MEDDIC-MS SSI 2002 Data Book

Medicaid Encounter Data Driven Improvement Core Measure Set
SSI Managed Care

Wisconsin Independent Care (*i*Care) Program

State of Wisconsin

Department of Health and Family Services
Division of Health Care Financing, Bureau of Managed Health Care Programs

May 2004

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Introduction and Background

Quality improvement pioneer W. Edwards Deming said, "You can't manage what you can't measure." His observation referring to data-driven quality improvement in manufacturing applies equally to health care.

In its 2002 book, ***Leadership by Example: Coordinating Government Roles in Improving Health Care Quality***, the Institute of Medicine (IOM) called for standardized, accurate, real-time performance measures for health care, particularly for publicly-funded programs. For example, it recommended:

- Measures "derived from computerized data and public reporting of comparative quality information."
- "Providers should not be burdened with reporting the same patient-specific performance data more than once to the same government agency."
- "Finally, effective performance measurement demands real-time access to sufficient clinical detail and accurate data. By the time retrospective performance measures reach decision-makers, it is too late for them to be useful. The current health information environment is far too fragmented, technologically primitive, and overly dependent on paper medical records."

In addition to being central to effective public health policy, as described by the IOM, standardized performance measures are required by federal law for all state Medicaid managed care programs, including those serving special populations such as individuals with disabilities. Specifically, 42 CFR §438.240(c) requires that states monitor managed care organization (MCO) performance using standardized performance measures and that MCOs submit data necessary for the performance measures to operate. Wisconsin has implemented new quality improvement performance measure systems in its managed care programs.

MEDDIC-MS SSI is a subset of encounter data driven managed care performance measures called MEDDIC-MS (Medicaid Encounter Data Driven Improvement Core Measure Set). It is specifically designed for Wisconsin's Independent Care (*i*Care) program, which serves enrollees eligible for supplemental security income (SSI).

Use of MEDDIC-MS SSI is implemented for *i*Care under its contract with the DHFS. In October 2003, the Agency for Healthcare Research and Quality (AHRQ) recognized MEDDIC-MS SSI for inclusion in the National Quality Measures Clearinghouse (NQMC®). To view the measure summaries on the NQMC, go to: http://www.qualitymeasures.ahrq.gov/resources/measureindex.aspx and scroll down to "State of Wisconsin."

MEDDIC-MS SSI

The ***Medicaid Encounter Data Driven Improvement Core Measure Set for SSI***, is a new performance measurement system for Wisconsin's SSI managed care program. It consists of two sets of measures; Targeted Performance Improvement Measures (TPIM), which focus on high priority areas identified by stakeholders and monitoring measures, most of which are utilization measures.

Innovations in program-wide performance management include:

- ***Reporting:*** *i*Care no longer reports on performance measures. This allows more resources to be devoted to performance improvement initiatives and reduces administrative cost and complexity.
- ***Encounter data-driven measures:*** MEDDIC-MS SSI utilizes encounter data and other applicable State-controlled data sources eliminating the need for medical record review. This reduces data acquisition costs and eliminates errors caused by inaccurate patient-supplied history. Medical record review continues to be used for data validity audits, ambulatory quality of care audits, cases where augmentation of encounter data is desired and for special audit functions.
- ***DHFS data extraction and measure calculation:*** The Department of Health and Family Services (DHFS) extracts data for each measure and calculates performance on the measure through a third party data services vendor. This reduces errors and inconsistencies due to possible misinterpretation of reporting specifications.
- ***Customer/vendor relationship:*** Traditional managed care performance measures allow managed care organizations to report their own performance. MEDDIC-MS SSI corrects this problem.
- ***Speed, relevance and trending:*** DHFS has the option to calculate measures as needed and in time frames other than traditional calendar year reporting.
- ***Accuracy:*** MEDDIC-MS SSI specifications use validated encounter data and, in some measures, other state-controlled data sources.
- ***Performance improvement goals:*** Performance goal setting is designed to first establish baseline levels using MEDDIC-MS SSI technical specifications and then through a collaborative process, establish realistic intermediate goals for subsequent years to facilitate "ramping up" performance on the TPIMs. Data in this report is considered baseline data for the measures.

Complete technical specifications for the MEDDIC-MS and MEDDIC-MS SSI measure sets are available upon request. Contact: Gary R. Ilminen, RN at (608) 261-7839 or ILMINGR@DHFS.STATE.WI.US.

