

TRICARE Consumer Watch

North ♦ Quarter 1 CY 2005

HEALTH PROGRAM ANALYSIS & EVALUATION DIRECTORATE

North: Sample size-13,112 Response rate-33.8%

MHS: Sample size-50,000 Response rate-31.0%

Inside Consumer Watch

TRICARE Consumer Watch is a brief summary of what TRICARE Prime enrollees in your region say about their healthcare. Data are taken from the Health Care Survey of DoD Beneficiaries (HCSDB). The HCSDB includes questions from the Consumer Assessment of Health Plans Survey (CAHPS) version 3.0H, a survey designed to help consumers choose among health plans. Every quarter, a representative sample of TRICARE beneficiaries are asked about their care in the last 12 months and the results are adjusted for age and health status and reported in this publication.

Scores are compared with averages taken from the 2004 National CAHPS Benchmarking Database (NCBD), which contains results from surveys given to beneficiaries by civilian health plans.

Health Care

Prime enrollees were asked to rate their healthcare from 0 to 10, where 0 is worst and 10 is best.

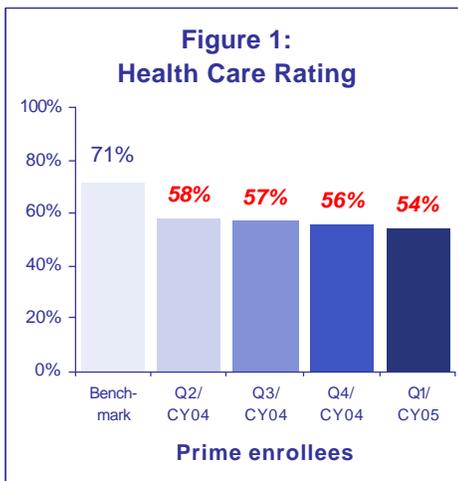
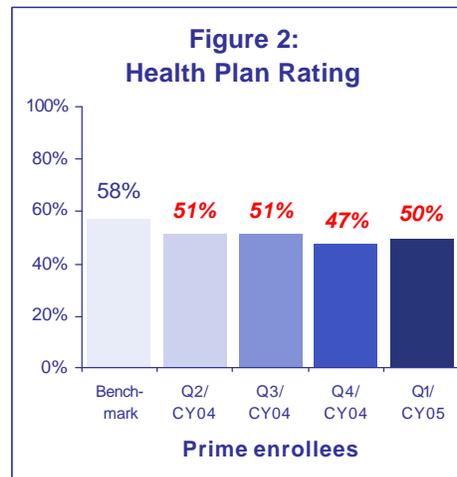


Figure 1 shows the percentage who rated their healthcare 8 or above in the survey fielded in the 1st quarter of 2005, describing the period January

2004 to December 2004, and each of the 3 previous quarters. Numbers in red italics are significantly different from the benchmark ($p < .05$). Health care ratings depend on things like access to care, and how patients get along with the doctors, nurses, and other care providers who treat them.

Health Plan

Prime enrollees were asked to rate their health plan from 0 to 10, where 0 is worst and 10 is best. Figure 2 shows the percentage who rated their plan 8 or above for each reporting period.

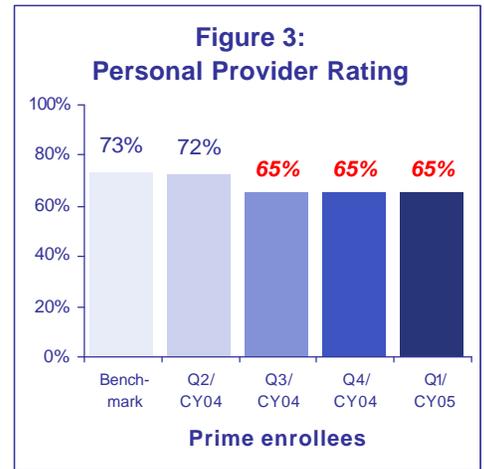


Health plan ratings depend on access to care and how the plan handles things like claims, referrals and customer complaints.

