

NWX-HHS-AOA-1

**Moderator: Lauren Solkowski
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1:00 pm CT**

Coordinator: Welcome and thank you for standing by. At this time all participant lines are in a listen only mode. After today's presentation if you would like to ask a question, you may press star then 1 at that time. Today's conference call is being recorded.

If you have any objections to this, please disconnect now. And now I would like to turn the call over to your host for today, Ms. Lauren Solkowski. Miss, you may begin.

Lauren Solkowski: Great. Thank you so much. And good afternoon to everyone and thank you for joining us today for the Administration for Community Living's business acumen webinar that is entitled Community Based Organizations Impact on Health System Quality and Performance Measures.

So this webinar is the first of a three part series that will focus on health system quality measures, in particular how the services and supports provided by community based organization can help health systems and other integrated care entities, meet their quality measures, improve consumer satisfaction, improve health and also save money.

So today's webinar will focus on the healthcare effectiveness data and information set, otherwise known as HEDIS measures. And so for today we have invited Tim McNeill to present on the HEDIS measures and the opportunity again that they present for CBOs, to further demonstrate the value that they can provide to integrated care entities.

So this is, as the operator mentioned, Lauren Solkowski with ACL. And I will be facilitating our webinar today. So before we begin Tim's presentation, I have a few housekeeping announcements.

So to start, please use the link included in your calendar appointment, to get onto WebEx so that you can follow along with the slides as we go through them, and also so that you can ask you questions when you have them, through chat.

If you don't have access to the link that was emailed, you can also go to www.WEBEX.com, click on the Attend a Meeting button that is located at the top of the page and then enter the meeting number. So our meeting number today is 666435108. Excuse me. That was 666435108.

If you have any other problems getting into the WebEx, please call the WebEx technical support number at 1 (866) 229-3239. That's 1 (866) 229-3239. And again, as the operator mentioned, all of our participants are in a listen only mode.

However, we do welcome your questions throughout the course of the webinar. And there are two ways that you can ask your questions. The first is through using the Web function - or through the Web excuse me, using the chat function in WebEx.

So you can enter your questions in the chat box and then I will sort through them and answer them at - once Tim has completed his presentation. And then the second way to ask questions is through the audio line.

So when that time comes, the operator will give us instructions again, as to how to queue up to ask your questions. If there are any questions that we do not answer during the course of the webinar, we will follow up with you to be sure that we get them answered.

If you think of any questions or have comments, please feel free to email them to me. I've put my email address in the chat box on the screen. And that is Lauren.Solkowski@ACL.HHS.gov.

As the operator mentioned, we are recording the webinar. We will be posting the recording, the slides and a transcript of the webinar online for your reference. And I will notify you once those are posted. Okay, so with that I would like to introduce and welcome our speaker for today, Tim McNeill.

Tim is an independent healthcare consultant, specializing in health program development and sustainability. Tim, thank you so much for being with us today and I'll turn it over to you.

Tim McNeill: Great. Thank you so much. So this is the first in a series of three webinars on quality measures. And this first one is going to focus primarily on HEDIS measures. And then the next one will be the Medicare Advantage Stars program and the third one will be ACL Quality Managers.

In each of these what I try to do is provide tangible examples for community based organizations to apply the concept in their local market as it relates to

their potential interaction with an integrated care organization, as part of an overall contract capture strategy. Next slide.

So I'm going to review - I'll provide an overview of HEDIS measures, speak about the role of HEDIS measures with MCOs and this pertains to all types of managed care organizations. So that's Medicare Advantage Plans, Medicaid Managed Care Plans and commercial plans.

The role of the community based organizations - the roles they could play in relation to HEDIS and MCOs and then how to use this data in a contracting capture strategy. Next slide. So what is the HEDIS measure? HEDIS is an acronym that stands for Health Effectiveness Data and Information Set.

Everyone refers to it as HEDIS and you say that long title, most people won't know what you're talking about. But if you say HEDIS they'll instantly - if they're in managed care, they'll instantly gravitate to understanding what you - what the term is.

And so it essentially is a tool to measure performance of health plans. And so from a population health standpoint, it measures the overall health indicators of the population of beneficiaries that are managed by a health plan during a specific performance year.

And so for example, for 2014 the data is available, publicly available on the HEDIS performance of health plans for that 2014 period, looking at the overall health as it relates to certain quality measures for the population that is defined.

Ninety percent of all health insurance plans use HEDIS. And HEDIS is actually a registered trademark of the National Committee for Quality

Assurance, so NCQA. And many of you have heard about NCQA as a not for profit organization and it was founded in 1990. And they own HEDIS.

And so updates to HEDIS, any changes to HEDIS comes from NCQA. Next slide. So it's important to measure health plan quality and so why is that important?

It allows the consumer whether that be the beneficiary - the consumer could be the state that is contracting with the Medicare - with the managed care plan. It can be CMS that's contracting with a health plan to operate a Medicare Advantage Product.

HEDIS allows the customer to use an independent neutral criteria to evaluate the effectiveness of that health plan in delivering and managing the overall health of the population. It really gives the consumer an apples to apples comparison of two plans, side by side.

The HEDIS measures provide a validated way of comparing them. All NCQA accredited health plans must report HEDIS. And NCQA as of now, the primary contractor with CMS so accredit all Medicare Advantage Plans and health insurance exchange plans.

So what that means is, if you in your local market, are seeking to contract with the Medicare Advantage Plan, then that Medicare Advantage Plan is either currently accredited by NCQA or in process of getting accredited by NCQA and therefore the HEDIS outcome measures are keenly important to that health plan.

And whether they are performing well or need improvement are all things that they have to continually monitor to stay in good status of their accreditation.

Next slide. So what exactly does HEDIS measure? It looks at the indication of how health plans perform on quality measures.

And it actually is an indication of actual delivery of care. And so the example that I review with a lot of people that's very tangible, is if you compare two health plans and the health plan has a pool of women that are in the health plan that are at risk for breast cancer.

And the - this is important and it's a HEDIS measure, that all of the women that are at risk for breast cancer have a mammogram.

And so if apples to apples, a side by side comparison of two health plans would be to review what percentage of women at risk for breast cancer actually completed and got a mammogram. And then health plans that have high performance rates in that category score well.

Health plans that have a poor performance rate in that category, do not score well. And then that becomes a side by side comparison. So there are specific measures that are involved. And most of them relate to clinical outcomes for those members during the defined reporting year.

Their - in addition to clinical quality managers there's also consumer satisfaction. And so that's the CAHPS survey. It's also - HEDIS also includes the CAHPS survey and CAHPS is an acronym for Consumer Assessment of Healthcare Providers and Systems.

And so it evaluates the consumer experience. So things like access to care, availability of appointments, those types of things which is completely subjective data that's obtained through a representative sampling survey of the members that are enrolled in the health plan.

All of those things go into the overall weighting of the health plan and is reported by HEDIS measures. Next slide. So HEDIS measures are essentially increasing more important to a health plan because one, it is a component of NCQA accreditation.

So the example I gave is that if a health plan wants the contract to be a Medicare Advantage Plan they submit their information to CMS.