Care Analysis Projects

Since 2001, the DHFS has implemented an innovative program-wide (managed care and fee-for-service) proactive approach to performance improvement called Care Analysis Projects (CAP). Through CAP, recipient-specific health care needs are identified and the data about those needs are shared with *i*Care. In this way, the DHFS seeks to assist directly in quality improvement by allowing focused outreach to individuals with potential unmet care needs.

CAP focuses on several chronic conditions and on the provision of key preventive services. Chronic conditions included are congestive heart failure, asthma, and diabetes.

MEDDIC-MS SSI and CAP work together. CAP provides data-driven targeted intervention and MEDDIC-MS SSI allows accurate, rapid performance assessment.

Performance Improvement Projects

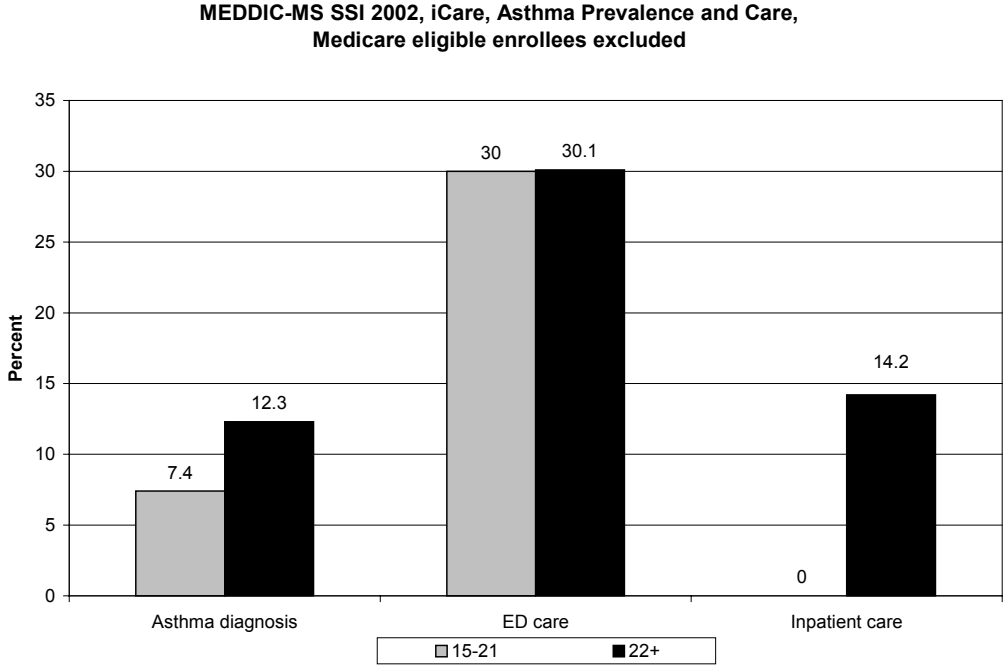
The *i*Care contract requires it to complete at least two performance improvement projects in each calendar year and submit reports about them to the DHFS annually. The projects encourage interventions for performance improvement on topics of importance to *i*Care enrollees.

Note on performance rates:
Some *i*Care enrollees are eligible for services under Medicare as well as the SSI program. As a result, some services may have been obtained under that program and may not be reflected in *i*Care encounter data. In order to prevent under-reporting of services provided by iCare, individuals eligible for Medicare have not been included in the denominators for measures reflecting services covered by Medicare. The chart title indicates which measures are affected.

Results on Clinical Performance Measures

Asthma care

Monitoring measure



Asthma is a chronic respiratory condition affecting the lungs. People with asthma suffer episodes where airflow in and out of the lungs is reduced by constriction of the airways in the lungs and by excess mucous. Between 12 and 15 million Americans have asthma, including nearly 5 million children. Nationwide, in 1997, the disease caused 1.2 million emergency room visits, over 445, 000 hospital days and has been fatal in some cases.

Episodes of asthma can be reduced with effective management and patient education. For these reasons, early diagnosis, patient/parent education and medical management are crucial to prevention of exacerbation and maintenance of good quality of life.

Asthma prevalence among *i*Care enrollees age 15-21 years of age was 7.4 percent; it was 12.3 percent among enrollees over age 22. The rate of use of emergency department (ED) care by enrollees 15-21 years of age was 30 percent; it was 30.1 percent among enrollees over age 22. No inpatient care was reported for asthma among enrollees age 15-21 years; the inpatient care rate was 14.2 percent among enrollees over age 22.