Personal Provider

Prime enrollees who have a personal provider were asked to rate their personal provider from 0 to 10, where 0 is worst and 10 is best.

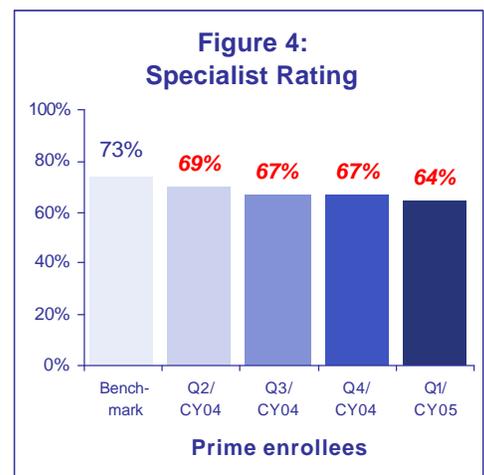
Figure 3 shows the percentage who rated their doctor 8 or above for each reporting period. Personal doctor ratings depend on how the patient gets along with the one doctor responsible for their basic care.



Specialist

Enrollees who have consulted specialist physicians were asked to rate from 0 to 10 the specialist they had seen most in the previous 12 months.

Figure 4 shows the proportion of enrollees who rated their specialist 8 or above for each reporting period. Specialist ratings depend on beneficiaries' access to doctors with the special skills they need.



Health Care Topics

Health Care Topics scores average together results for related questions. Each score is the percentage who “usually” or “always” got treatment they wanted or had “no problem” getting a desired service. Asterisks show values significantly different from the NCBDB benchmark ($p < .05$).

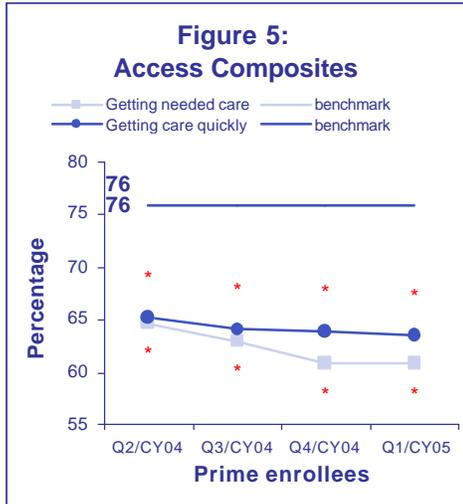
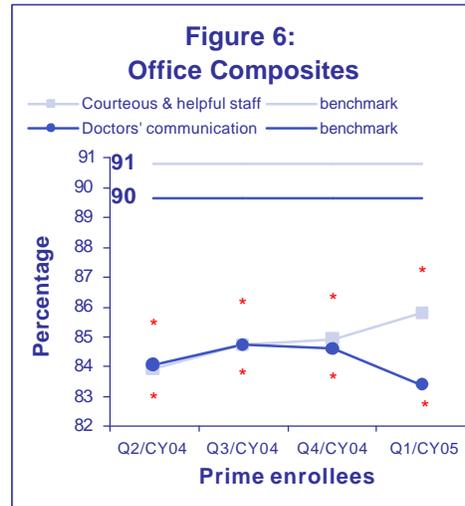


Figure 5 (Access Composites) includes the composites “Getting needed care” and “Getting care quickly.” Scores in “Getting needed care” are based on patients’ problems getting referrals and approvals and finding a good doctor. “Getting care quickly” scores concern how long patients wait for an appointment or wait in the doctor’s office.

Figure 6 (Office Composites) includes the composites “Courteous and helpful office staff” and “How well doctors communicate.” Scores in “How well doctors communicate” are based on whether the doctor spends enough time with patients, treats them respectfully and answers their questions. “Courteous and helpful staff” scores measure both the courtesy and helpfulness of doctor’s office staff.

