. Twenty-seven percent of all CHIP MCO Program ED visits were due to an ACSC-related condition. This can be compared to the previous annual chart book results for CHIP in which 30 percent of all ED visits were related to an ACSC.

3. There was some variation among health plans with all plans evidencing between 21 percent and 30 percent of ED visits due to an ACSC. Amerigroup, FIRSTCARE, and Parkland experienced the highest percentage of ED visits related to an ACSC at 30 percent each. El Paso First enrollees experienced the lowest percentage of ACSC visits at 21 percent.

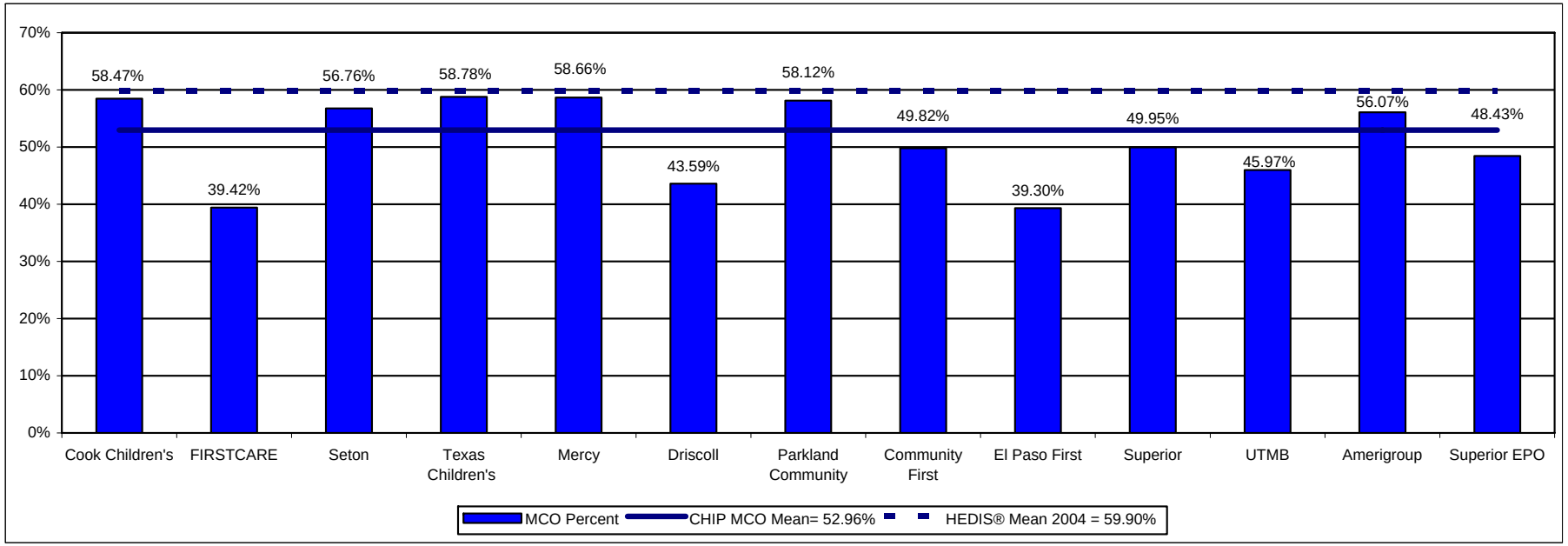
4. While preventable hospitalizations and emergency room visits are costly and do not reflect good quality of or access to care for enrollees, this measure can only identify those occurrences that may have been preventable. Additional analysis would be required to confirm whether an individual occurrence was indeed preventable.

5. National comparison data are not available for this measure.

Chart 7. HEDIS® Well-Child Visits in the 3rd, 4th, 5th, And 6th Years of Life

CHIP MCOs - September 1, 2004 to August 31, 2005

CHIP Enrollees in Age Group = 27,036



Reference: CHIP Table PI-2

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.[5]

2. The HEDIS® Well-Child Measure includes rates of visits for children in the first 15 months of life. Only 112 children state-wide in CHIP meet the age and enrollment criteria for this measure. With the exception of Texas Children's Health Plan, all MCOs have fewer than thirty members eligible for this measure.