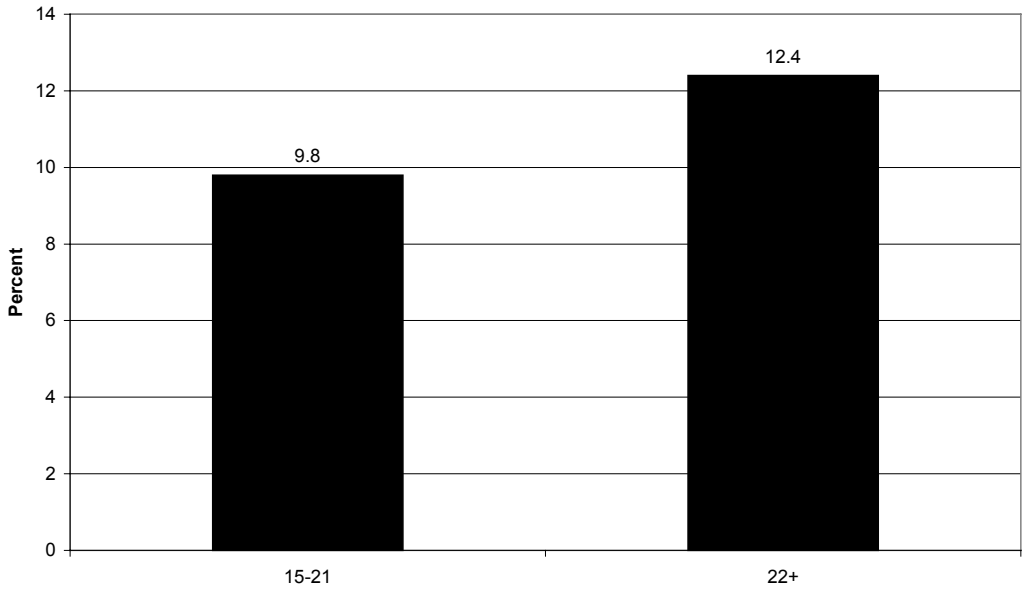
Dental (preventive) services

Targeted performance improvement measure

Preventive dental services include initial and comprehensive dental examinations, prophylaxis, topical application of fluoride and application of sealants.

Dental care can prevent development of dental caries, tooth loss, oral infections, abscesses and other problems.

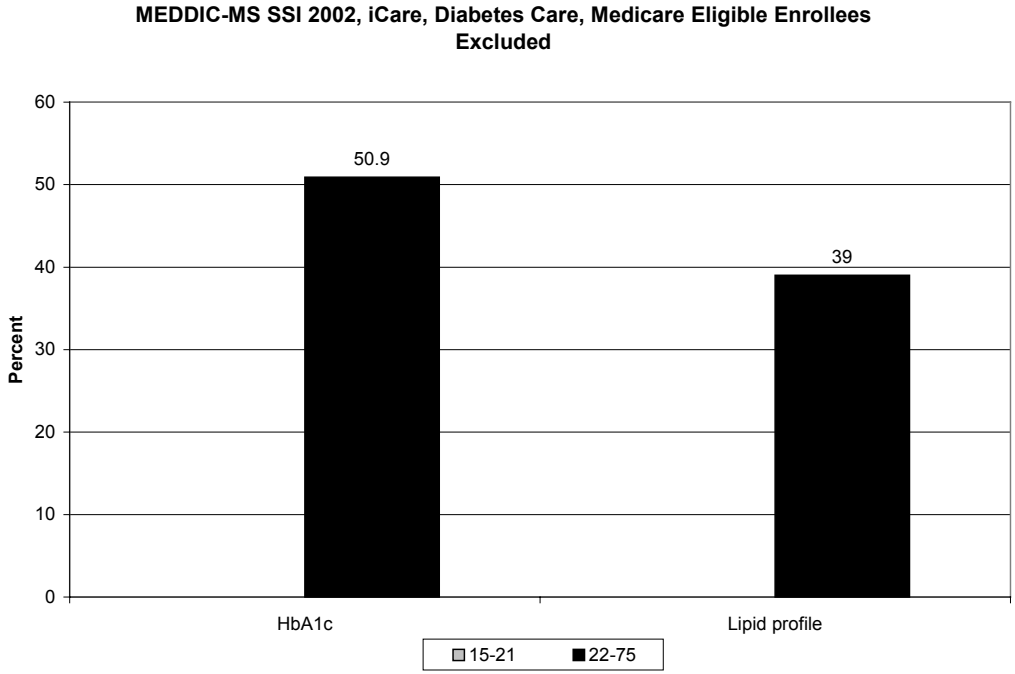
About ten percent of iCare enrollees age 15-21 years had at least one dental care encounter where preventive services were provided. Just over 12 percent of enrollees age 22 and older had such dental visits.