If CMS requires that their health plan maintain NCQA accreditation, if they fail on these HEDIS measures then they could essentially have their contract be placed in jeopardy, to operate as a Medicare Advantage Plan. So it's increasingly important.

And there's - as I'll talk about on the next webinar series, a lot of the HEDIS measures also apply to (STARS) and there are significant implications there for Medicare Advantage Plans if you've had any involvement with the (STARS) program.

But we'll go into great detail on that in the next webinar. In addition to that, the HEDIS measures reflect the overall quality of care for the population.

So conceivably, the poor performance on a health plan - one, it can put their NCQA accreditation in jeopardy; new members - if a person is now going to select a health plan and they are comparing two health plans together and one scores very poorly on HEDIS measures and one scores higher, then in all likelihood the plan with the highest - higher performance could get a greater enrollment of new members.

And members that are in other plans or in plans that are currently enrolled in their performance is poor, they could have people exit. And then lastly, as I said, federal and state health plan contracts can also be placed into jeopardy, all around how those - how the health plan performs on HEDIS measures.

Next slide. So HEDIS measures also impact physicians. So I know that some organizations seeking and working with hospitals, health systems, ACOs and physicians and trying to find ways to really define the value of contracting with community based organizations.

So HEDIS measures directly impact them. So especially now as we move more and more towards value based payment models, managed care organizations are increasingly contracting with physician groups based on HEDIS outcomes.

So what that means is, physician groups that - whose panel of patients score poorly on defined HEDIS measures, lose - in some cases, are losing their contracts to be a network provider in that health plan or they're getting less than preferred reimbursement rates for operating as a network provider because of their HEDIS performance.

And then lastly, many, many health plans are moving towards pay for performance contracting so they're (giving) the providers a minimum base and then - of revenue or reimbursement for delivering services to assigned or attributed beneficiaries.

And then they get additional bonus payments based on how well they're able to perform on these HEDIS measures for the population.

And in addition to what's something that's been - much to do with health plans in that providing additional incentives to physicians to help them - to incentivize them to close gaps in care.

When we say close gaps in care they may give the physician a list of their panel of patients and that panel of patients, beside that list, will be a listing which - beside each consumer will be a listing of all the HEDIS measures that they have failed to capture during that year.

And then each HEDIS measure that that position is able to close or capture the data in, then the health plan will pay them a bonus. So a tangible example of that would be diabetes.

So one of the HEDIS measures for diabetes around comprehensive diabetes care, is making sure that you have a current hemoglobin A1C on every consumer that has a diagnosis of diabetes, as part of a physician panel.

And then with that then the - if the physician does not have a current hemoglobin A1C for some of their patients, then their health plan will - could provide that physician with a financial incentive for each beneficiary that they're able to get into the office and capture the data, perform a hemoglobin A1C test, document the results, provide the results back to the health plan.

Then they get an additional payment over and above delivering the service because they're helping the health plan close a gap in care. High performing physician groups related to HEDIS also get preferred contracting status. And they also have the benefit of getting larger patient panels.

This is highly publicized or the results - the impact of this is highly publicized. About six months ago if you saw - there was this big discussion

with physician groups that were being dropped from United Healthcare's Medicare Advantage panels.

And they actually - the physicians actually sued the United Healthcare as a result.

And a lot of it was it was an arbitrary decision where they looked at all of their physician groups that did not - that scored in the lower tier as it relates to HEDIS performance for the panel of patients those physicians were managing, and then they terminated their contracts.

So it's very important to the health plan but it rolls downhill. The health plans, because it's their priority to score highly on HEDIS measures, they're putting increasing pressure on the physicians and hospitals, to assist them in this effort.

And so they're - it's all financial contracts and incentives moving down to the provider level as well. Next slide. So consumers actually influence HEDIS outcomes as well. So because HEDIS measures indicate services that were actually rendered.

It's not - they don't measure the intent of rendering services. So the example I just gave with the mammograms for women that are at risk for breast cancer.

If a woman comes in, she has an annual exam with her provider, she's at risk for breast cancer, she's given an order from her physician to get a mammogram and then she doesn't follow through, then that negatively impacts on the HEDIS performance of that physician, because it says that that person that was at risk that under that physician's care, did not get the needed service.

Although the physician had them come in, gave them the order, encouraged them, educated them on the importance but the consumer failed to follow through. It still is a negative outcome measure. So consumer adherence or noncompliance is not accounted for whatsoever in HEDIS.

And so it impacts the physician's HEDIS score as well as the health plan score. Next slide.

So some of the common HEDIS measures that are more commonly tracked and discussed, are diabetes measures because diabetes plays a tremendous role in the health system as it relates to costs, especially with complications of care.

And so some of the HEDIS measures for diabetes include hemoglobin A1C testing, foot screening, retinopathy screening, triglycerides or cholesterol testing. So all of those things are a part of HEDIS. And it's really an all or nothing score.

So either the consumer has documentation to prove that they had retinopathy screening and completed the retinopathy screening or they did not. If they don't, if they did not for whatever reason, then they fail on that measure.

Next, preventive healthcare - colonoscopy screening; breast cancer screening; so all of those things also are HEDIS measures. Immunizations - flu and pneumonia are additional HEDIS measures that scored. And it is a population health view.

So really we're looking at the percentage of the entire population that for example, should have gotten a flu shot this year. And what percentage actually

has documented claims evidence that they got a flu shot and what percentage did not?

And then plans that score in the higher percentile have a better HEDIS score for that measure. Next slide. So an example of how consumer choice impacts HEDIS. These are all fictional examples. But they have real - real implications to physicians and health plans.

So this fictional person, Mrs. Jones, she has diabetes. She has an order for retinoscopy screening.

And the physician - a business physician practice didn't have a lot of time to really educate her and said, you know, you really - it's time for you to get your annual screening and I want you to get retinoscopy screened and writes an order.

And the consumer leaves out because what, I just got my glasses to be done. And so I went in and they didn't say I had any problems so I'm not going to go get this retinoscopy screening.

The consumer in this instance did not realize that seeing an optometrist to get your vision testing is not the same as a retinoscopy screen.

And because there wasn't really time in the doctor's office to educate the consumer on the difference, now the doctor, the health plan all failed in a positive measure as it relates to Ms. Jones, because she was not compliant with the request for her to get retinoscopy screening for diabetes.

Although they are - both the health plan and the physician had the best of intentions, still the outcome was she didn't get the needed screening. The next

example with Mrs. Jones - she lives alone in an assisted living facility with limited caregiver support.

Is unable to secure transportation and no show for her colonoscopy screening. She said well I got one last year, it wasn't necessarily a pleasant experience. I don't have anybody to drive me so I'm just going to skip it this year. Well once again, the physician practice, the health plan failed in this.

Because it's an all or nothing measure. Either the person at risk got the service or they did not. And so since it is a population health view, for most HEDIS measures health plans want to have at least 80% compliance. And so there's always some people that fall through the cracks.

And that's understandable. But you want to have at least 80% of the population, in most instances, that are compliant, with your services. And so health plans have to develop multiple strategies to assist and support the population in achieving these goals.