3. Overall, 53 percent of CHIP in Texas enrollees received at least one well-child visit in their 3rd, 4th, 5th or 6th year of life. While this figure is less than the 60 percent of enrollees receiving preventive care for Medicaid health plans reporting to NCQA, it shows

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

improvement over the 48 percent of CHIP in Texas enrollees who received at least one preventive care visit for this age group in the previous year's annual chart book.

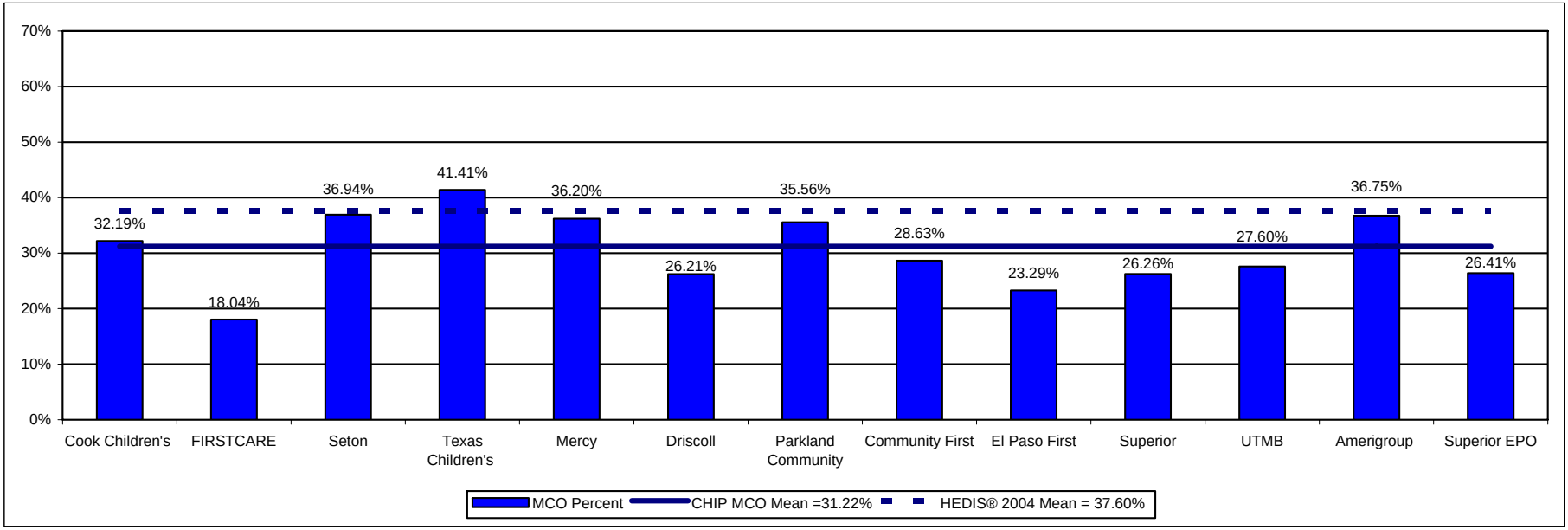
4. There was some variability among CHIP in Texas plan performance. FIRSTCARE and El Paso First had the lowest percentages of children in the 3rd, 4th, 5th, and 6th years of life receiving a well-child visit (39 percent). Texas Children's Health Plan and Mercy Health Plan (59 percent) had the highest percentages of children in this age cohort receiving well-child visits.

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.