The results on this measure may indicate the difficulty in assuring adequate access to dental services for individuals in Medicaid in general and for disabled individuals on SSI in particular.

Diabetes care

Targeted performance improvement measure



Diabetes mellitus is a chronic condition that can have devastating effects including heart disease, kidney damage and blindness.

Diabetes is a condition that is considered sensitive to ambulatory care. That is, serious consequences can be reduced or prevented with proper management.

Two important diabetes management tests are monitored in the MEDDIC-MS SSI measure system.

One test is the hemoglobin A1c (HbA1c), which is a blood test that indicates the level of blood sugar control over time. The other test is the lipid profile, which is a blood test that monitors the levels of "fats" (lipids) in the blood stream. Though these tests do not allow definitive assessment of quality of life for diabetic individuals nor of total quality of care for diabetes, they do allow assessment of key indicators of diabetic management.

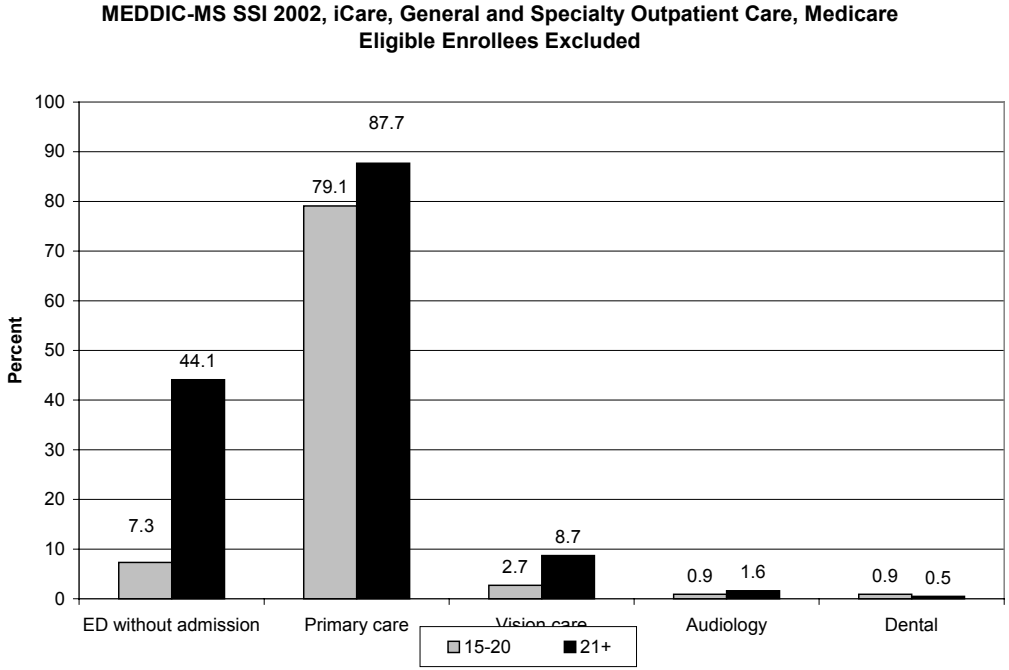
The HbA1c and lipid test rates for enrollees 15-21 years of age was not reported due to a small number of individuals in the denominator--fewer than 30. The HbA1c rate for enrollees age 22-75 was 50.9%, the rate for lipid profiles in that age cohort was 39%.

General and specialty care-outpatient

Monitoring measure

Access to outpatient or ambulatory care for a variety of health care needs is essential for overall health maintenance and improvement.

