

Web Conferences

The Medicare Health Outcomes Survey:
Data Driven Strategies for Quality Improvement

Seminar # 2: May 31, 2005



Medicare Advantage QIOSC Learning Series

- Lumetra, the California Quality Improvement Organization (QIO), is pleased to host this collaborative learning series with our partners from the Health Services Advisory Group (the Arizona QIO), and Florida Medical Quality Assurance, Inc. (the Florida QIO).
- Goal of Medicare Advantage (MA) QIOSC: provide technical support, spread knowledge, and clarify regulations related to the managed care community.

The Web Conference Series at-a-Glance

PURPOSE

Demonstrate practical uses of the Health Outcomes Survey (HOS) data by MA plans and QIOs

CONTENT

1. Strategies for using the Medicare HOS data
2. Resources available to plans and QIOs
3. Questions and answers

Today's HOS Web Conference Topics

"Using the Medicare HOS Data to
Identify Strategies for Managing
Chronic Conditions"

"Using the Medicare HOS Data to
Identify At Risk Beneficiaries"

Today's Faculty

- Arlene Bierman, MD, MS
University of Toronto and St. Michael's Hospital
- Dave Drachman, PhD
*Health Services Advisory Group (HSAG),
the Arizona Quality Improvement Organization*
- Merry Tantaros, MA, RN, CPHQ
*Lumetra,
the California Quality Improvement Organization*

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Overview

- Survey launched in 1998
- First outcomes measure used in Medicare managed care
- Over 1.5 million Medicare beneficiaries surveyed
- National participation from Medicare Advantage plans
- Mail survey with telephone follow up
- Longitudinal survey: Beneficiaries are surveyed at baseline and again two years later
- Assesses each health plan's ability to maintain or improve the physical and mental health functioning of its Medicare beneficiaries over a two-year period
- Plan reports are distributed through the Health Plan Management System (HPMS). QIO reports are distributed through the QualityNet Exchange application.

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Survey Content

Physical Health Status

Mental Health Status

Chronic Medical Conditions

Clinical Symptoms

Activities of Daily Living



Depression Indicator

Smoking Status

Urinary Incontinence

Healthy Days

Demographics

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The QIO's Role

- Initiate quality improvement projects with MA plans where the QIO has identified opportunities to improve care
- Collaborate with MA plans that may approach QIOs with ideas for using HOS data
- Provide technical assistance to MA plans

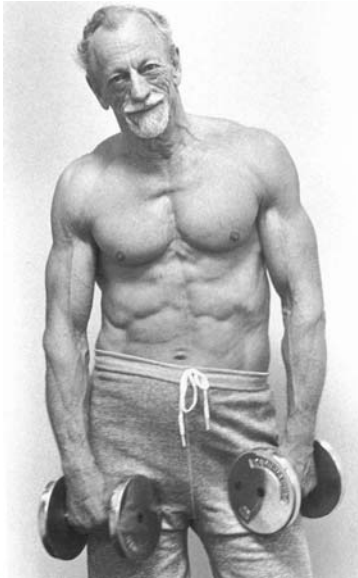
*Source: SDPS Memorandum Number 04-509-OD
December 14, 2004*

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Using HOS Data for QI Activities

1. Identify Strategies for Managing Chronic Conditions
2. Profile At Risk Beneficiaries for Interventions

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1. Strategies for Managing Chronic Conditions

Medicare Modernization Act

- Section 722 (a)(1)(2): “Each **chronic care improvement program shall have a method for monitoring** and identifying enrollees with multiple or sufficiently severe chronic conditions...”

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1. Strategies for Managing Chronic Conditions

What matters to patients

- Major goals of health care for elderly Medicare beneficiaries
 - maintain independence,
 - prevent functional decline
 - improve health-related quality of life
- Physicians do not routinely assess function in their elderly patients.
- Physicians are often unaware of their patients' functional limitations.
- There are large gaps in quality of care in areas that can impact function.

