Bringing medicine, patients and community-based services together.

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How Community-Based Organizations (CBOs) Can Impact Quality Measures for Health Plans and Medical Provider Groups

Evidence-based programs, assessments & risk screening to address quality measures

Presentation to ACL Business Acumen Learning Collaborative

April 2, 2014

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The Triple Aim & Other Motivators

- Healthcare is motivated in these 3 areas:
  - Better population health
  - Better patient experience of care
  - Lower per-capita costs
- Patient experience and population health are in the quality domain
- Member retention is a primary metric for health plans – also related to quality
- Healthier & well-managed patients means better satisfied physicians

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Better Population Health

- Better care coordination
  - Care Transitions
  - Service coordination, navigation
  - Improved access – transportation, assist with scheduling, companion, etc.
- Improved functioning & behavioral health
  - EnhanceFitness, Fit & Strong, Healthy Moves, Tai Chi
  - PEARLS, Healthy IDEAS
  - Stanford programs

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Better Patient Experience

- Represent the plan or provider group (not your agency/network)
  - Hospital visits
  - Home visits
  - Relationship with care coordinator
  - Transportation & assistance w/appointments
  - Benefits Checkup
  - Find free/discounted services

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Lower Per-Capita Costs

- Quality enhancements must be at least cost neutral
  - Better to have a positive ROI
- Reduce falls
  - Matter of Balance, Healthy Moves, HomeMeds
- Reduce ED visits
  - Fall prevention, symptom management, self-management, call center – 911 alternatives
- Reduce admissions/readmissions
  - CTI, Bridge
  - EnhanceFitness, Stanford Self-Management Programs (SMPs)

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Healthcare Effectiveness Data and Information Set (HEDIS) Older Adult Measures

- During year received:
  - Advance care planning
  - Medication review
  - Functional status assessment
  - Pain assessment
- All typical Waiver or Case Management (CM) services or included in assessment
- One home visit would meet all measures

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Star Ratings – Medicare Advantage

- Yearly review of all medications/supplements being taken
- Yearly pain screening or pain management plan
- Controlling blood pressure
- Reducing risk of falling
- Readmission to a hospital within 30 days of being discharged
- Plan members 65+ on high-risk drugs, when there may be safer drug choices
- Medication adherence for hypertension: Taking meds as directed

Bonuses for 4 & 5 Star Plans – growing!!

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HEDIS for Physicians

- Percentage of Medicare members 66+ who received at least one high-risk medication
  - Goal is low %. High-risk typically means Beers Criteria related to risk of falls, confusion, gastric bleeding, etc.
- Fall Risk Management: Discussion & Management
- Potentially Harmful Drug-Disease Interactions

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HEDIS Physician Standards – deeper dive

- **Percentage of Medicare members 66 + who received at least one high-risk medication**
  - Associated with higher hospitalization in community-dwelling elders[1]
  - Associated with adverse drug reactions and cost across settings[1]
- **Potentially Harmful Drug-Disease Interactions in the Elderly:**
  - Chronic Renal Failure and NSAIDS or Cox-2 Selective NSAIDS
  - Dementia and Tricyclic Antidepressants or Anticholinergic Agents
  - Falls and Tricyclic Antidepressants, Antipsychotics and Sleep Agents
  - Potentially Harmful Drug-Disease Interactions: Overall Rate

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[1]Jano E, Aparasu RR, **Healthcare outcomes associated with Beers' criteria: a systematic review.** Ann Pharmacother. 2007 Mar;41(3):438-47. Accessed at: http://www.ncbi.nlm.nih.gov/pubmed/17311835?dopt=Abstract

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Door Openers: Fall Prevention

Fall risk management: % of Medicare members 65+ who had a fall or had problems with balance or walking in the past 12 months who received fall risk intervention in past 12 months.

- Tarrant County, TX (Ft. Worth)
  - Local fall prevention collaborative w/hospitals, pub health
  - Fire Dept. mapping 911 calls for falls
  - Target Matter of Balance & HomeMeds for frequent fallers

http://www.qualitymeasures.ahrq.gov/content.aspx?id=43758

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Door Openers: Meds Management

- HomeMeds[SM] addresses multiple quality domains
  - Fall risk management
  - High-risk medications
  - Hypertension control
  - Pain control/assessment (and dangerous side effects of pain meds)
- In Care Transitions serves as medication reconciliation – required by the National Committee for Quality Assurance (NCQA) for health plans

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What else can we do?

- % Screened – glaucoma, mammogram, etc.
  - Transportation
  - Assistance with scheduling
  - Reminders/encouragement
- Clinical outcomes
  - BP/HTN control – assistance with med adherence
  - Cholesterol – meals, dietary counseling, med adherence
  - Diabetes – purchase of monitoring supplies, meals, dietary counseling, med adherence, DSMP, family counseling

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Healthy People 2020 – Older Adults

- Confidence in managing their chronic conditions
  - Chronic Disease Self-Management Program (CDSMP) and variants
- Receipt of Diabetes Self-Management Benefits
  - Diabetes Self-Management Program (DSMP)
- Leisure-time physical activities among older adults
  - EnhanceFitness, Fit & Strong, etc.
- Caregiver support services
  - Savvy Caregiver; Powerful Tools
- ED visits due to falls among older adults
  - HomeMeds, MOB, Healthy Moves

http://healthypeople.gov/2020/topicsobjectives2020/pdfs/OlderAdults.pdf

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NCQA CM Accreditation

- Health Plans Must Assess/Evaluate Members'
  - Clinical hx & medications
  - ADLs
  - Cognitive function
  - Psychosocial issues
  - Health behaviors
  - Life-planning activities
  - Cultural/linguistic needs, preferences, limitations
  - Visual/hearing needs, preferences, limitations
  - Caregiver resources/involvement
  - Available benefits
  - Community resources
- For high-risk members a phone call won't do

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Can we hurt quality measures?

- Health plan delegation rules – accreditation or license for care management
  - Must follow all NCQA standards
  - Documentation/systems
  - Quality assurance
  - Metrics
- Customer service
  - Timeliness – not on waiver timeline, but hospital
  - Who was that stranger who called?
    - We will represent the plan

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Usual work, new standards

- What we do now can help quality measures for health plans, hospitals, Accountable Care Organizations (ACOs), and provider groups
- We have to do it better & faster
  - New Culture: How high?!!
- We have to measure & improve constantly
  - Data – We MUST require contracting partners to share data and information so we can improve

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