Chart 8. HEDIS® Adolescent Well Care Visits

CHIP MCOs - September 1, 2004 to August 31, 2005

CHIP Enrollees in Age Group = 95,482



Reference: CHIP Table PI-2

Key Points:

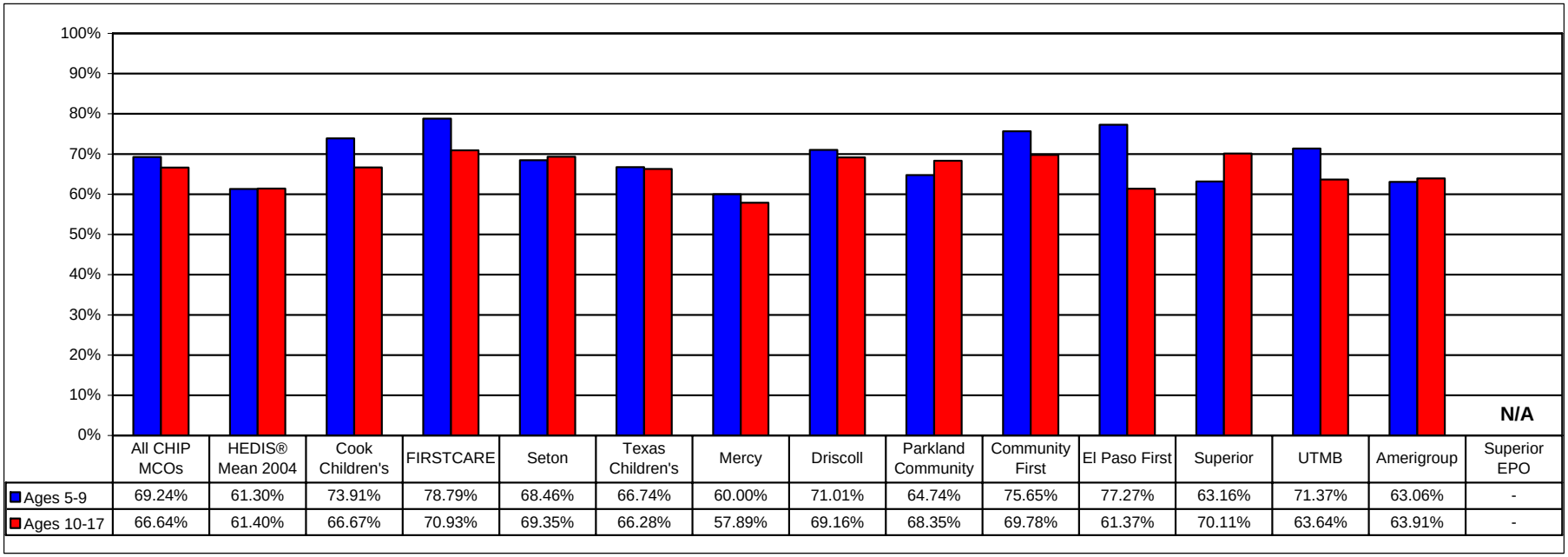
1. Overall, 31 percent of CHIP in Texas enrollees received at least one adolescent well care visit compared to 38 percent of enrollees in Medicaid health plans reporting to NCQA. This year's overall results show some improvement over the 30 percent of adolescent CHIP in Texas enrollees who received at 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 plan performance. FIRSTCARE had the lowest percentage of enrollees with an adolescent well care visit (18 percent). Texas Children's had the highest percentage for adolescent well care visits (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 children in this age group.

Chart 9. HEDIS® Use of Appropriate Medications for People with Asthma

CHIP MCOs - September 1, 2004 to August 31, 2005 CHIP Enrollees in Age Group: Children = 2,058 Adolescents = 3,435



	All CHIP MCOs	HEDIS® Mean 2004	Cook Children's	FIRSTCARE	Seton	Texas Children's	Mercy	Driscoll	Parkland Community	Community First	El Paso First	Superior	UTMB	Amerigroup	Superior EPO
Ages 5-9	69.24%	61.30%	73.91%	78.79%	68.46%	66.74%	60.00%	71.01%	64.74%	75.65%	77.27%	63.16%	71.37%	63.06%	-
Ages 10-17	66.64%	61.40%	66.67%	70.93%	69.35%	66.28%	57.89%	69.16%	68.35%	69.78%	61.37%	70.11%	63.64%	63.91%	-

Reference: CHIP Table PI-4

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

Note: N/A indicates Superior EPO not included. Measure requires two years of pharmacy data; Superior EPO became active September 2004.