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1. Strategies for Managing Chronic Conditions

Functional decline and health care costs

- Two year longitudinal cohort of community-dwelling elders
 - 20% of elders with functional dependence or who declined accounted for almost half of total expenditures
 - 2 year excess of approximately \$10,000 in expenditures
 - 10% who declined accounted for more than 20% of expenditures

Source: Fried, *Archives of Internal Medicine*, 2001

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1. Strategies for Managing Chronic Conditions

Managing chronic illness in the elderly

- Risk for functional decline and frailty
 - Progression of chronic disease: e.g., heart failure
 - Acute event: e.g., hip fracture, stroke
- Comorbidity is the norm
- Pathophysiologic and pharmacokinetic changes of aging

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1. Strategies for Managing Chronic Conditions

Three strategies for improving functional health outcomes

- Prevention
 - Risk factor reduction
 - Health promotion
- Improved Management of Chronic Conditions
 - CHF, diabetes, arthritis
- Improved Diagnosis and Management of Geriatric Syndromes
 - Falls, incontinence, dementia

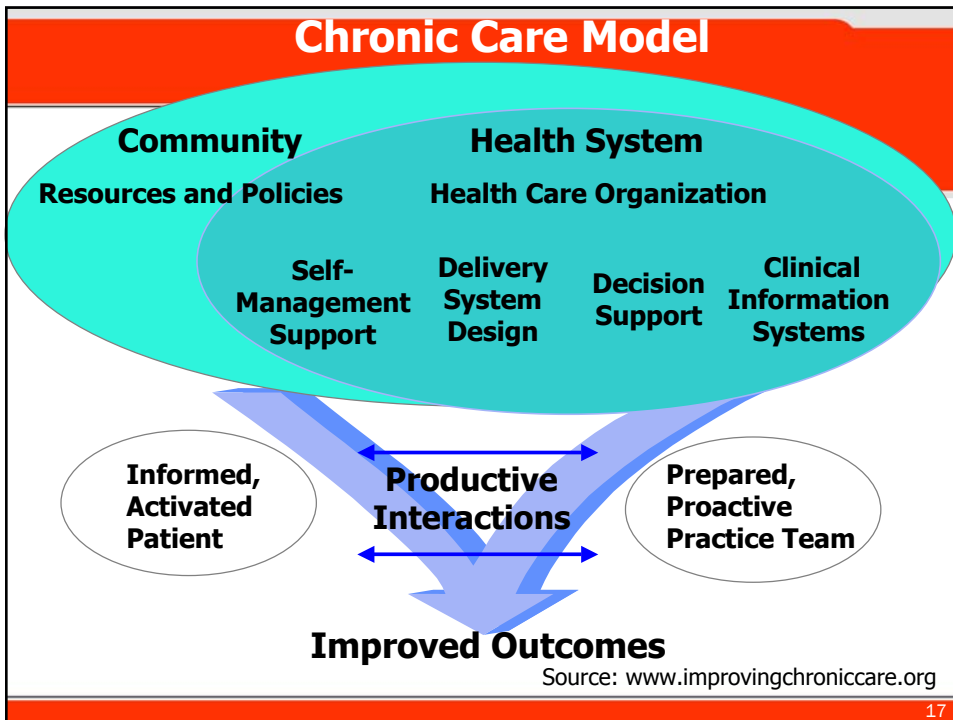
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1. Strategies for Managing Chronic Conditions

Can we improve functional health outcomes?