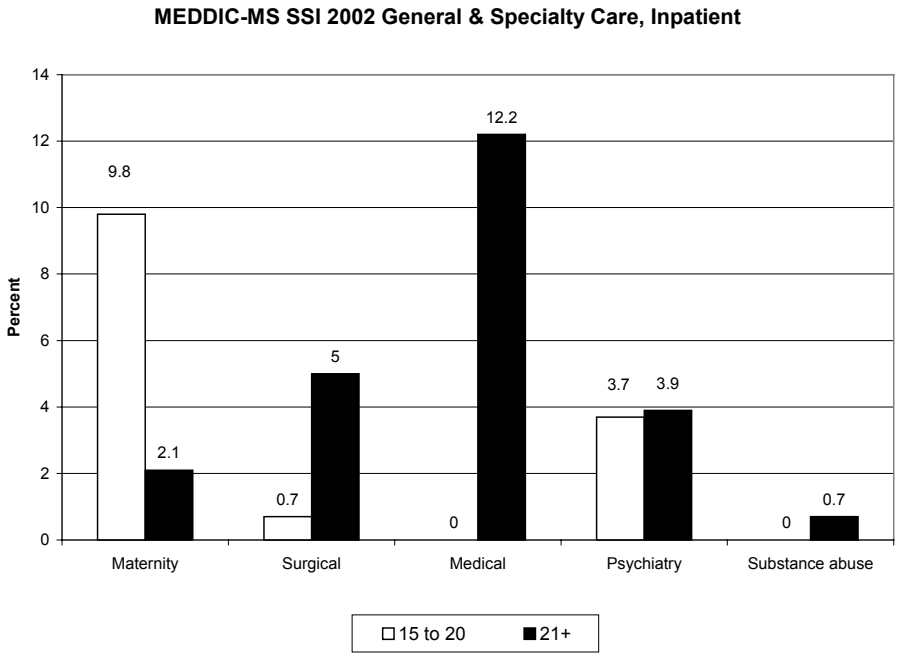
This MEDDIC-MS SSI measure is designed to assess access to emergency care that does not result in subsequent hospitalization, access to primary care, to vision care, audiology services and dental care. The measure tracks what percentage of *i*Care enrollees had access to those services on at least one occasion during the look-back period.



About 4 in 10 enrollees over age 21 years of age had at least one emergency room visit that did not result in admission to the hospital in the look-back period (CY 2002). Eight out of ten enrollees under age 21 had at least one primary care visit in 2002, while nearly nine out of ten enrollees over age 21 had at least one primary care visit. Vision and audiology care was used more often by enrollees over age 21 than by those under 21, but general dental services utilization was about the same for both age groups.

General and specialty care-inpatient

Monitoring measure



Some conditions may require care or services that cannot be provided on an ambulatory or outpatient basis. Those conditions may require hospitalization, referred to as inpatient care.

Inpatient care may be necessary for many different conditions. For the purposes of the *i*Care performance monitoring program, five general categories of care are used: maternity, surgery, medical, psychiatric and substance abuse.

This monitoring measure is useful as a tool in assessing access and utilization of inpatient care services. By itself, this measure is not an all-inclusive indicator of sufficiency of access to services, or of appropriateness of care. However, when used in conjunction with other data such as satisfaction, grievance and appeal data, outpatient care data and other measures, it provides a reasonable basis for assessment of overall service delivery.

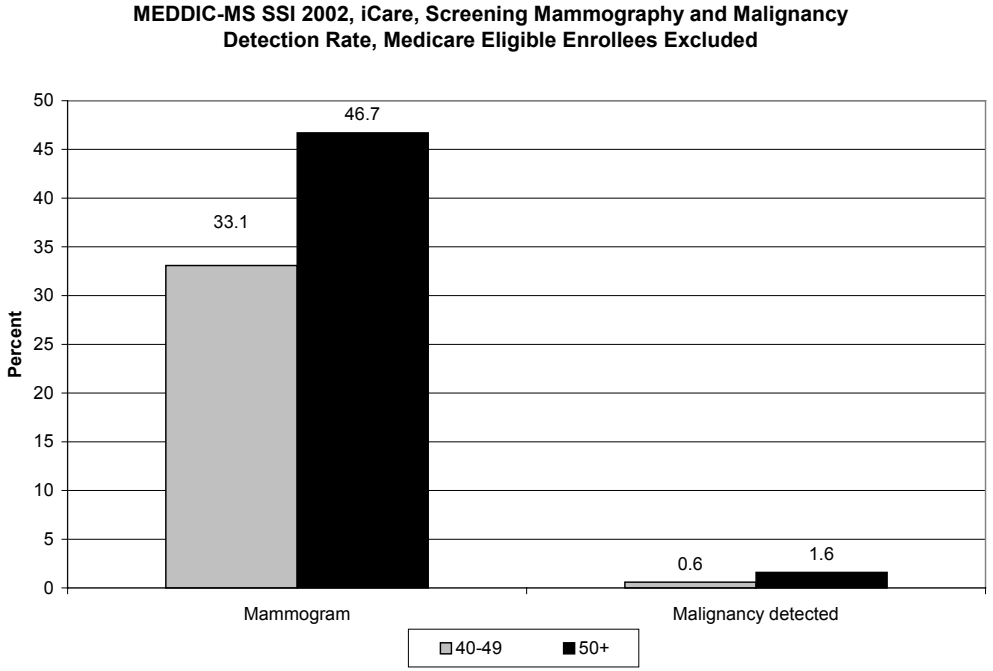
Mammography (screening) and malignancy detection

Monitoring measure

Early detection of breast cancer dramatically improves outcomes of treatment and long-term survival.