Figure 7 (Claims/Service Composites) includes composite scores for “Customer service” and “Claims processing.” Scores in the “Customer service” composite concern patients’ ability to get information about their

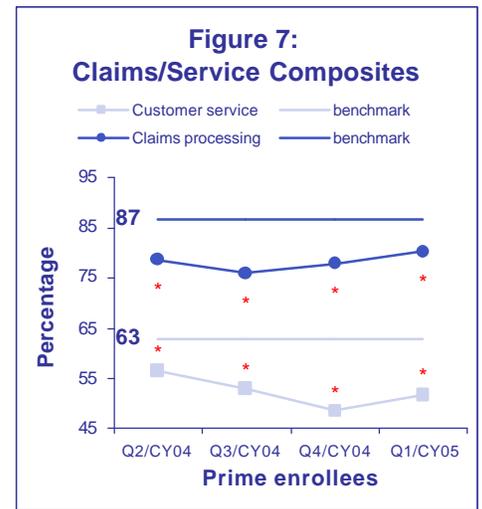
health plan and manage its paperwork. “Claims processing” scores are based on both the timeliness and correctness of plan’s claims handling.



Preventive Care

The preventive care table compares Prime enrollees’ rates for diagnostic screening tests and smoking cessation with goals from Healthy People 2010, a government initiative to improve Americans’ health by preventing illness.

The mammography rate shown is the proportion of women 40 or above with a mammogram in the past two years. Pap smear is the proportion of adult women screened for cervical cancer in the past three years. Hypertension is the proportion of



adults whose blood pressure was checked in the past two years and who know whether their pressure is too high. Prenatal care is the proportion of women pregnant now or in the past 12 months who received prenatal care in their first trimester. Normal weight is defined by Department of Agriculture guidelines based on body mass index (BMI), which is calculated from height and weight. The non-smoking rate is the proportion of adults who have not smoked in over a year. Counseled to quit is the number of smokers whose doctor told them to quit, over the number of smokers with an office visit in the past 12 months.

Rates that are significantly different ($p < .05$) from the Healthy People 2010 goal are shown by red italics.

Preventive Care					
Type of Care	Qtr 2 CY 2004	Qtr 3 CY 2004	Qtr 4 CY 2004	Qtr 1 CY 2005	Healthy People 2010 Goal
Mammography (women ≥ 40)	<i>83</i>	<i>81</i>	<i>85</i>	<i>82</i> (448)	70
Pap Smear (women ≥ 18)	<i>95</i>	<i>93</i>	<i>94</i>	<i>95</i> (1101)	90
Hypertension Screen (adults)	<i>90</i>	<i>90</i>	<i>91</i>	<i>90</i> (2346)	95
Prenatal Care (in 1st trimester)	<i>95</i>	84	88	87 (135)	90
Percent Normal Weight (adults)	.	<i>38</i>	<i>37</i>	<i>37</i> (2311)	60
Non-Smokers (adults)	<i>79</i>	<i>81</i>	<i>78</i>	<i>79</i> (2318)	88
Counseled to Quit (adults)	70	68	74	72 (331)	-

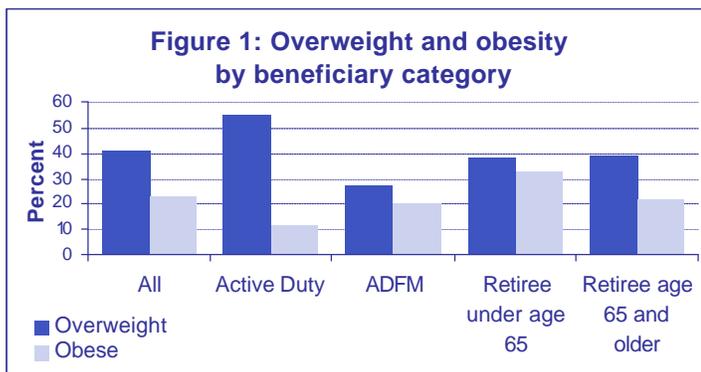
Issue Brief: Overweight Beneficiaries in the Military Health System

Each quarter, we publish a brief discussion, or issue brief, of a health policy issue relevant to users of TRICARE, based on data from the Health Care Survey of DoD Beneficiaries (HCSDB). This quarter, the issue brief concerns overweight beneficiaries of the military health system (MHS).