- There is growing evidence functional health outcomes in the elderly, as measured by the SF-36, can be improved
- Providers
 - Primary Care (Reuben, Boulton)
 - Discharge from Acute Care Hospital (Cohen)
 - Home Care (Tinetti)
- Patients
 - Chronic Disease Self-Management (Lorig)
- Community
 - Preventive Occupational Therapy (Clark)

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1. Strategies for Managing Chronic Conditions

Advantages of the HOS measure

- Measures what is meaningful to patients
- Patient-centered outcome measure
- Reflects net result of care
 - Multiple conditions
 - Multiple sites and settings

1. Strategies for Managing Chronic Conditions

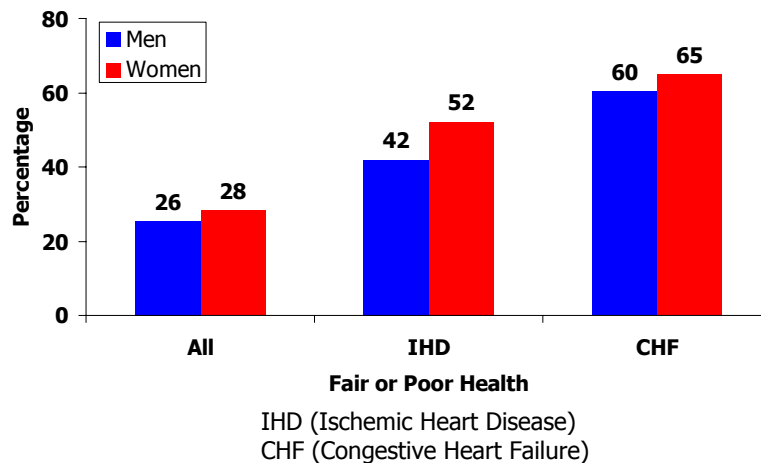
Using HOS data to identify strategies to improve chronic disease management

- A. Assess health and functional status
- B. Identify conditions contributing to poor functional health outcomes
- C. Examine patterns of comorbidity
- D. Identify opportunities for improved symptom management
- E. Identify at risk enrollees

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A. Assess health and functional status

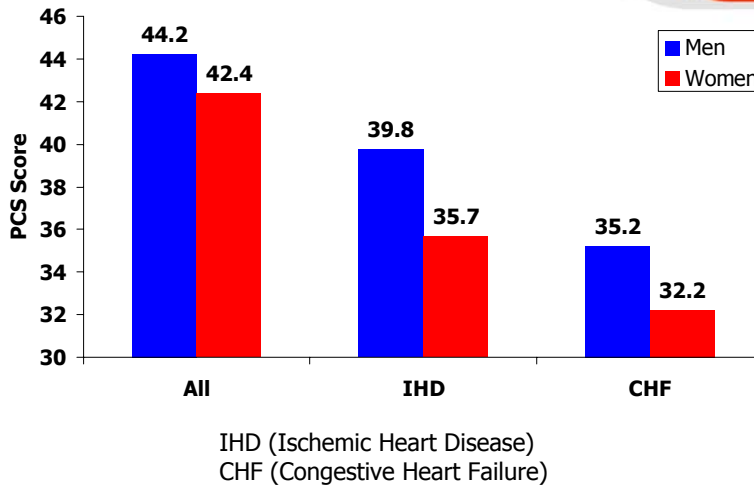
Global health



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A. Assess health and functional status

Heart disease and physical functioning



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B. Identify conditions leading to poor outcomes

Top 10 chronic conditions leading to poor physical function

- Arthritis
- Ischemic Heart Disease
- Hypertension
- Low Back Pain
- Urinary Incontinence
- Asthma/Chronic Obstructive Pulmonary Disease
- Congestive Heart Failure
- Diabetes
- Stroke
- Depression

Source: Medicare HOS Cohort I, 1998.
(female seniors)

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B. Identify conditions leading to poor outcomes