Key Points:

1. In 1998, an estimated 17 million Americans, or 6.4 percent of the population, had asthma. Children represent a substantial number of asthma cases in the United States, accounting for 4.8 million Americans with asthma.[6] 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.[7] 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.

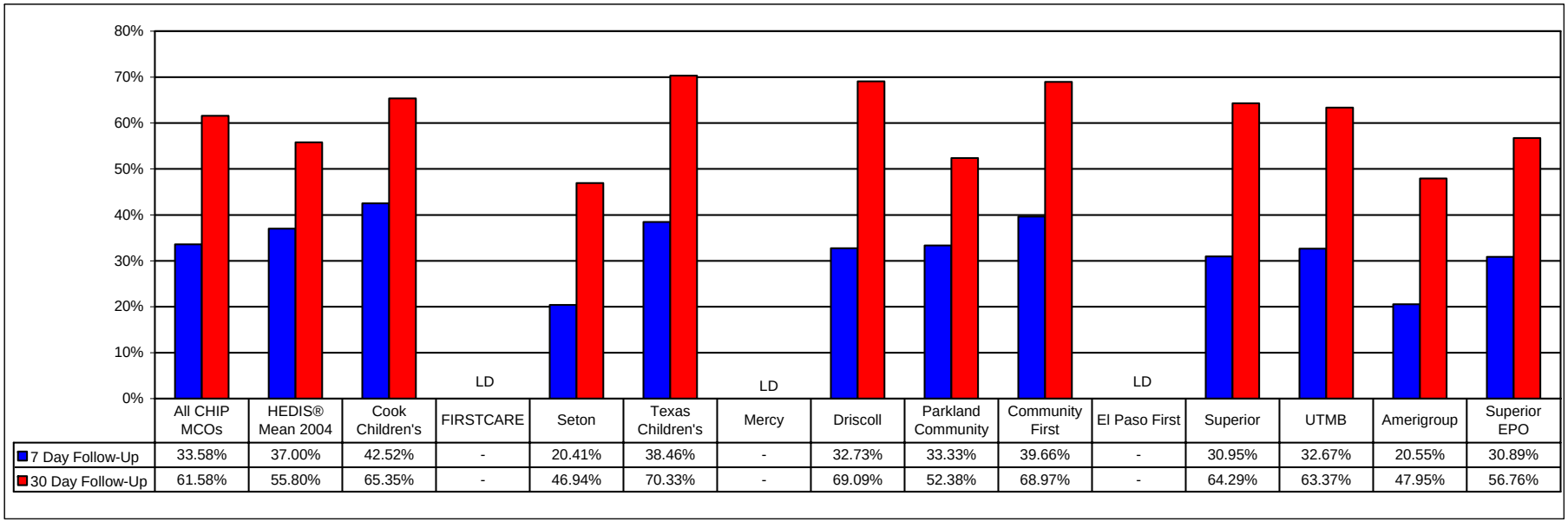
[6] Centers for Disease Control and Prevention (CDC). December 4, 1998. *Morbidity and Mortality Weekly Report*. 47 (47): 1022-25.
[7] National Center for Health Statistics. National Hospital Discharge Survey and National Health Interview Survey.

2. The findings for this indicator are positive. Overall, CHIP MCOs exceeded the HEDIS® Medicaid 2004 mean for both children and adolescents. Sixty-nine percent of CHIP enrollees ages five through nine with asthma received appropriate asthma medications compared to 61 percent of enrollees with asthma of Medicaid plans reporting to NCQA. Sixty-seven percent of children with asthma ages 10 through 17 received appropriate medications compared to the national average of 61 percent.