Mammography is recognized as a highly effective method for early detection of breast cancer.

The American Cancer Society and the National Cancer Institute each recommend that women over age 40 have regular screening mammograms.

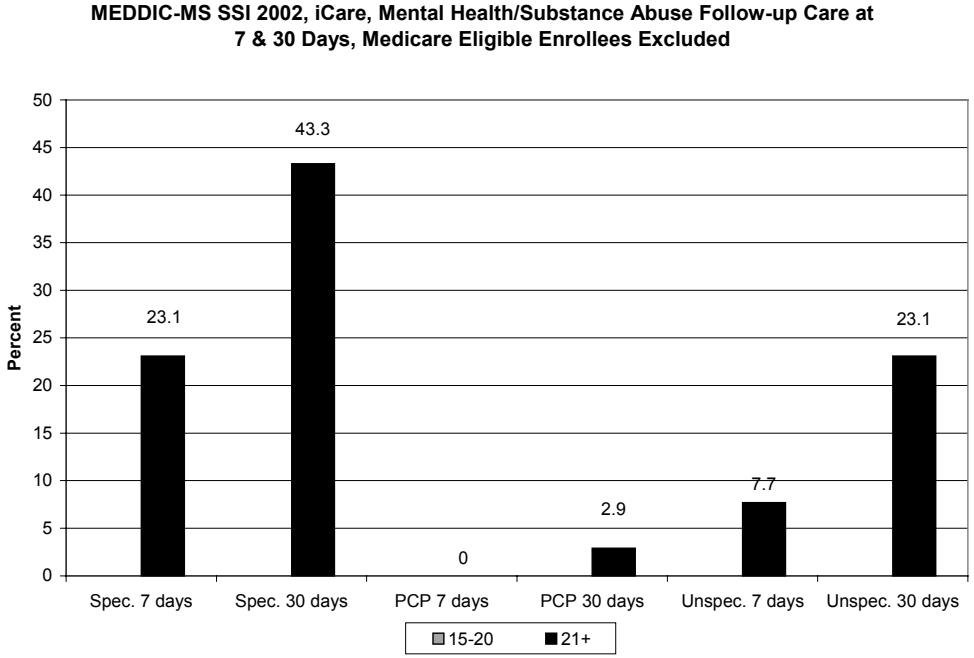


Facilitating and tracking the provision of screening mammography is important for women served in the *i*Care program because of the benefits of early detection and treatment.

The screening mammography rate for women between the ages of 40 and 49 years was 33.1 percent, with a malignancy detection rate of 0.6 percent. For women over 50 years of age, the screening mammography rate was 46.7 percent and the malignancy detection rate was 1.6 percent.

Mental health/substance abuse follow-up care within 7 and 30 days of inpatient discharge

Targeted Performance Improvement Measure



Research[1] has shown that follow-up care on an outpatient basis for individuals who have had inpatient care for mental illness or substance abuse is effective in reducing readmission to the inpatient setting for the same diagnosis.

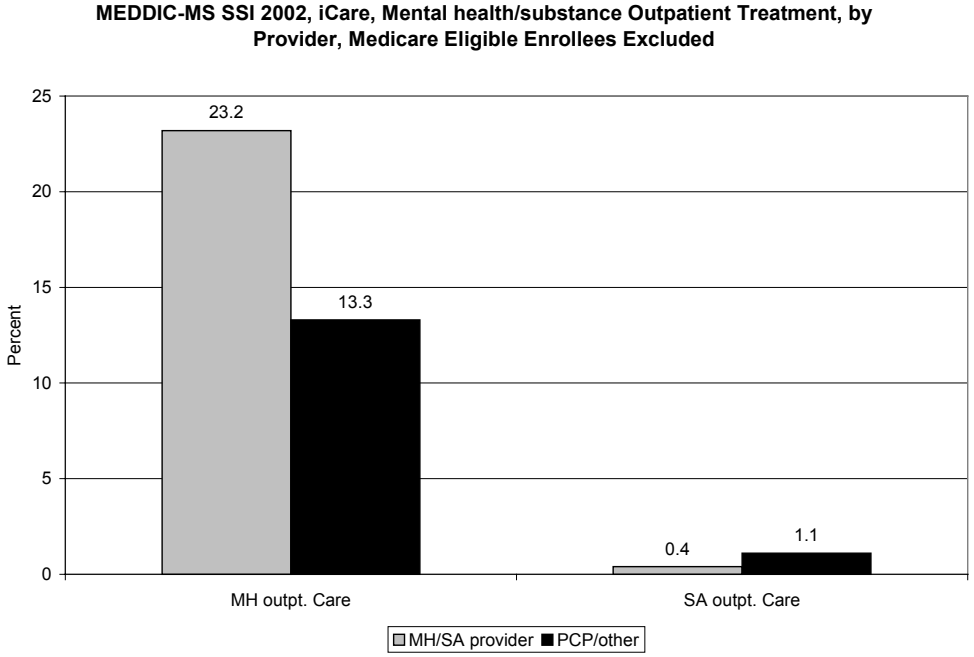
The MEDDIC-MS SSI measure set evaluates provision of follow-up care by both specialty care providers and primary care providers as well as outpatient care provided within 7 days of discharge and within 30 days of discharge. Since appropriate service codes at times appear on encounter records, but the provider type is not specified, the measure set includes these encounters in the category of "unspecified" to prevent underreporting.