Top 10 chronic conditions leading to poor mental function

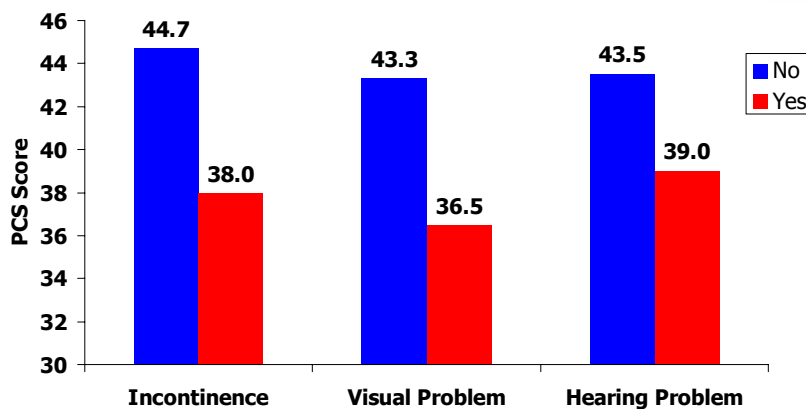
- Urinary Incontinence
- Difficulty Hearing
- Low Back Pain
- Inflammatory Bowel Disease
- Other Heart Conditions
- Asthma/Chronic Obstructive Pulmonary Disease
- Difficulty Seeing
- Stroke
- Diabetes
- Ischemic Heart Disease

Source: Medicare HOS Cohort I, 1998.
(female seniors)

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B. Identify conditions leading to poor outcomes

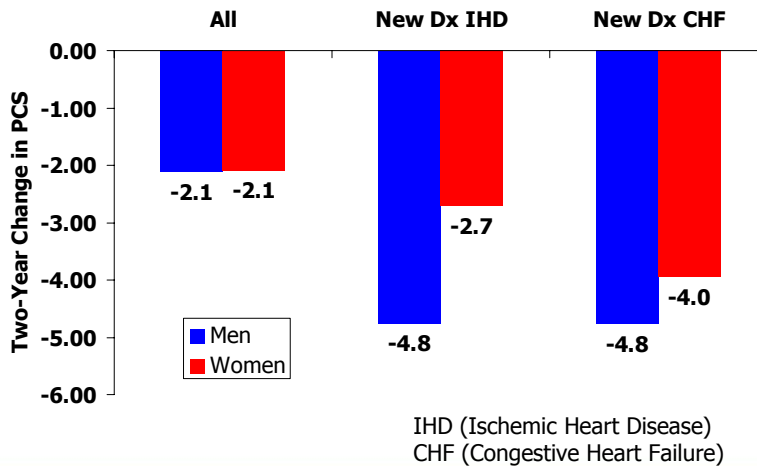
Geriatric syndromes and PCS scores



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B. Identify conditions leading to poor outcomes

Change in functional status associated with new diagnosis



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C. Examine patterns of comorbidity

Comorbidity and heart disease

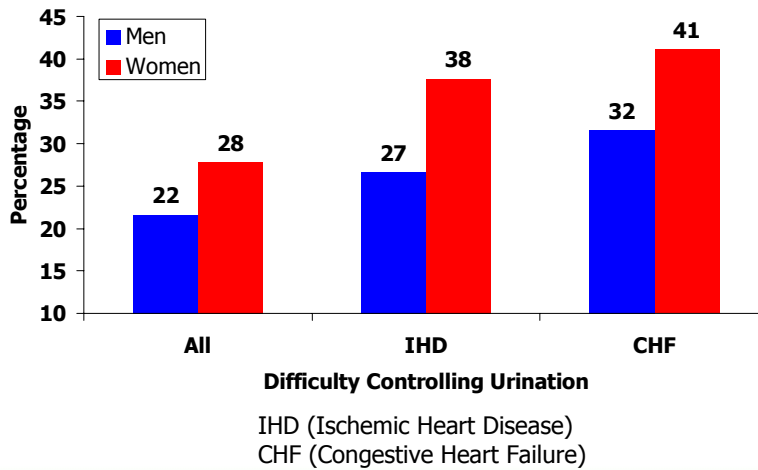
	All %	IHD %	CHF %
Hypertension	51	68	72
Diabetes	16	26	32
Stroke	8	17	21
Arthritis	48	56	60
COPD/Asthma	12	18	25
Visual impairment	6	9	13
Hearing impairment	13	16	19
Three or more conditions	47	86	92