3. Overall, asthma indicator results for fiscal year 2005 are slightly lower than those reported in the previous annual chart book. For fiscal year 2005, 69 percent of CHIP enrollees ages five through nine with asthma received appropriate asthma medications while 72 percent of enrollees received appropriate medications for the previous year. Also, 67 percent of children with asthma ages 10 through 17 received appropriate medications compared to last year's average of 72 percent. Despite a slight decrease in the percentage of children receiving appropriate asthma medications, the findings for this indicator are positive and exceed the HEDIS® mean.

Chart 10. HEDIS® Follow-Up after Hospitalization for Mental Illness

CHIP MCOs - September 1, 2004 to August 31, 2005 CHIP Mental Health Hospitalizations = 1,075



	All CHIP MCOs	HEDIS® Mean 2004	Cook Children's	FIRSTCARE	Seton	Texas Children's	Mercy	Driscoll	Parkland Community	Community First	El Paso First	Superior	UTMB	Amerigroup	Superior EPO
7 Day Follow-Up	33.58%	37.00%	42.52%	-	20.41%	38.46%	-	32.73%	33.33%	39.66%	-	30.95%	32.67%	20.55%	30.89%
30 Day Follow-Up	61.58%	55.80%	65.35%	-	46.94%	70.33%	-	69.09%	52.38%	68.97%	-	64.29%	63.37%	47.95%	56.76%

Reference: CHIP Table PI-5

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

Note: Due to inability to consistently identify provider type in the encounter data, MH follow-up is defined by diagnosis code on subsequent visits rather than provider type as specified by HEDIS®.

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.[8] Appropriate follow-up is particularly important for children who have serious emotional disturbance due to the complexity of their needs. HEDIS® contains a measure designed to assess outpatient follow-up at 7 days and 30 days after an inpatient stay for mental illness.

2. The HEDIS® measure includes follow-up visits with a mental health provider only. The measure reported for CHIP in Texas 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.

[8] 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.

3. Thirty-four percent of CHIP enrollees who had an inpatient admission for mental illness had an outpatient follow-up within seven days. These results are slightly lower than the HEDIS® 2004 mean for outpatient follow-up (37 percent) and the previous year's annual results (35 percent).

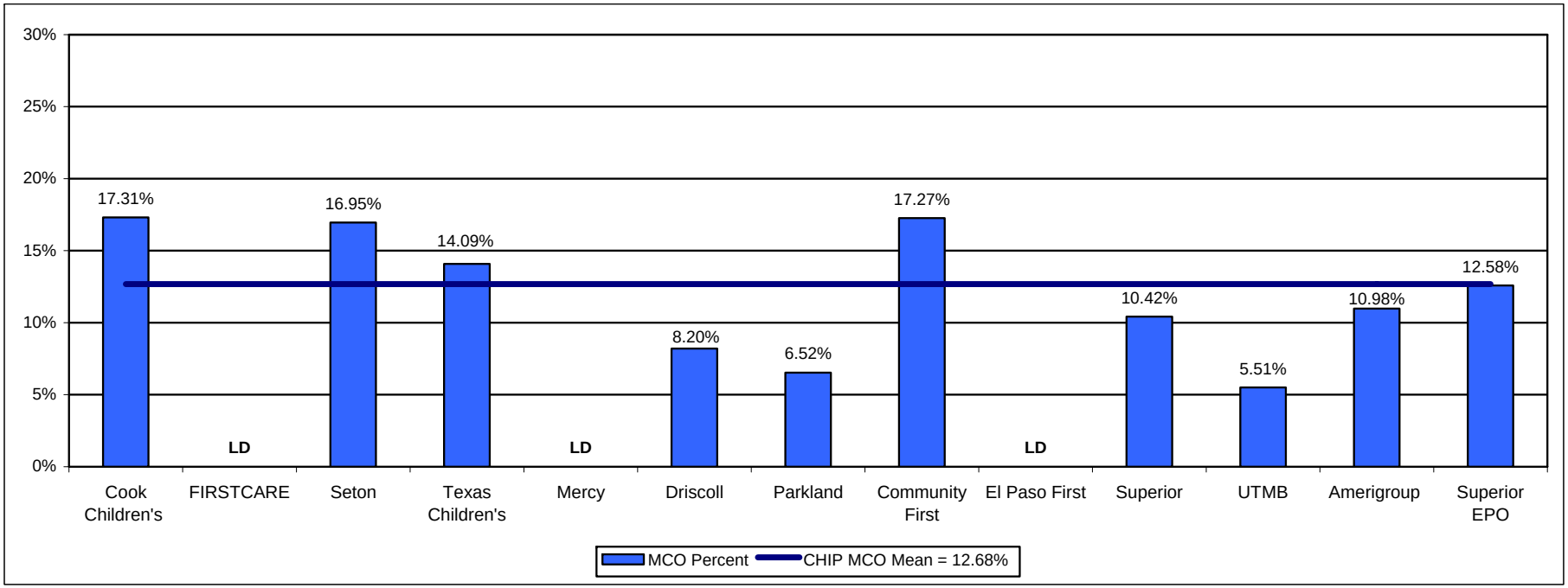
4. Sixty-two percent of CHIP enrollees had a follow-up within 30 days of their inpatient admissions. The CHIP overall 30 day follow-up average is higher than the 56 percent average for Medicaid Programs reporting to NCQA. This represents a slight decrease from the 67 percent reported for the CHIP Annual Chart Book which covered measures for December 1, 2002, through November 30, 2003.

