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New Measures in the Medicare Health Outcomes Survey – Preventive Care and Vulnerability

Judy Ng, Sarah Scholle, Lok Wong

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NCQA
Measuring quality.
Improving health care.

Agenda

- Purpose
- Quality measures
- HOS study population
- Defining vulnerability status
- Results
- Implications

Purpose

Examine whether receipt of preventive counseling or care for prevalent conditions in elderly Medicare managed care enrollees varies by vulnerable status

Preventive Measure Development

- Developed by NCQA/CMS Geriatric MAP
- Aims to prevent geriatric syndrome
- Guideline recommended preventive counseling and care for seniors
  - I. Physical Activity: Discussion & advice
  - II. Urinary Incontinence: Discussion & treatment
  - III. Fall Risk Management:* Discussion & treatment
  - IV. Osteoporosis Testing in Women:* Ever got testing
- Reports plan performance rates to drive QI

* 1st year measures for 2006

HOS Preventive Counseling Measures

	Eligibility	Rate 1	Rate 2
Physical Activity	Age 65 and over	Discussed physical activity with physician	Received advice
Urinary Incontinence (UI)	Age 65+ who endorse small/big UI problem	Discussed UI with a physician	Received UI treatment
Falls Risk Prevention	Rate 1: All age 75 & over, age 65-74 w/problem Rate 2: Age 65+ w/problem	Discussed falls risk with physician	Received falls intervention
Osteoporosis Testing	All women age 65 and over	Ever had a bone density test	

Study Sample

- **Eligibility criteria:**
  - **Non-institutionalized, non-proxy respondent, elderly 65+ years**
  - **Returned usable baseline or follow-up English-language survey in 2006 (≥80% survey completed)**
  - **Did not indicate they wanted to be removed from list of surveyed individuals**
  - **N=110,238**
- **Data on care received in past 12 months since survey in spring 2006**
- **Both baseline and follow-up samples used**

Vulnerability Status

- **Combination of 3 self-reported traits:**
  - **Race (black // white)**
  - **Education level (≤high school grad but no college // at least some college)**
  - **Perceived health (excellent, very good, good // fair, poor)**
- **Prefer convergence of factors, instead of studying individual factors separately: better captures reality, large dataset**

Final Vulnerability Status Measure

Fewer vulnerability characteristics

More vulnerability characteristics

Vulnerability Characteristics		
Race	Education	Perceived Health
White	Some college+	Good Poor
	HS grad or less	Good Poor
Black	Some college+	Good Poor
	HS grad or less	Good Poor

Vulnerability Group Differences

Vulnerability Status	Discuss Physical Activity	Advise Physical Activity	Discuss UI	Treated for UI	Osteo Test	Discuss Falls Risk	Treat Falls risk
% of Overall Elderly Who Received Care	52%	45%	55%	35%	69%	23%	51%
White – High Educ							
Good health	–	–		–	–	–	–
Poor health	–	–	–	–	–	++	++
Black – High Educ							
Good health	–			–	–	–	
Poor health	–	++	+	–	–	++	++
White – Low Educ							
Good health	+	+			++	–	–
Poor health	++	+	+		+	++	++
Black – Low Educ							
Good health	+	+	+	+	–	–	–
Poor health	+	++	++	+	–	++	++

+ Denotes modest difference (3-6% points) favoring vulnerability status group.
++ Denotes larger difference (>6% points) favoring vulnerability status group.
– Denotes any size difference favoring overall group of elderly.

Main Findings: Preventive Counseling and Care Associated With Vulnerability Traits

- **Low education:**
  - **Physical activity discussion & advice, UI discussion and treatment, Osteoporosis testing**
- **Poor health**
  - **Physical activity advice, UI discussion and treatment, falls risk discussion and treatment**
- **Race:**
  - **Blacks more likely to get advice on physical activity**
  - **White more likely to have osteoporosis testing**

Conclusions

- **Differences in vulnerability status associated with preventive care**
- **Combination of all 3 vulnerability traits NOT worst off. In fact, low education & poor health generally 'best off' in receiving preventive counseling or treatment**
- **Convergence of certain vulnerability traits does matter**

Implications for Policy and Practice

- **Good news! Physicians are targeting counseling to patients perceived to be at higher risk**
- **Opportunities for improvement need to focus on making discussion of risks part of conversations of all patients**