IHD (Ischemic Heart Disease)
 CHF (Congestive Heart Failure)
 COPD (Chronic Obstructive Pulmonary Disease)

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C. Examine patterns of comorbidity

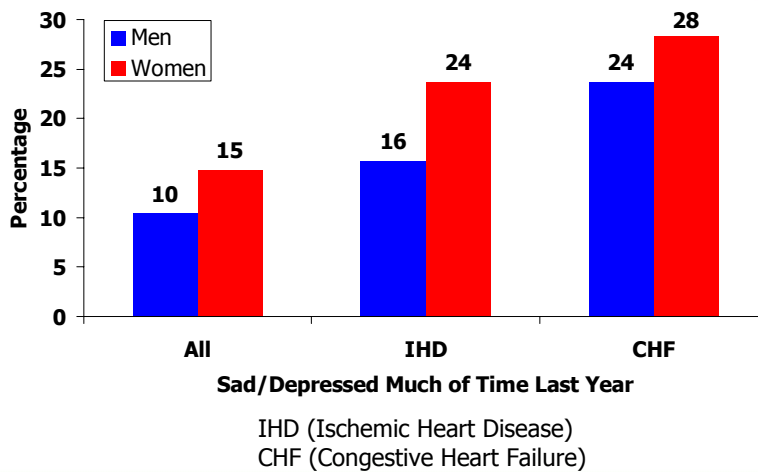
Urinary incontinence



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C. Examine patterns of comorbidity

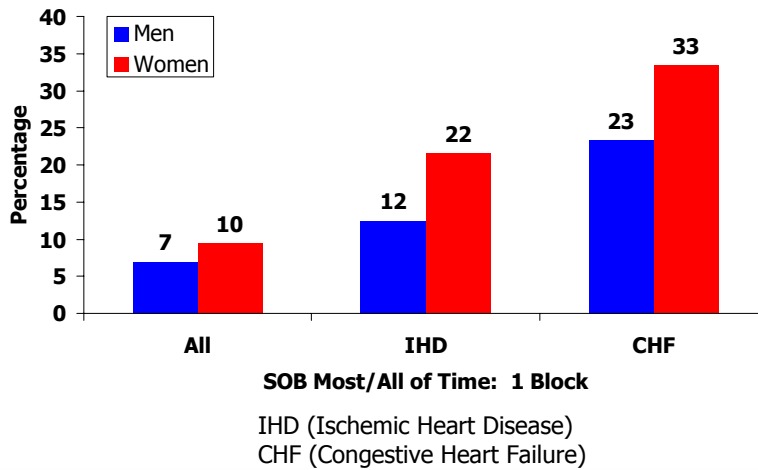
Depressed mood



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D. Identify opportunities for symptom management

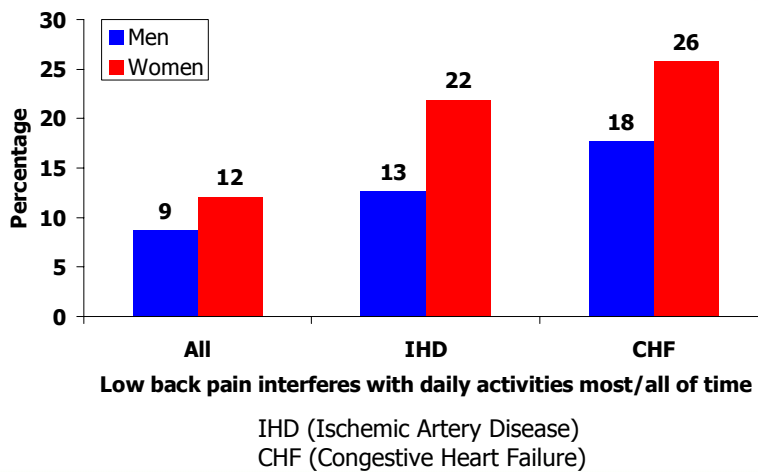
Shortness of breath (SOB)