And what they've been doing mostly lately, is really pushing on physicians and health systems, providing different types of financial incentives to increase compliance. Also using robo-calls and call centers to try and encourage consumers and reminders for them to get in and get these things.

But I think that it also represents a great opportunity for community based organizations if they can show that they have access to the population they can provide support, education and assistance to the population in achieving these things.

The same painful gaps in care to be closed, health plans are providing to physicians, I have seen specific examples where health plans have contracted

with community based organizations in an effort to try and help them to close similar gaps in care. Next slide.

Lauren Solkowski: Actually Tim, before we go to the next slide, I just wanted to - I got a comment that I just saw on the chat. So we actually have someone from NCQA on - that's participating in the webinar.

And she wanted just to clarify that I think a couple of slides back that she thought that she heard you say that Medicare Advantage Plans are required to be NCQA accredited.

Tim McNeill: Oh, part of this - part of the quality management - so when NCQA is a contractor with CMS to accredit Medicare Advantage Plans. And most Medicare Advantage Plans are moving towards obtaining accreditation. You've got to have accreditation or seek an accreditation. Most.

Lauren Solkowski: Okay. Right. I think she just wanted to clarify that they're required to submit the HEDIS in CAHPS but they do not have to be NCQA accredited, but...

Tim McNeill: Okay.

Lauren Solkowski: ...moving towards that.

Tim McNeill: Right. And (unintelligible).

Lauren Solkowski: Okay. I just - well we'll go to the next slide. Okay. Go ahead.

Tim McNeill: So (unintelligible) 81 measures across five domains of care. And they're updated annually. And the instance - HEDIS measures are essentially the

product of NCQA and the updates come from NCQA. And new measures are introduced so modifications to current measures occur in the annual update.

And it is very conceivable that adjustments can occur to a measure based on feedback from provider groups to - and the overall internal analysis by NCQA can make modifications. So it's very important for providers, health plans and so forth, to keep up to date on what the current HEDIS measures are.

And updates can be obtained directly from NCQA. Next slide. So HEDIS data sources - so there are two data sources. There are two primary data sources - the HEDIS measures; one primary and the second is supplemental. The primary data source is claims data.

So the example I gave with hemoglobin A1C or a mammogram is either the particular consumer got the service; there generally is a claim filed and the filing of the claim is proof that the consumer got the service. So that's usually seen as a primary data source.

And the supplemental data sources include things like laboratory result files, pharmacy data, electronic health records in the file. And then there's also data from NCQA certified measure systems.

And so some vendors are able to obtain certification and really promote their NCQA certified to report HEDIS measures. And information from those certified systems also can support documenting HEDIS measure reports. Next slide.

So primary data source utilization - so claims data is the primary data source. It provides a definitive source to validate that a service was provided. And so as I said, an example is (first) cancer screening.

Another example that applies to a lot of organizations that are doing community based care transitions, is the all cause readmission measure.

So that is a clear example of one where the consumer had an initial admission and if they had a repeat or a readmission within 30 days and it was not a planned readmission, then there's a claim that was filed and then based on that claim analysis, there's a number of consumers that have a readmission with 30 days.

And then there's a number of consumers that did not have a readmission. And then that equates out to a HEDIS score for all calls readmission. Next slide. So examples of the impact of data source on HEDIS. And so here's one that is - it's a real life example that I've worked with, with physician groups.

So a data source example is preventive care, so flu shots. The same example of Mrs. Jones. She received the flu shot at her local senior center. So she goes to a senior center, they're having a vendor fair. A local (FQAC) comes by and they got a grant from a health plan to do an immunization fair.

So they come and they give "free shots," free flu shots to the community. Mrs. Jones gets that flu shot at the senior center. Later she sees her doctor. The doctor says it's time for you to get your flu shot. She refuses the flu shot and then leaves.

And - the reason she refuses the flu shot is because she just got the flu shot at the senior center. There's no record of the flu shot in the claims data. Mrs. Jones did not report to the doctor that the reason of her refusing the flu shot was that she just got one.

And since there was not a claim filed, that Mrs. Jones got the flu shot as part of an overall immunization fair. So there's not a primary data source to document that Mrs. Jones got the flu shot. So therefore, there's no proof she got it. So there's - it failed that measure.

And I've seen this specific example play out many, many times. And so getting the physician to help in getting that data back to show that a consumer got these things, is essential. Next slide.

So another example of primary data reporting - so again, all calls readmission and I bring this up because I get a lot of request about how the care transition programs can support health plans.

So all calls readmissions happen in the following manner, where you have a count of 30 day readmission minus plan readmission and that's divided by count of index hospitals phase. And so that claims data provides the outcome of the (unintelligible) measure for (Catholic) and health involvement of the members during that defined reporting period.

And I do get a lot of questions about what exactly is a planned readmission. So you see a lot of plan readmissions in the area of oncology. And a good example of that - I'll stick to the breast cancer theme.

If someone comes in and they have maybe Stage 4 breast cancer. Oftentimes, the surgeon will admit the consumer and then remove as much of the tumor as possible, and may place a port for chemotherapy. But then, that person will be discharged home for a short recovery period, and then readmitted soon thereafter to begin chemotherapy.

So that's where we had a specific plan. We're going to remove the tumor, we're going to get - have a short convalescent period, and then bring the person back and start chemotherapy and radiation. And so that's a planned readmission. It would not count towards a readmission.

A readmission would be - in the same example, that person comes in, has their surgery, begins chemotherapy, gets discharged to home, gets home and then has an infection that was related to the surgery. Comes back and then has to have a round of antibiotics based on the infection - and so that was not a planned readmission, and so that would count toward a readmission number.

Next slide. Unacceptable data sources - so data sources that are not acceptable here to report include things such as member health surveys. So we're just filling out a health survey at a health fair -that type of information, even if they documented from memory what some of things are and those match - like they wrote on the form, "I had a hemoglobin A1c and it was 10."

That is not an acceptable data source - a member-completed health risk assessment. And it's generally not acceptable, unless that health risk assessment is completed with a practitioner and the practitioner reviews it directly with the consumer. Then it would be acceptable. But just randomly completed health risk assessments is generally not an acceptable data source.

Self-reported data through the phone. So the health plan says, "Oh, we're missing our hemoglobin A1C measure for all our diabetics, so let's just do robocalls." And call them all and ask them, "Did you see a doctor? Do you remember what that hemoglobin measure was when you went in to your doctor last?" That's not an acceptable validated data source for HEDIS reporting.

And so, data sources generally - the general theme is that it needs - the data source - because an acceptable data source it has been viewed and validated by a qualified practitioner.

Next slide. So I gave the example of health risk assessment data that specifically drilled down on this one, because I know some community-based organizations are completing limited health risk assessment data, and it would be nice if they could work with a provider and a health plan to have that health risk assessment data acceptable as it relates to HEDIS reporting.

So if the general health risk assessment - as reviewed and completed by a practitioner with the member present - then that generally is an acceptable supplemental data source. And the key there is that it's reviewed and completed by the practitioner with the member present.