As among civilians, weight problems appear to be increasing among MHS beneficiaries. Excess weight is implicated in many diseases and chronic conditions, including hypertension, type 2 diabetes, heart disease, stroke, and arthritis. Hence, the prevalence of overweight is a key indicator of population health.

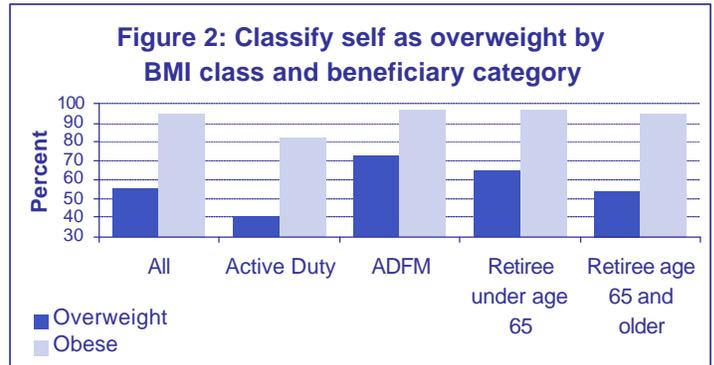
Prevalence

The most commonly used measure of overweight is the body mass index (BMI), which is calculated from weight divided by the square of height. A BMI of 25 or more is considered to indicate overweight, while a BMI of 30 or above indicates obesity (NHLBI, 1998). Classification based on BMI is not very accurate because weight increases when fat is replaced with muscle, but it is widely used because information on height and weight is easy to get. In this brief, we will refer to a BMI between 25 and 30 as overweight to distinguish it from obesity, which is a BMI of 30 or above.



From the HCSDB, we collect self-reported height and weight and use them to calculate the BMI of respondents. Figure 1 shows that nearly two-thirds of all MHS beneficiaries are overweight (41%) or obese (22%) according to their BMI. In particular, nearly two thirds of active duty are classed as overweight or obese. However, only 12 percent of active duty are obese. Obesity is much higher among retirees under 65, 33 percent of whom are obese.

Most active duty classed as overweight do not consider their weight to be a problem. As shown by Figure 2, only about 40 percent of active duty who are overweight according to their BMI consider themselves overweight. Men, who make up the majority of active duty, are less likely than women to think their weight too high, whether overweight or obese. For men and active duty, measured



overweight may be overstated due to muscle. Family members of active duty and retirees and their family members who are overweight are more likely than active duty to consider their weight a problem. In contrast with the overweight, most obese beneficiaries in all categories do believe that their weight is too high.

Table 1 indicates that overweight beneficiaries (middle columns) are not significantly more likely than beneficiaries of normal weight (first columns) to rate their health as fair or poor. Beneficiaries under age 65, including active duty, who are classed as overweight by BMI are more likely to report limitations in their activities due to their health. Compared to the overweight, the obese are much more likely than those of normal weight to rate their health as fair or poor and to report activity limitations.