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D. Identify opportunities for symptom management

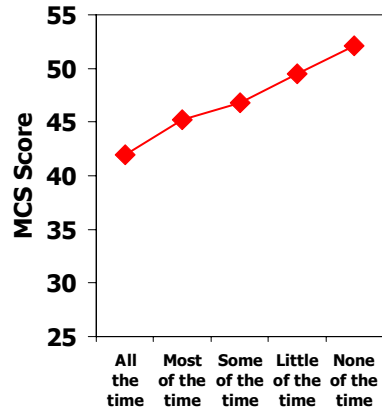
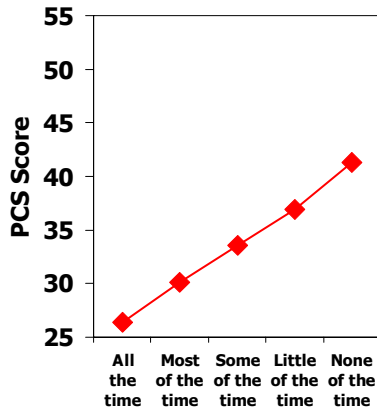
Low back pain



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D. Identify opportunities for symptom management

Shortness of breath while climbing one flight of stairs: CHF

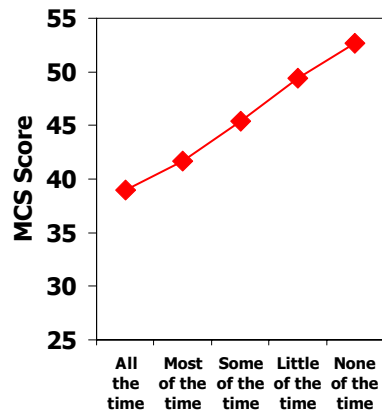
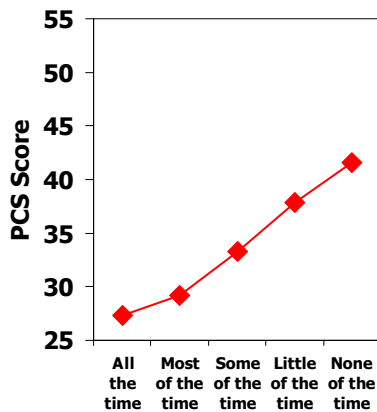


CHF (Congestive Heart Failure)

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D. Identify opportunities for symptom management

Chest pain/pressure while exercising: IHD

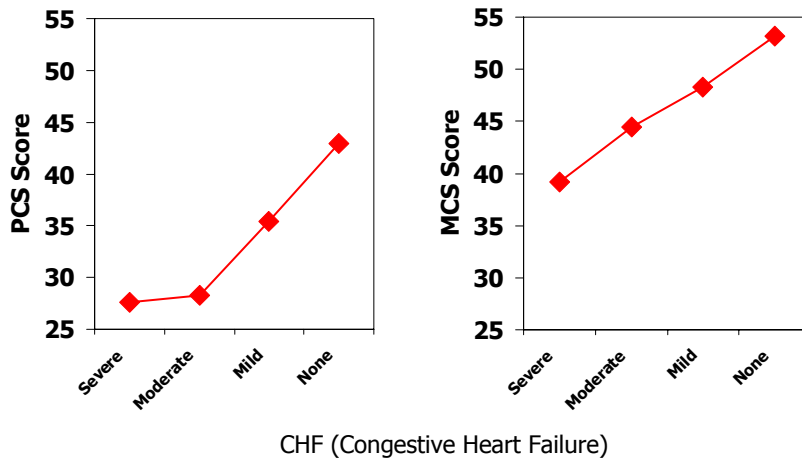


IHD (Ischemic Heart Disease)