Community-based organizations can support the practitioner in collecting that data, but it still needs to be reviewed - signed off by the practitioner - for it to be validated data. If it was a situation where a community-based organization without practitioner involvement just captured data, and then submitted data, and it was not reviewed and validated, then it wouldn't necessarily be accepted data to meet that requirement.

Next slide. So how could a community-based organization support the reporting of HEDIS measures? So, definitely the capture report of these adventures can be supported by community-based organizations.

It's important for CBOs to be aware of what the current HEDIS measures are, try their best to support the collection of necessary data or impact that data - like All-cause readmissions. And also, using acceptable data sources to collect the data and become a valid-added service provider with the health plan.

I've spoken to a community-based organization in Pennsylvania. They were looking at purchasing health IT software. And one type of software they were looking at was NT2A-certified. The other one was not. And they were going to negotiate with their plan - was to contract with managed care plan - and really present that they would be a value-added community-based provider of services for care transition and other things, and they wanted the contract.

And so I said, if it's an apples-to-apples comparison and the cost is different, you want to - as part of your strategy - is to contract with a managed care plan.

That managed care plan is NT2A-accredited, then if you're making a selection between two vendors - if it was me - I'd choose the NT2A-certified vendor product, and make that part of my presentation to the health plan about how we would work with them to close gaps in care as it relates to HEDIS measures.

Next slide. So, key takeaway for HEDIS reporting - claims data is always the primary data source, so it's very important that that consumer kicks in for provider to obtain those services that produces a claim, and then that is a primary data source for meeting that requirement.

Supporting consumer completion of identified tasks - (ALTS) that can be go-to insurance definitely helps. So, things like a simple diabetes self-management program class.

So if you look at this ad for diabetes health manager program class- and you saw earlier on the slides - there were diabetes measures around hemoglobin A1c, foot screening, eye exams, retinopathy screening and so forth.

So if you look at that diabetes self-manager program from Stanford, there is significant sections where you're educating the consumer about the importance of getting those screening tests and encouraging them to follow back over the doctor to obtain that.

You also have a lot of patient activation and self-management incurring that - encouraging that consumer to take charge of their health and obtain these tests. Now, that - supporting that consumer and then that consumer completes the testing - and it can be attributed to your activation of the consumer - education on the needs that definitely helps that health plan meet that requirement.

And that's kind of a secondary benefit of being flagged health education programs in helping consumers not only to prevent complications of disease, but as a secondary benefit to the health plan by helping them to meet their HEDIS measure requirements.

And so, last, if they see your wish to support capturing HEDIS measures using acceptable data sources, it's important to collaborate with a practitioner having the member present, and so these things allow the provider to capture that data in a supplemental data source that can go towards meeting HEDIS measure requirements.

Next slide. So an example of CBO supplemental data capture for HEDIS. I'm going to go to the conference of medication review. So it's a new measure that could be linked closely to Medicare (unintelligible) star ratings. So a community-based organization can support data collection that's reviewed and validated by a pharmacist for his qualified member. So it requires a detailed and visual review of some of these elements.

The elements include a review of the medication medical history, a review of the prescribed medications, a review of medication adherence, a review of their use of over-the-counter drugs, herbal supplements, vitamin usage - so forth.

And the key thing is that it has to be reviewed with the member and a qualified practitioner - in this instance, the pharmacist. A CBO can support getting the member engaged, support capturing the data, linking the consumer with the pharmacist, helping the pharmacist to complete this process - but the practitioner has to complete and have the direct communication with the beneficiary in order to meet the requirements.

Next slide. So an unacceptable example would be a CBO's randomly collects medication - a list of possible discharge medications - as part of a care transition intervention. That CBO has screened the list of provider medication using the Beers criteria for potentially inappropriate medication use and all (trade-offs).

And then their system produces alerts. They then refer those alerts to a pharmacist, and that pharmacist just addresses the alerts that were sent. And so that is a good practice. It's definitely a benefit to the consumer, but it doesn't meet the requirement of being a conference of medication review.

And so, therefore, if they sold this to a health plan as we're going to help you meet a requirement to complete a conference of medication review on as many other benefit services as possible.

And this is our process, where we will capture the list of medications, screen them using the Beers criteria and then refer alerts to a local pharmacist - and then that pharmacist just addresses the alerts and does not review over the

counters, herbals, a complete medical review, a complete review of their total medical - medication usage history - then they're not meeting the requirements.

Next slide. So, problem for me in meeting this requirement here is the example I just gave - because if the pharmacist only addresses the alerts, and they don't address all of the items until the end that last - you've got total interaction is not documented in an acceptable supplemental data source and there's no claim filed for the service, then it's not a validated data source to meet the requirement.

Next slide. So another unacceptable example would be a community-based organization collects a list of discharge medications. Again, runs that list through a system that checks using the Beers criteria for potentially inappropriate medication use in older adults.

There were no alerts noted, and so the CBO said, "You're all fine. Looks like everything's on track." And the consumer goes. So that process also would not meet the criterias of documented at a conference of medication review was completed.

Next slide. So, the last example, the conference review by the pharmacist did not directly engage the consumer. It was not a direct interaction between the qualified practitioner and the member, and the competent collection of data also was not documented in a validated primary supplemental data source.

Next slide: So some of the HEDIS measures that community-based organizations could support and influence - and this is just a random sampling of something.

All-cause readmission, that's definitely - that's one. Prevention - things like breast cancer screening, colorectal cancer screening, glaucoma screening, comprehensive diabetes care, influenza shots, immunizations, body mass index assessment, fall risk management older adults, aftercare planning for older adults.

Those things really fall in the realm of things that a community-based organization could support providers and/or health plans in capturing this data on a defined population at risk.

Next slide. With fall-risk management - two components of fall-risk management discussions of all this. It's actually looking at consumers at risk - 65 years or older - that are at risk for falls. And then, managing fall risk.

So the numbers that are identified at risk and then either referred or accepted into a fall-risk management program. So these definitely are two areas where community-based organizations that are actively engaged - both in supporting the awareness of falls, supporting screening and getting consumers in to be screened for fall risk and define them, and then getting them into community-based programs that can address all this.

Next slide. The all-cause readmission is another one that is often discussed. And again, 30-day readmission - the numerator is a set of at least one acute readmission for any diagnosed within 30 days of indexed discharge minus planned readmissions.

I gave examples of planned readmissions, like often seen in oncology or cancer treatment. Also surgery - sometimes people will have multiple scheduled surgeries during a period of time, and they can have a planned readmission for a subsequent surgical procedure also would be an example of

a plan readmission, which would not count towards readmission. And then nominated description would be acute inpatient discharges for commercial members.

Next slide. So, an overall contract capture strategy. HEDIS is an important component overall on contracts - that's health plan contracts and strategy - if a community-based organization seeking to work with a health plan that understands the role of HEDIS, understands how a health plan is performing on HEDIS managers, and can clearly define their potential role in helping the health plan and the population at risk to meet those performance managers.

It definitely is a value-added benefit and the reason why a health plan should contract with the community based organization. So your ability to support capturing the data, as well as - it is always important as part of a contracting strategy to define the return on investment. And having both of those things as part of your overall presentation to a health plan will assist in, you know, in a successful contracting strategy.