The rate of post-discharge follow-up care by specialist providers was 23.1 percent within 7 days and 43.3 percent within 30 days. The rate for post-discharge follow-up care furnished by primary care providers (PCP) within 30 days was 2.9 percent. The rate of follow-up care by an unspecified provider was 7.7 percent within 7 days and 23.1 percent within 30 days. The rates for enrollees under 20 years of age were not calculated due to a small denominator--fewer than 30 individuals.

[1] *Evaluation and the Health Professions, Special Edition, State Medicaid Quality Programs*, "Outpatient Utilization Patterns and Quality Outcomes after First Acute Episode of Mental Health Hospitalization," Delmarva Foundation, December 2000.

Mental health/substance abuse-evaluations and outpatient care

Monitoring measure



The possibility that access to mental health and substance abuse (MH/SA) evaluation and treatment services may be inappropriately restricted in the SSI managed care program is a concern. Monitoring the rate of evaluation and treatment services is useful to detect access trends.

Statewide data shows that psychiatric disorders are the second most prevalent affecting SSI program recipients, being diagnosed in 32 percent of the population. Substance abuse is the 12th most prevalent diagnosis in this population. Often, the two diagnoses occur together. These facts show that access to mental health and substance abuse care is very important.

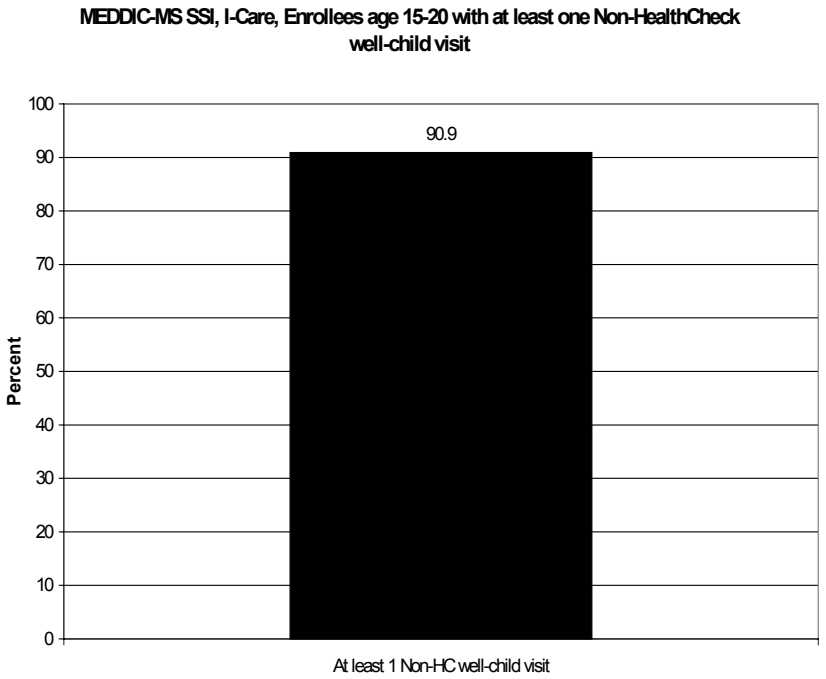
Many mental health and substance abuse conditions can be successfully treated on a day treatment or outpatient basis. Often, people prefer such treatment to inpatient care. Thus, access to day and outpatient treatment services is both preferred by enrollees and useful to reduce the need for inpatient care. This measure tracks provision of evaluations and outpatient care. Evaluations are tracked using all provider types and outpatient care is tracked by provider type, that is specialists in mental health or substance abuse and primary care providers (PCP).