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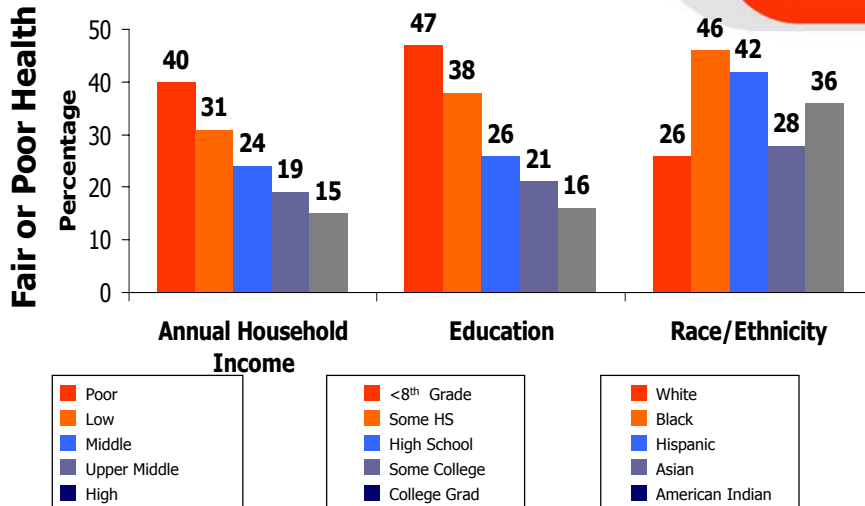
D. Identify opportunities for symptom management

CHF symptom severity



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E. Identify at risk enrollees



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1. Strategies for Managing Chronic Conditions

Summary

- Treatable symptoms such as exertional chest pain and shortness of breath on exertion are strongly associated with physical and mental functioning measured with the SF-36.
- Elderly enrollees have a high prevalence of comorbid conditions that can influence treatment decisions and outcomes.
- Improved clinical management of both primary and comorbid conditions can result in improved functional health outcomes.
- An understanding of gender, socioeconomic, and ethnic differences in symptom severity and comorbidity can inform the design of quality improvement interventions.

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"It's not how old you are,
but how old you feel."

--Essie Smith

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Today's HOS Web Conference Topics

“Using the Medicare HOS Data to Identify At Risk Beneficiaries”

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2. Profile At Risk Beneficiaries

The Basic Strategy

STEP 1

From HOS data, identify beneficiaries who are at risk for the condition of interest

STEP 2

Identify beneficiaries from the TOTAL plan enrollment who are statistically similar to the at risk beneficiaries

STEP 3

Screen the at risk beneficiaries

STEP 4

Give providers a list of the beneficiaries in their caseload who screened positive, along with practice guidelines and protocols

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2. Profile At Risk Beneficiaries

Example: Depression

STEP 1

Risk profile: Diabetes *OR* heart disease *OR* stroke *OR* dual eligibility *OR* female* gender aged 75 and over

STEP 2

Apply profile to plan's entire population, using diagnostic and demographic information from the plan's administrative database

STEP 3

Mail depression screening tool to the beneficiaries who meet the risk profile

STEP 4

Give each provider a list of the beneficiaries in his/her caseload who screened positive, along with practice guidelines and protocols

* Indicates a correction to the May 31 content

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2. Profile At Risk Beneficiaries

Urinary Incontinence is now a HEDIS measure

- Of the beneficiaries who reported a urine leakage problem, only 55% discussed it with their provider
- Of the beneficiaries who discussed their leakage problem with their provider, only 57% received treatment

Source: Medicare HOS, Cohort VII Baseline data, age 65 and older

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2. Profile At Risk Beneficiaries

Example: Urinary Incontinence

STEP 1

Risk profile: Age greater than 75 *OR* female gender *OR* diabetes *OR* stroke *OR* 3 or more comorbidities

STEP 2

Apply profile to plan's entire population, using diagnostic and demographic information from the plan's administrative database

STEP 3

Give each provider a list of the beneficiaries in his/her caseload who screened positive, along with practice guidelines and protocols