Next slide. So, I get a lot of questions around return on investment, so I wanted to spend a little time just talking about what it means to define return on investment.

And so, return on investment definitely should be part of a presentation of - whenever you're selling something or offering a service, the customer should know what value your program is providing to the customer in exchange for the price point that you're wanting that customer to pay.

So how can you calculate the return on investment? There's a lot of different models. This is one. Where you look at net savings from changes in utilization

divided by program costs which equal return on investment. I'm going to go through an example of this.

Next slide. So if the return on investment in this model is greater than one, then there is greater than expected savings. If it's less - and you're trying to invest less than zero - there's less than expected savings. And between zero and one, then the results are very small and inconclusive.

So a return on investment of two essentially tells the customer that \$2 in reduced health care expenses are produced for every \$1 invested in the program. So they're getting a 2-for-1 return on investment.

And if it was less than zero, then they're actually getting no return on investment, and they're paying more than the return that they're receiving. They - the customer being the health plan.

Next slide. So here is an example of a calculation of return on investment for a care transition program. And so I made up a fictional care transition program that I'm calling Anywhere Triple-A CCTP.

And in their cost calculation, they have a rate. Their rate - their CCTP rate is \$400 per eligible discharge. And in the specific hospital that they're working with - with CCTP - there's 20,000 eligible discharges per year.

And this does not mean that they delivered services to 100% of the population. So, but there are 20,000 potential consumers that were admitted that were eligible to receive services from this program, and their rate of those services was \$450. So now if you take their rate, \$450 times the potential pool of consumers that were eligible to receive the services, you get \$9 million. So...

(Lauren), was there a slide before this one? I think I went two slides forward. No? Okay. I'm sorry. Go to the next one. I thought there was another slide. So the return on investment calculation. Because there was a discussion on how you calculate the net savings. Maybe it's on the next slide.

So the net savings - if it's not on the next slide, I'll just explain it. So the net savings in this scenario was \$19,200,000 and the cost was \$9 million, so when you divide the net savings by the cost of the health plan, you get a return on investment of 2.13. So this is a positive return on investment.

Next slide. Can you go back one? No, let me just speak. Yes, I think I missed one. But let me speak briefly on the net savings calculations. How did I get to that \$19,200,000 in net savings?

So, for this particular health plan, they - oh, excuse me. Not health plan. For this particular CCTP program, this is the hypothetical scenario that I created stated that anywhere Triple-A - after a year of implementing their program and working with their project officers in there - it was determined that they had a 50% reduction in readmissions that was attributed to their care transition service at that hospital.

And that particular hospital - so they had a 50% reduction in readmissions, and at baseline, they had a 20% readmission rate. So, with a 20% readmission rate, and they had 20,000 eligible discharges per year, essentially said 20% of that 20,000 eligible discharges would have readmitted without our intervention.

Because their baseline readmission rate was 20%, they have 20,000 eligible discharges per year, so with no intervention in place, if things just went on as

they were, we would expect 20% of that population to readmit, which would have given us 4000 consumers.

Our intervention then reduced the readmission rate by 50%. So, instead of 4000 readmissions, they would have achieved only 2000 - so with a 50% reduction. So that my net savings is the cost of the 4000 readmissions that would have occurred if there was no intervention put in place minus the 2000 readmissions that still occurred after our intervention was implemented. The difference between the two creates the net savings.

And I used the number that CMS uses for the average cost of readmission - it was around \$9000. So essentially, 4000 readmissions would have been expected with no intervention times the \$9000 figure would have been the cost of utilization if there was no care transition program operated at this facility.

The - subtract that by 2000 eligible discharges - which represents the 50% reduction in readmissions, because of our intervention - and multiply that 2000 readmissions by that same \$9000 figure, and that gives us an overall net savings - \$19,200,000. And so then divided by the cost of the health plan, which was a \$450 times the total number of eligible discharges per year, to get the return on investment of 2.13.

Next slide. So, as far as the no-law contract strategy in this example, they have a defined return on investment of 2.13. And then they engage a Medicare Advantage plan, or a commercial plan in their market, and (would) present their return on investment that's been proven.

In lieu of their efforts with CCTP - but also discuss the value-added benefits that - if you were attending the medical loss-ratio webinar - you know that

efforts to health plans expenditures on efforts to reduce readmissions can be attributed directly to the medical loss-ratio requirement.

So now, an additional value-added benefit is that the health plan can apply 100% of their funding to pay for readmission prevention services that are delivered by this community-based organization. They can apply 100% of that cost to the medical loss-ratio requirement. That's one value added.

They can continuously have improved HEDIS outcome measures for all-cause readmissions because we've proven to have a 50% reduction in overall readmissions at the facility, based on our work. And that Triple-A can also capture - if they're able to capture data in the institute-certified system - and have that assist that health plan in having supplemental data sources to demonstrate their ability to impact the readmission numbers.

And they collaborate with a local pharmacist to conduct the full conference of medication review for each individual member, then they're able to have additional value-added benefits to the health plan - not just in return on investment for their care transition service, but also their assistance with helping the health plan meet additional HEDIS requirements, until there is a plus-plus, win-win for the health plan to then contract with this organization.

And so that type of presentation is much different from "We have this excellent care transition program and that everybody likes." And so, moving the needle, and having data and outcomes and presenting that to the health plan as part of an overall contract capture strategy is essential.

Next slide. There are - there's a tool - a tip sheet on how to assess health plans HEDIS performance. And there's a - the web link is here. And it's one of the benefit acumen documents. You see, you download this tip sheet, and now I'm

going to review a sample report that I've pulled from - directly from (Anti-chu-ay), which is a clearinghouse that has all of the performance data that relates to health plans.

This is a particular health plan that's working actually with one of the business acumen collaborative organizations in Wisconsin. And so, they are a Medicare plan. When you look at - if you take a look at the tip sheet, it shows you how to pull a report for commercial plans, Medicaid plans and Medicare plans. And this is that pool in there - (Anti-chu-ay) health insurance plan ranking for this Medicare plan, which is UCare of Wisconsin.

And they scored overall - had a very good score on many of the items. And in Wisconsin, the collaborative there has very strong fall-prevention programs. So you see - and the first section, there's a lot of information around getting care and consumer satisfaction. So, like, 5 is a high score and a 1 is a low score.

So plans want to give many of these measures in the high score - a high score (RAM). So as many 5s as possible in this. So there's the satisfaction with physicians, satisfaction with health plan services, and then you scroll down and then we come down to prevention.

And so they're doing very well in prevention. And then - hold on - we're now beginning to see they're slipping a little bit where there could be areas for improvement. And so they're only average as it relates to colorectal cancer screening, glaucoma screening, and so, vaccination for adults age 65 and older.

So specifically, flu vaccinations. So how many community-based organizations in Wisconsin are holding supporting flu fairs - flu shot fairs - in

the community and could work collaboratively with UCare Wisconsin to help improve that score?

So having this knowledge of exactly where the health plan scores on these measures and knowing how your program could potentially impact that score - prior to having a meeting and discussion with that health plan - is essential.

Can you scroll down some more?