Weight loss methods

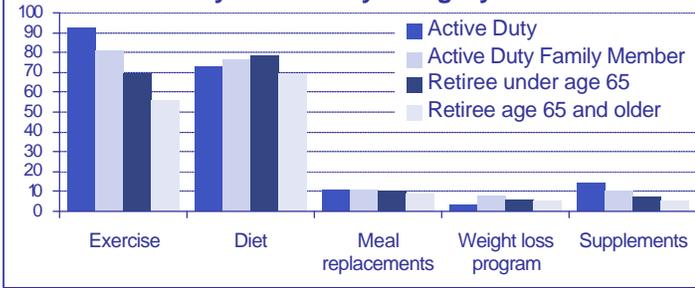
Most beneficiaries who are obese consider their weight to

	Normal		Overweight		Obese	
	Poor/fair health	Limited	Poor/fair health	Limited	Poor/fair health	Limited
	Percent					
Active Duty	7	18	6	25*	14*	36*
ADFM	5	13	8	17*	15*	24*
Retiree under age 65	13	24	15	35*	25*	47*
Retiree age 65 and older	26	43	24	41*	34*	62*

* Greater than normal at $p > 0.05$

Issue Brief: Overweight in the Military

Figure 3: Weight loss methods by beneficiary category

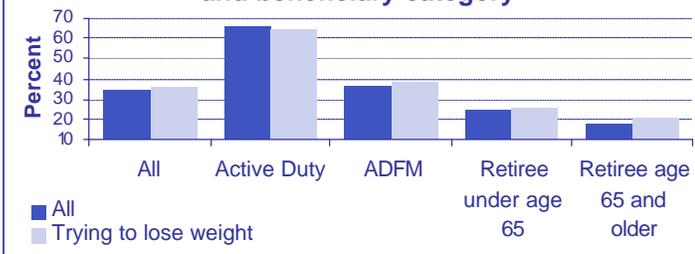


be too high and most (82 percent, not shown) are trying to lose weight. Figure 3 indicates that most who are trying to lose weight do so through both diet and exercise. Among active duty, exercise is favored. More than 90 percent of active duty who are trying to lose weight are using exercise compared to 73 percent using diet control. Retirees and their dependents use diet more often than exercise as a method of weight reduction, though a majority, even of retirees over 65, tries to lose weight through exercise. Approximately 10 percent of beneficiaries trying to lose weight in each beneficiary group use meal replacements as part of their regimen, while smaller numbers participate in weight reduction programs. Active duty are more likely than other groups to use dietary supplements (14 percent) as a weight loss method and less likely to use weight loss programs.

Exercise

Exercise offers health benefits besides weight reduction. These benefits include strengthening bones, muscles and joints, reducing stress and anxiety and lowering the use of health care services. Results from the HCSDB indicate that two-thirds of active duty take at least 20 minutes of vigorous exercise three or more times per week. Other beneficiary groups exercise substantially less. Among active duty family members about one third get as much vigorous exercise as active duty, and among retirees under age 65 only 25 percent do. There is little difference in the frequency of vigorous exercise between those trying to lose

Figure 4: Vigorous exercise at least 3 times a week by weight loss goal and beneficiary category



weight and those who are not, in spite of the many who report they are using exercise to reduce their weight.

Conclusion

The prevalence of overweight and obesity in the MHS population is similar to their prevalence in the civilian population. Nearly two thirds of civilians report they are overweight or obese according to their BMI, and over 30 percent are obese (CDC, 2004). Most active duty are overweight according to the BMI methodology, yet fewer than half of these consider their weight to be too high. According to their responses, the prevalence of overweight does not reflect an unhealthy active duty lifestyle. Most active duty vigorously exercise on a frequent basis, and their overweight may be due to muscle, not fat. Even among non-active duty family members the prevalence of vigorous exercise exceeds the Healthy People 2010 goal of 30 percent, and the proportion of civilians exercising vigorously (USHHS, 2000).

The prevalence of obesity and its adverse consequences for health increase among retirees and their dependents. Although this group may be more physically vigorous than its civilian counterparts, exercise levels decline following retirement. The earlier reliance of active duty and their families on exercise to maintain weight control may result in problems with obesity when their lifestyles become less active. Encouragement to maintain an active lifestyle among retirees and more attention to diet among active duty may reduce these problems.

Sources

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