5. The results for this quality of care indicator are fairly positive overall, but some individual MCOs need to improve their performance. Seton continues to lag behind the performance of other health plans with approximately 20 percent of the enrollees having an outpatient follow-up within seven days of discharge. Texas should consider sharing results with each MCO and the successful aftercare strategies developed by MCOs should be analyzed and disseminated.

6. Cook Children's Health Plan, Texas Children's Health Plan, and Parkland Community have continued to show improvement throughout fiscal year 2005. While these plans had less than 30 percent of enrollees with an outpatient mental health follow-up visit within seven days during Quarter Two, annual results for these plans exceeded 30 percent.

Chart 11. Readmission within 30 Days after an Inpatient Stay for Mental Health

CHIP MCOs - September 1, 2004 to August 31, 2005 CHIP Inpatient Mental Health Stays = 1,246



Reference: CHIP Table PI-6

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.[9,10] For that reason, mental health readmissions are frequently used as a measure of an adverse outcome.[11]

[9] 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.
[10] 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.
[11] 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.

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 6-month follow up period. About seven percent of the readmissions occurred within 30 days of discharge.[12]

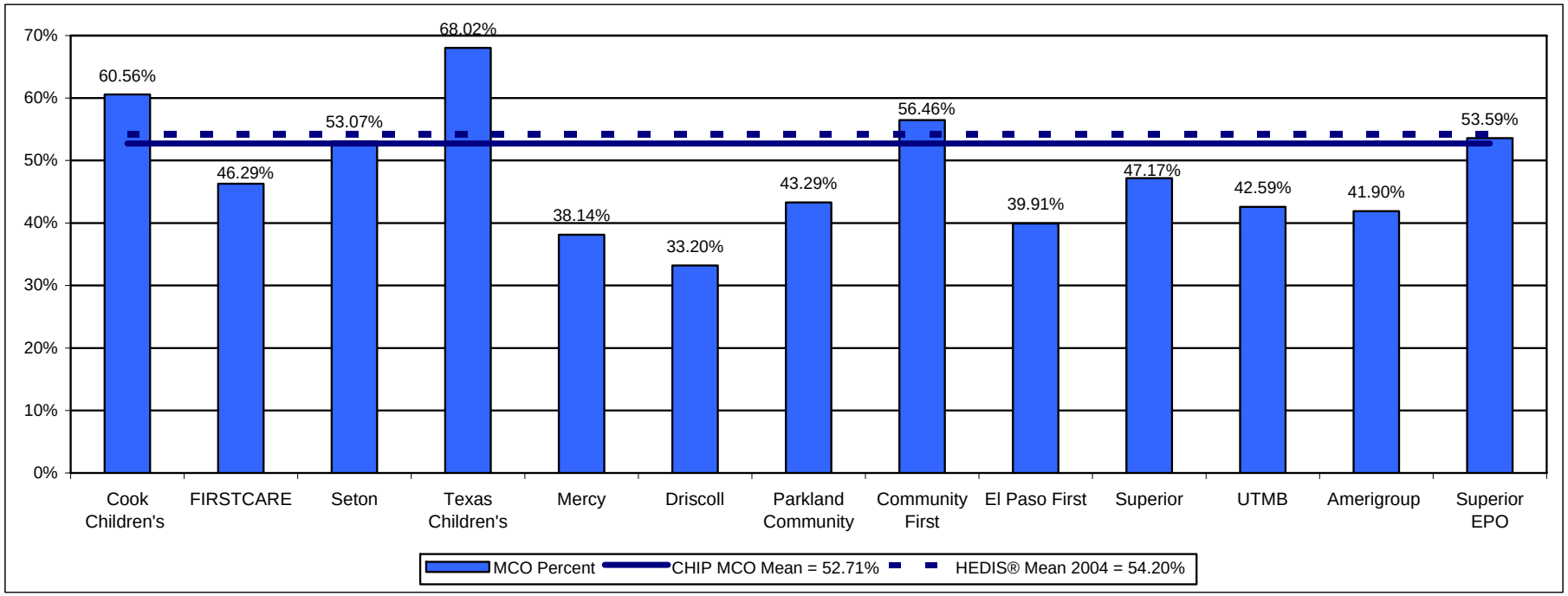
3. Thirteen percent of CHIP enrollees who were hospitalized for a mental health problem were readmitted to an inpatient facility within 30 days of discharge. This is comparable to the 14 percent of enrollees who were readmitted within 30 days during the reporting period of the previous annual chart book. There was great variability in plan performance with UTMB and Parkland Community having six and seven percent of enrollees, respectively, readmitted to an inpatient facility within 30 days and Community First, Cook Children's Health Plan, and Seton having 17 percent of enrollees readmitted to a hospital within 30 days of a mental health inpatient stay.