And now, we get into specific clinical treatments. So here, the first one is diabetes. So still scoring fairly well as relates to diabetes and - continue to scroll down - we get into heart disease - depression screening. Until and adhering to depression medication treatment. Potential areas of improvement.

And now we go down - we see managing fall risk. Actually scored a 1 in terms of managing fall risk. And so, now the same cadre of community-based organizations that have very strong fall prevention programs in the community and working potentially with the health brand, working with beneficiaries, have fall-prevention programs all over the community, and really delivering an effective fall prevention screening and program delivery model.

Meeting with the health plan and having a discussion of with their quality team on how the health plan can buy access to this robust network of fall-prevention programs and work collaboratively with the health plan and the local providers to begin improving its score around managing risk of falls.

So this is a real-time example of a health plan that's doing great. And so you can just walk in the door and say, "We want to work with you," but really diving into, "These are our strengths. Our strengths as community-based organizations is this robust network of fall prevention and screening

programs. And we want to deliver those fall-prevention programs to your populations."

And they're thinking we'll be setting for your population as ease of access, we're collaborating with the physicians, and we really want a contract with you, and we will assist you in tracking over time the value-added benefit on how we can help you perform this specific measure, increase this specific measure in terms of your performance going forward by accessing our network.

And so that is a very targeted direct conversation, and should be included as part of an overall contracting strategy with the team in Wisconsin and this particular player.

And so in addition so this is a little example of a health plan score and you could do a few different things. You can look at past year scores. So if you really wanted to hone in on one particular plan that had dominance a specific market you could look to see how their scores trended from year to year.

That's an important thing to see if they continued say if this same health plan had a one for the last two years. Then they likely implemented a program to try and address their managing fall risk score with that population.

And if the trend was that they continued to score poorly then likely they're looking for a new intervention that can address that. And so that's important to know if they continually are doing poor on the same measure over time.

In addition this platform that (unintelligible) provides you allows you to do an apples-to-apples comparison of other competing health plans in the same market.

So this particular health plan in Wisconsin likely has other competitors in the same marketplace. And so now it would begin looking at the other players in the marketplace.

Let's see how they score on the same measure and then maybe then prioritizing those health plans in terms of our contract capture strategy would put them on a priority list.

So we can address the needs and begin talking to the health plan systematically across the marketplace on how as a neutral entity we could serve all their needs if everyone is all scoring poorly as it relates to fall prevention and we have a robust program that can support their beneficiaries and we do seek in managing their fall risk in collaboration with the physicians in that same community.

We see how that is a very different approach especially if you talk to the physician group. We can provide a value added benefit to you as a physician group.

So say in the same community there is an ACL, this physician group that's contracted with this health plan and we're already working with the physician group.

So another strategy is let's collaboratively go to the health plan and you the physician group identify us a community based organization network that's doing fall prevention programs.

And we will both agree to adhere to the steady algorithm which the Center of Disease Control has developed and we will be the delivery arm of community based fall prevention programs.

And as the primary provider of the community based fall prevention programs for this physician network we go to the payers and negotiate a rate in the value to the health plan is improvement in this measure getting improved services to their members having more access to a network that can deliver targeted services to help address a point of pain for them because they have great scores going all the way down.

The only one that they had is that market. And so if I have strength that correlates with their point of pain, their point of pain documented proof of point of pain here is that.

So anyone that is remotely involved with managing improving quality and HEDIS measures at this particular health plan has got to have some interest in how they can move the marker on managing fall risk for their population based on the fact that they have got a one score for the past year in that measure.

And so if I have an -- if they have a problem I have a solution and then let's mesh the two and now we just need to discuss return on investment. And the return on investment goes back to that return on investment calculation.

And so now we're having a very targeted conversation about moving towards contracting and you using public data sources provided by NCQA. Your knowledge of HEDIS measures and the correlation between medical loss ratio and other things as part of an overall contracting strategy to move towards getting paid to deliver these services in the community.

Lauren Solkowski: Okay so I'm going to go back to (unintelligible) because I see we have a lot of questions coming in. So Operator if you could provide participants with instructions for asking a question through the phone line that would be great.

Coordinator: Certainly, if you would like to ask a question over the phone please press star then 1, please un-mute your phone and record your name when prompted. If at any time your question has been answered you may remove your request by pressing star 2.

Once again please press star 1 if you'd like to ask a question over the phone.

Lauren Solkowski: Great, so while we're waiting for questions to come in we have received several through the chat. So the first -- let me see so I think going back to slide 8 when you were talking about consumer influence on HEDIS outcomes and the consumer adherence or non-compliance are not accounted for and directly impact HEDIS measures.

So the question is do you think or worry that an unintended consequence maybe that patients are denied services or told that they must go to another primary care provider for care?

Tim McNeill: So there has been -- okay consumer advocacy groups have continually expressed not just as related to HEDIS measures but even as relates to pay for performance models and other things that health systems, doctors and so forth will begin to selectively avoid high risk consumers and not want them to be part of their panel because it could impact their numbers which would also impact their finance.

But so there are supposed to be safeguards in place to monitor that and to prevent what's commonly called to as dumping where the health plans are identifying the highest risk consumers and then making it increasingly complicated for them to obtain care.

And really encouraging them as well, you know, all of the providers that you want to go to they're not in that work and so hint, hint, hint it would be a good idea for you to look at our sister health plan across the road and then sign up with them.

So that type of steering or dumping is frowned upon, it's monitored. I can't say it's 100% effective and we're catching all players because as you know fraud exists constantly, fraud abuse exists constantly but it is being monitored and I can tell you that there is great attempts and the CMS has this whole center for program integrity and that's one of the things that they also look at and to make sure that this type of dumping and avoidance of high risk consumers does not occur.

Lauren Solkowski: Okay thanks. So the next question and I think this is referring to when you were talking about the health risk assessment data that could be reviewed and completed by a practitioner and I think you might have mentioned a qualified practitioner.

And so they're asking what do you, could you qualify what you mean by qualified practitioner?

Tim McNeill: Sure, so an example of this is like a conference of medication review. The expectation there is that the pharmacist works with that consumer. So a pharmacy technician that reviews that information with the consumer absent

of the pharmacist wouldn't be a qualified practitioner that could deliver that service.

Another example would be maybe a consumer's health risk assessment is reviewed by a medical assistant in the physician practice but the consumer never actually has a review or validation of that health risk assessment data by the physician themselves.

Then that medical assistant supporting the physician is not qualified to validate the data as accurate and so therefore then it would not be deemed as such.

But the instance with community based organizations and the medical (unintelligible) capture the data, review that data with the physician, with the nurse practitioner and then them meeting with the consumer and validating the data.

One it saves a lot of time for the busy provider so that's one value add and then maybe the additional information that could be captured that maybe a busy physician practice is not able to do.

And then when they then review all the data that their partner community based organization works with them to capture then they quickly can review, now they sign off and then it would meet that requirement.

So generally in most instances a qualified practitioner is the licensed person and whatever service they provide falls within their realm and scope of practice.

Lauren Solkowski: And then another question, can a comprehensive review by a pharmacist be done with a member by phone or by tele-medicine?