STEP 4

For each beneficiary on the list, provider initiates discussion of urinary incontinence

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2. Profile At Risk Beneficiaries

Selecting a Target Condition

- Prevalent
- Frequently overlooked
- Responds well to treatment
- Examples:
 - Depression
 - Diabetes
 - Arthritis
 - Urinary Incontinence

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2. Profile At Risk Beneficiaries

Analytic Tools

- *Logistic regression* can be used to identify the strongest predictors of the condition of interest
- Available in SAS, SPSS, and other common software packages for statistical analysis

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2. Profile At Risk Beneficiaries

Other Potential Targets for Risk Profiling

- Large declines in PCS or MCS scores
 - Take advantage of the longitudinal design
- The disadvantaged beneficiary
 - Let the data tell you which demographic groups have the poorest outcomes
 - The results may surprise you

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2. Profile At Risk Beneficiaries

Variations

- The “Ford”
 - Base your profile on the literature
- The “Cadillac”
 - Fine-tune the profile by linking HOS data to your plan’s encounter data
 - You will need to work with your QIO

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2. Profile At Risk Beneficiaries

Variations

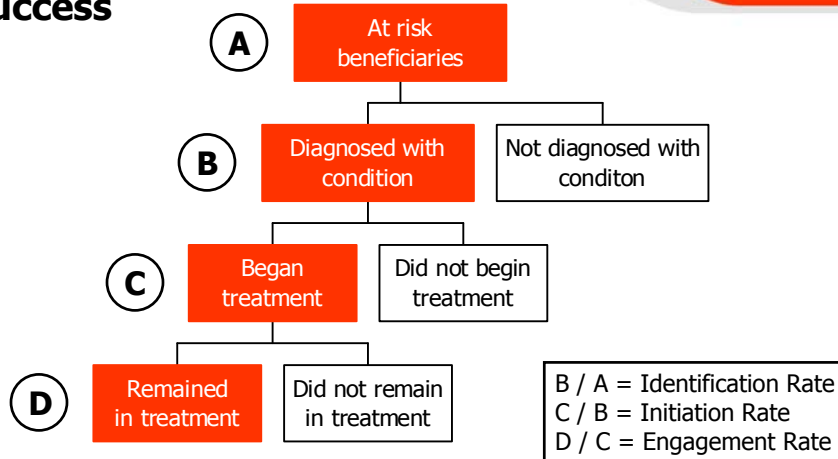
- Target *Providers* as Well as Beneficiaries
 - Which providers have the highest percentage of at risk patients in their caseloads?
 - Focus provider training where it will have the biggest payoff
- Administer the HOS to specific groups on a custom schedule*

* *Must obtain prior permission from CMS*

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2. Profile At Risk Beneficiaries

Evaluating the Project's Success



Adapted from McCorry et al., *Joint Commission Journal on Quality Improvement*, 2000

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For More Information

- <http://www.cms.hhs.gov/surveys/hos/>
(HOS background, questionnaire, reports and publications)
- Today's PowerPoint slides will be posted on this site
- Faculty Contacts
 - Arlene Bierman, MD arlene.bierman@utoronto.ca
 - Dave Drachman, PhD ddrachman@azqio.sdps.org
 - Merry Tantaros, MA mtantaros@caqio.sdps.org
- HOS Technical Support
 - Medicare HOS information and technical support telephone line: 1-888-880-0077
 - E-mail: hos@azqio.sdps.org

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For More Information

- A recording of today's Web conference will be posted at: <https://ifmcevents.webex.com/>
- Register for the remaining seminar in this series at: <http://www.lumetra.com/HOSconferences>
 - Seminar #3 June 28, 2005 10:00 am Pacific Time
 - Using the HOS Data to Evaluate Disease Management Programs
 - Using the HOS Data for the Pharmacy Management of Depression

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Your Questions and Comments

- How has *your* organization utilized the survey results?

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