The overall evaluation rate was 0.3 percent for all ages and provider types. Outpatient care for mental health needs was provided by specialists 23.2 percent of the time, and by PCPs 13.3 percent of the time. Specialists provided care for substance abuse in 0.4 percent of encounters and outpatient care was provided by PCPs in 1.1 percent of encounters.

Since mental health and/or substance abuse may often have been diagnosed prior to an individual becoming eligible for SSI, the need for initial evaluations is significantly lower than in the general population.

Non-HealthCheck well-child care visits-age 15-20 years

Monitoring measure



Non-HealthCheck well-child visits are primary care visits that may be too limited in scope to qualify as "HealthCheck visits," but do result in delivery of some preventive or other health services. A common example of such visits is a postnatal visit for a new mother that is timed to coincide with the due date for immunizations for the child, where the immunizations are given, but may not involve the full HealthCheck exam.

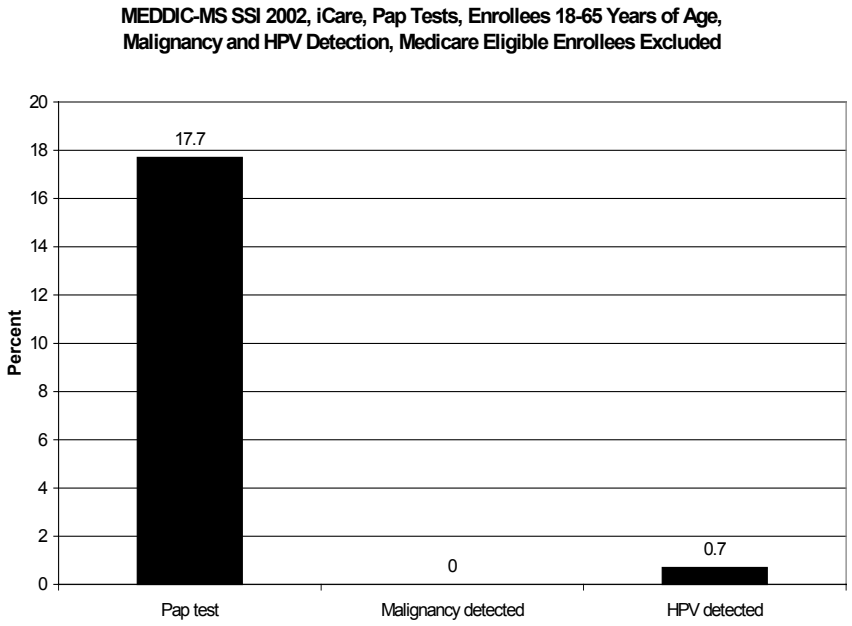
The positive health and economic effects of well-child services, as indicated by reduced preventable hospitalizations, have been reported in a recent study.[2] Since *i*Care does not enroll children under age 15 years, this measure covers only children age 15-20 years.

The measure indicates that nine out of ten enrollees age 15-20 had at least one non-HealthCheck well-child visit during the look-back period (CY 2002).

[2] *Effectiveness of compliance with pediatric preventive care guidelines among Medicaid beneficiaries*. Hakim RB, Bye BV. July 2001. PEDIATRICS, Vol. 108, No.1:90-97.

Pap tests-cervical cancer screening

Monitoring measure



Cervical cancer is diagnosed in approximately 15,000 women in the United States each year. According to the Centers for Disease Control (CDC), cervical cancer remains a leading preventable cause of death among women and, after three decades of decline, the mortality rate has begun to rise. Early detection is relatively easy and is the key to a high probability of survival. The most common method for early detection is called the "Pap test."

The Pap test is generally performed every three years, beginning when the woman becomes sexually active or by age 18 years. Thus, the Pap test is not required annually, and the MEDDIC-MS SSI measure is designed to take this into account.

The rate of provision of cervical cancer screening tests (Pap tests) was 17.7 percent. Outcome measure results, the rate of detection of malignancy, for this service was 0.

Human Papillomavirus (HPV) infection is believed to be a causal factor in many cases of cervical cancer. According to the Centers for Disease Control and Prevention (CDC), more than 90 percent of cervical cancers are caused by HPV infections. This measure assesses not only the rate of Pap testing, but also the detection rates for HPV infection. The HPV detection rate was 0.7 percent.

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