4. There are multiple factors that can influence readmission to a psychiatric hospital, including patient severity, family resources, after care planning, and community supports. Texas should consider identifying plans that have performed well on this indicator and request that they analyze and disseminate successful strategies.

[12] 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 12. HEDIS® Appropriate Testing for Children with Pharyngitis

CHIP MCOs - September 1, 2004 to August 31, 2005 CHIP Eligible Children = 19,136



Reference: CHIP Table PI-14

Key Points:

1. Sore throat is one of the most common reasons for a child to visit their primary care provider.[13] 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).[14] 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, 53 percent of CHIP enrollees with pharyngitis received appropriate Group A streptococcus testing. This figure approaches the HEDIS® 2004 mean of 54 percent and exceeds the 47 percent of CHIP enrollees who received appropriate testing in the previous year's chart book.

[13] Gerber, M.A.. 1998. "Diagnosis of group A streptococcal pharyngitis." Pediatric Annals. 27: 269-73.
[14] 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 68 percent, Texas Children's Health Plan had the highest percentage of children receiving appropriate testing for the fiscal year. At 33 percent, Driscoll had the lowest percentage of enrollees who received appropriate testing for the fiscal year.

4. Consideration should be given to disseminating strategies utilized by more successful MCOs, such as Texas Children's Health Plan and Cook Children's Health Plan. Consideration should be given to the sharing of results with other MCOs who have been less successful in ensuring appropriate testing for children with pharyngitis.