Tim McNeill: So absolutely tele-health is fully supported and it can occur by phone but it has to be a conference of medication review. So it couldn't be, you know, it could not be have a short phone chat again with the consumer and I'm only going to review the couple of things that are of concern.

So there were two conflicting medications maybe they were ordered two different types of blood thinners or they have two hypertension medications that potentially compete.

And so that was an issue and so the pharmacist has all the data that's collected by a community based organization and then has direct interaction with the consumer but only addresses those things that were of concern and does not complete a complete review of all of the things with the consumer by phone that doesn't count.

So yes you can, they can complete that by phone they can complete that by tele-health where there is real time two way video and audio communication which is how tele-health is defined.

That is completely allowable and acceptable to complete that measure.

Lauren Solkowski: Great thank you and Operator have we had any questions come in on the phone?

Coordinator: We have had no responses from the phone lines.

Lauren Solkowski: Okay I'll keep moving to the ones on chat. Let's see, does the new guidance on medication reviews mean that home meds plus is no longer an acceptable intervention?

Tim McNeill: So I don't know the details, I don't know home med plus so I can't address that question. All I know is that if you look up what's required for a conference in medication review and if you want to support a health plan achieving the completion of a conference on medication review then you have to meet that criteria.

It's very cut and dry either there is a full review of all of those elements, their medication, over the counters, herbal supplement use, medication adherence it has to be a full review of all those elements and it has to be direct interaction with every consumer and the pharmacist to review all those elements.

So if all of those things are in place absolutely it meets the requirement. If those things are not in place it doesn't meet the requirement. Now it doesn't mean that that intervention is not of value, it doesn't mean that a health plan would not want that.

It doesn't mean that that intervention doesn't reduce cost and improve outcomes. This what I'm discussing here when I'm meeting with a health plan and specifically targeting my value add to the health plan is to help them improve the HEDIS measure scoring outcomes with the population at hand.

And so I need in order to do that I have to match my intervention to the HEDIS requirement and then I have to have a real discussion with internally about how I can develop an infrastructure to meet that requirement before I go and market myself to a health plan as being able to meet certain requirements.

Lauren Solkowski: Okay let's see this says your ROI calculation was or the return on investment is based on a reduction in readmission rates. Where can we find data that shows reduction in readmission rates for existing projects?

Tim McNeill: Data return on investment for you said existing projects?

Lauren Solkowski: Yes that is the question. I can ask her to clarify and we can come back to it.

Tim McNeill: So just in general return on investment is something that in an organization go to the process to document and calculate. And so externally if you're looking for kind of a broad scale proof of return on investment of X program that's operated in multiple sites across the country.

You'll be hard pressed to find that because it really is site by site, community by community, locale by locale, individual assessment of return on investment because a reduction in readmission that's tied to volume again with that same example and say we're at I don't know male clinic and they have a ton of hospitalizations and we're doing, we're really cranking it out.

And say now I'm in a care transition program that in rural Mississippi Delta and I gave an example of 20,000 eligible discharges per year maybe that same site may have 1000 eligible discharges per year.

So the volume is much lower and so the impact of the readmission has a greater impact on the return on investment because the pool is smaller. And so you won't because of those variations across the country you won't see where there is one defined return on investment for X program across the country it's really calculated locale by locale in that manner.

Lauren Solkowski: Okay, let's see could you please describe the NCQA certified system?

Tim McNeill: So NCQA has a certification process where a vendor, a health information technology and quite a few electronic health record systems and care management systems that first seek certification of meaningful use through the office of the national coordinator which is important.

And so once they achieve recognition as a certified meaningful use certified product then they can also it's not a prerequisite but many do also can seek certification by NCQA for HEDIS reporting.

And then once they have that certification when it comes to validation of meeting quality for supplemental data sources then because that data is captured and documented in a NCQA certified system then for audit purposes it automatically is accepted in terms for audit and validated because the data source was captured in a NCQA certified system.

And so from a marketing contract capture strategy if my goal is specifically to target managed care if I have a product that's meaningful use certified that automatically means because it's meaningful use certified that I can communicate through my system directly with every other meaningful use certified product in the market.

Which means every physician in every health system has been mandated and incentivized to death to set up and establish a meaningful use certified electronic health record system.

If I have a meaningful use certified product then I can automatically communicate with them and I can automatically communicate with every health plan.

And now if I also have a system that (unintelligible) NCQA certification then when it as it relates to supplemental data sources that can be used to validate completion of HEDIS measures then that is an additional value add.

And there's a lot of products in the market that meet both the meaningful use certification. There's a listing you can obtain a list through the U.S.

Department of Health and Human Services Office of the National Coordinator and I know that's a long kind of odd name.

But the Office of the National Coordinator is the office that coordinates health IT policies. So they have a listing of all products, care management products, electronic health record products, you know, tids and bits that provide support for care transitions and other things.

If they have achieved meaningful use certification they're listed on the Office of the National Coordinate Web site and you can obtain a list because there's a long list.

But you can also cross check so if you're seeking a software and you are looking at three or four vendors one thing that you could do is cross reference those vendors to see if they're on the list and see or if they can provide with you with proof that they have meaningful use certification.

So then as it relates to communication with health systems, doctors, health plans that box is checked by them being meaningful use certified. Then lastly the ability to have the system that can have validated supplemental data towards meeting HEDIS requirement, capturing that in a NCQA certified system.

Then allows you to have audit proof data that supports the health plan so the health plan can receive that data from your system and because your system is NCQA certified then they can have that as validated data sources to meet the requirement.

And so then they incorporate the health plan, incorporate that as part of their overall HEDIS scores. Remember I gave you the example of health plans are actively seeking and engaging physicians and other vendors to help them what's called closed gaps in care.

Essentially give the health plan pools a list of members who have failed certain HEDIS measure markers. And again I'll give you an example of hemoglobin A1C.

So (unintelligible) consumers who are diagnosed with diabetes that have not had a hemoglobin A1C based on their claims data and then that's the panel that's a problem.

And I'll go back to Wisconsin so the same network of community based organizations that are doing fall prevention they also have this robust diabetes education program.

And so they give us a panel of diabetes, consumers with the diagnosis of diabetes that have failed their hemoglobin A1C measure and we're in Madison.

So I have this list, I have a network of programs and now I'm delivering diabetes self-management education and it's linked with my care transition program at my community site.

I'm then capturing, I'm working with their physicians, the lab, we're getting people into education and we're documenting what their hemoglobin A1C results are.

We're documenting it in a NCQA certified system we're exporting that data back to the health plan. The health plan then says we have validated proof this person has met this measure.

And so now we've helped the health plan meet the measure and they can automatically incorporate your data as part of the report because you capture the data in a NCQA certified system.

Lauren Solkowski: Okay, Operator checking back to see if we've had questions come in on the phone.

Coordinator: At this time we have no questions but once again if you would like to ask a question over the phone please press star 1.

Lauren Solkowski: Okay since we still have some time here Tim we have a couple more questions. So the next question is, what if a plan covers multiple areas in a state or several states can you drill down to a PSA?

Tim McNeill: So if in terms of HEDIS reporting it's much harder to drill down to a specific PSA within a state. But for health plans many times if you have a health plan that operates in multiple states they oftentimes operate as a separate tax ID number or separate entity.

So a United Healthcare of Texas or United Healthcare of Florida or Care First Washington, DC and Care First California they have the same umbrella name

but are separate independent entities and often are registered or accredited at NCQA as a separate entity.

So I can pull the score for United Healthcare of Texas and I can pull the score for United Healthcare of Florida and I will get distinctly different results that apply only for that local market.

Now if I pull the results for United Healthcare of Florida and I wanted to drill down and say how was United Healthcare of Florida doing in Palm Beach County I can't do that.

Not for HEDIS you can't do that or NCQA might but that data is not publicly available.

Lauren Solkowski: Okay, let's see so in terms of the question from earlier in regards to the return on investment question. So she says the question is do we have any data that we can use to suggest actual reductions in readmission?

Tim McNeill: Actual data so for a program that's actively operating one of the data sources if the hospital so or the QIO is another or (Quin) QIO now as they're called is another source of data.

So there should have been some established baseline of what the readmission rate is for the target population. And then at if the program has been operating there should be some delta or change in that outcome measure and that's how you begin to find the return on investment for that service.

Now if a program has never started or is not implemented not done any services you can't define, you know, in this (message) you can't really define a tangible return on investment for a program that hasn't started.

So because it's inconclusive at that point that there is a clearly defined return on investment that will address that particular population if the program or the intervention has never gotten off the ground.

Lauren Solkowski: Okay I'll check back again. Operator any questions on the phone?

Coordinator: We have had no responses.

Lauren Solkowski: Okay another question Tim, if the (CVO) used the steady algorithm what services exactly would they provide in the community? It seems the doctor must be the one to perform the steady algorithm.

Tim McNeill: So the steady algorithm is not an intervention. So and I think that's a common misconception because I was meeting specifically with a medical director of a health plan and they were telling me that we don't want to buy matter of balance we want to buy steady.

And I was like well steady isn't an intervention steady is just an algorithm to screen for falls. And at the end and then I had to point out to them at the end of the steady algorithm it says now if this person needs an intervention you should refer that person to a community based resource to do the intervention.

And so completing the steady algorithm we are the completer we closed out the steady algorithm because it ends with a intervention and your doctors aren't going to do a 12 week fall prevention program in the office but we are going to do that and so that's the point.

So the steady algorithm is not really an intervention. It does and it is clinically focused, it is kind of led by providers whether that be a physician, nurse practitioner or a physician assistant.

Community based organizations can assist because one of the things that's a steady algorithm is complete a medication, review to see how medication impacts falls for that particular consumer.

A lot is to do an objective assessment of that person's fall risk whether that be time up and go testing, Tinetti testing and these things should, anybody doing fall prevention these things should ring true or you've heard them before or you may be doing them.

I can tell you countless programs I've met with and I say are you doing a time up and go are you doing Tinetti. Yes we do it all the time but where do you document it at. We don't document it.

So you didn't do it if you don't document it it's of no value to anybody but it is part of an overall steady algorithm. So now a community based organization working with the physician group that's implementing steady and we are doing the time up and go, we're doing the Tinetti we're capturing the medication, we're learning the physician where there is potential medication risk that make that person at risk for fall is helping the physician complete the steady algorithm.

And then as I said the steady algorithm if that person then has moderate risk for falls then they should be referred to an intervention and they specifically speak about referring that person to a community based program that can support that consumer in a fall prevention intervention that completes the cycle of the steady algorithm.

And as I said a steady algorithm is not an intervention it's just an algorithm to support people getting the things they need to prevent falls. It's not a true intervention to prevent falls.

Lauren Solkowski: Okay and let's see we have about one more minute left and I think I have one more question here.

Coordinator: We do have one on the phone as well.

Lauren Solkowski: Okay go ahead with the one on the phone.

Coordinator: (Mary West) your line is open.

(Mary West): Thank you. I went online and I've been looking at the health rankings but I can't find anything related to falls prevention in there. I'm wondering if that is at a later date. I'm looking at the 2014 to 2015.

Tim McNeill: So you're looking at the scores for the health plans because we just showed you like the plan in Wisconsin where they scored specifically on managing fall risks. Are you, what are you...

(Mary West): Right and I'm not seeing that same screen or information on the one that I'm at.

Tim McNeill: ...are you looking at a particular health plan?

(Mary West): Yes and I checked several of them that are effective here in Vermont and I can't find anything on falls prevention. There is a huge section on children and adolescents. I don't see what I'm doing wrong.

Tim McNeill: So when you select the type of plan that's where we're at. At the top when you go through the tip sheet and, you know, it links you to the NCQA site and then up at the top you select the type of plan.

And there's three types of plans you can select. You can select the commercial plan, you can select the Medicaid plan or you can select the Medicare plan.

If you selected the Medicaid plan the traditional Medicaid population is mother baby. And so managing fall risk in older adults is not likely a Medicaid measure.

You see when you look at the Medicaid measures there's things like sexually transmitted infections and rapes and that type of stuff because that is more akin to a Medicaid mother baby population not so much in older adult population although that's just changing.

But anyway so you got to make sure that you selected Medicare plan and remember many of these plans have multiple plans in the marketplace because they diversified their health risks over the market.

So they may have a commercial plan, a Medicaid plan and a Medicare Advantage plan. You see the fall risk managing fall risk akin to their Medicare product and it will report it from NCQA as part of the Medicare outcome measure.

(Mary West): And would that be because of the Affordable Care Act and now those falls measures are included in the annual bonus?

Tim McNeill: So HEDIS is a registered trademark owned by NCQA so I can't say that the Affordable Care Act clearly influences NCAQ but it doesn't dictate what NCQA puts in the HEDIS measures because they own the HEDIS measures.

And so they have a scientific panel that meets so it's a very long process, a very elaborate process that they go through looking at the state of the science, the changes in the industry and the other things to develop HEDIS measures.

And then they continually review them and that's why there is updates and changes every year.

(Mary West): Perfect got it.

Lauren Solkowski: Okay, well we're a few minutes over our time so I want to be respectful of everyone's time and actually I've gotten a couple more questions that have come in through chat in the Q&A function.

So what I will do is I will compile all of the questions. I will send them to Tim, we'll get the answers together for everyone and share to all the participants on the Webinar for any questions that we did not get to today.

If you have other questions again please feel free to send them to me.

Tim McNeill: I could also maybe if it's okay maybe the next since it's a series of three that there is like trends I can always address questions at that time too or in writing but sometimes it's helpful for the whole group to hear the question because they may have the same question.

Lauren Solkowski: Yes actually that's a great idea as well. So we're working on scheduling those two other the part two and three of the series. They will be in September and October.

We already have a Webinar scheduled for August but those dates will be coming out very soon. So in either case we will get your questions answered. So just thank you again to everyone for joining us today. Thank you to Tim for an excellent presentation and everyone enjoy your afternoon.

Coordinator: Thank you for your participation on today's conference call. At this time all parties may disconnect.

END